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DEVELOPMENT OF GUIDELINES FOR POST ABORTION CARE MANAGEMENT AT SELECTED HOSPITALS OF KWAZULU-NATAL PROVINCE, SOUTH AFRICA

BY

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DOCTOR OF PHILOSOPHY (PHDH)

UNIVERSITY OF VENDA

AUGUST 2019

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Development of Guidelines for Post Abortion Care Management at Selected Hospitals of KwaZulu-Natal Province, South Africa

By
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THESIS SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE:

Doctor of Philosophy

In the

School of Health Sciences

University of Venda

Promoter	**Co-Promoter**
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AUGUST 2019

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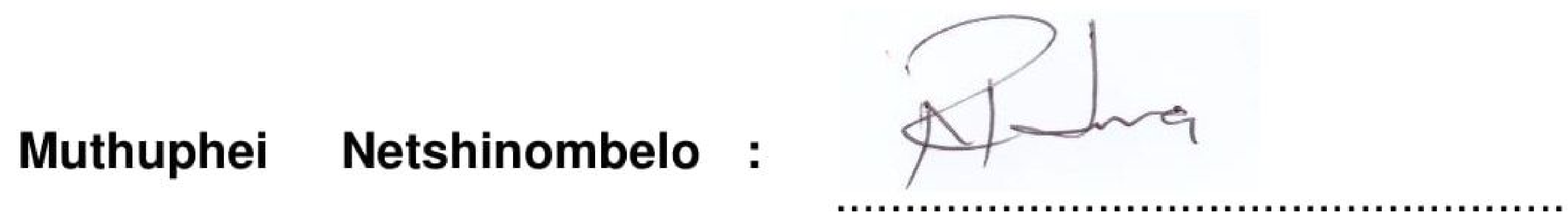
DECLARATION

I, **Muthuphei Netshinombelo**, **(11576212),** declare that the proposal entitled **"Development of Guidelines for Post Abortion Care Management at Selected Hospitals of KwaZulu-Natal Province, South Africa"** hereby submitted for the degree **Doctor of Philosophy in Public Health** at the **University of Venda**. The thesis is my work and has not been submitted previously for any other degree in any other institution. The sources that I have quoted have been indicated and acknowledged by means of complete references.



Muthuphei Netshinombelo : ....

Date Signed : 28-08-2019 ....

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DEDICATION

I dedicate this work to my family and friends for pushing me towards the finishing line

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ACKNOWLEDGEMENTS

I would like to express my warm thanks to the following individuals.

- Professor MS Maputle, my promoter, for her support and wisdom in guiding me through my thesis project.
- Professor DU Ramathuba, as a co-promoter, a special thank you for her advice and encouragement.
- A special thanks to Professor Nancy Eik-Nes, for editing assistance. I am so greatful for her patience, mentorship, and dedication to seeing my small idea grow into something tremendous.
- I would like to express my thanks to University of Venda for helping me fund the project
- My brother, Ramsey Netshinombelo for helping me to navigate graduate school.
- My mother Ms Cathrine Ramuhashi for being a true source of motivation.
- I would also like to thank my fellow student for giving support in hard times, Mrs T Mugivhi.
- Lastly, I would like to thank my family, friends, respondents and Department of Health KZN MCWH staff for their constant support and endless engagement.

- It has been quite a journey!

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Abstract

Background: Despite measures to curb unwanted pregnancies and to sustain and expand abortion services, a high number of complications and deaths still occur. The failure of these measures is evidenced by the high number of women who are admitted to the public hospitals of KwaZulu-Natal Province with complications from induced abortions. KwaZulu-Natal Department of Health has repositioned Family Planning to a key priority in its health program in order to improve the situation for women. However, in order to improve the situation, it is necessary to understand the underlying causes.

This study sought to identify challenges that affect women's access to Post Abortion Care (PAC) services in KwaZulu-Natal Province, South Africa. It also sought to shed light on the challenges faced by those who render PAC services, as well as assess the skills of those workers as observed while they provided PAC services.

After conducting the research on challenges related to access and rendering of post abortion care services, the researcher identified a need to develop guidelines for management of unsafe and induced abortion complications, with the aim to improve the life expectancy of women and prevent maternal deaths. Therefore, an outcome of the study was the development of a PAC management guideline.

Purpose: The purpose of the study was two-fold:

Phase 1: to explore the challenges faced by women when accessing PAC, and the health care workers who render PAC services, and to assess the PAC skills of the health care workers;

Phase 2: to use the findings of Phase 1 to develop guidelines for post abortion care management at selected Hospitals of KwaZulu-Natal Province, South Africa.

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Methods: The design of the study was guided by the Andersen model of Health Care Utilization. The model focuses on the contextual factors – enabling factors, predisposing factors and need factors – that influence the individual's utilization of health care services.

Five districts of KwaZulu-Natal Province, South Africa were selected for the study.

A convergent parallel mixed method was used to collect and interpret the data. A qualitative study was used to explore perceptions and challenges of women when accessing PAC; this was carried out by means of in-depth interviews with 23 women who accessed PAC services. Five Focus Group Discussions (FGD) were carried out with 50 health care workers to explore the challenges they experienced when managing abortion complications. A quantitative approach was used for direct skills observation of 92 health care workers. Thematic analysis was used to analyse the qualitative data; descriptive statistics were used to analyse the quantitative data.

Results: From the in-depth interview data, several main themes were identified. Women who accessed PAC identified a lack of facilities that offered PAC service, distance from the community to the hospital that provided PAC service, lack of transport, shortage of staff, unskilled staff, shortage of equipment, long waiting queues, stigma and discrimination as challenges associated with delay or avoidance of access to post abortion care services.

The main themes raised by the health care providers were lack of support from the management, shortage of staff, lack of training, burnout, unavailability of the guidelines or protocols and shortage of equipment.

The quality of PAC services was perceived as poor by both the women seeking care and the health care workers. The main concerns raised by the women were lack of respect, lack of privacy, sharing of bed and insufficient time with the health care provider. The results confirmed that guidelines are needed for the management of post abortion care services.

The findings from the qualitative and quantitative parts of the study were used by an expert group to develop PAC management guidelines. The development of the guidelines was in accordance with the WHO models, PICOS & GRADES. The

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guidelines were validated by the group using a close-ended checklist, analysed with simple descriptive statistics.

Conclusion: This study concludes that access to comprehensive quality post abortion care must be provided for all women at times of need. Quality PAC services should be rendered by skilled health care workers in a facility which is accessible and well equipped with functional equipments and updated guidelines.

Recommendations: The study therefore recommends that measures should be taken to ensure the provision of quality PAC services. The PAC services should be accessible with the increased number of facilities, adequate trained health care workers with functional equipment and guidelines. Health care workers must receive training and management support to enhance quality PAC services. Privacy and respect must be maintained during provision of PAC services to ensure quality of care and increase demand.

There must be continuous community awareness about PAC services which will encourage early-seeking behavior, and reduce fear of stigma and discrimination by the providers of PAC services before the complications arises. This study did not cover all the districts to identify the challenges on delaying PAC service. Therefore, this study recommends additional clinical, operations and community research which will give broader details and understanding on the challenges that cause delay for seeking immediate post abortion care services.

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LIST OF ACRONYMS AND ABREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AGI	Alan Guttmacher Institute
APA	American Psychological Association
AGREE	Appraisal of Guidelines Research and Evaluation
CAC	Comprehensive Abortion Care
CCTT	Consortium Community Task Team
CPG	Clinical Practice Guidelines
CTOPA	Choice on Termination of Pregnancy Act
CTOP	Choice on Termination of Pregnancy
DCSTADM	District Clinical Specialist Team Advanced Midwives
D&E	Dilatation and Evacuation
DHIS	District Health Information System
DOH	Department of Health
EDL	Essential Drug List
FGD	Focus Group Discussion
FP	Family Planning
FY	Financial Year
GDG	Guideline Development Group
GIS	Geographic Information System
GOPD	Gynae Out Patient Department
GRADES	Evaluating and Completing the Evidence for a Decision Framework for Each Recommendation
HIV	Human Immune Deficiency Syndrome
HPCSA	Health Professional Council South Africa
HPCSA	Health Professional Council South Africa
ICA	Incomplete Abortion
IEC	Information Education Communication
IUCD	Intrauterine Contraceptive Device
ICDP	International Conference on Population and Development
IUD	Intra Uterine Device
IOM	International Organization for Migration
KZN	KwaZulu-Natal
KZNDHISP	KwaZulu Natal District Health Services Pivot Tables
KZNDoH	KwaZulu-Natal Department of Health
LARC	Long-acting Reversible Contraceptive
MA	Medical Abortion
MatCH	Maternal Adolescent and Child Health

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MCWH	Maternal Child and Women's Health
MCWH&N	Maternal, Child, Women's Health and Nutrition
MDG's	Millenium Developmental Goals
MMR	Maternal Mortality Rate
MVA	Manual Vacuum Aspiration
NCCMD	National Committee for Confidential Maternal Death
NCCMD	National Committee for Confidential Maternal Death
NDHIS	National District Health Information System
NRF	National Research Foundation
NSPCTOP	National Strategic Plan for Choice on Termination of Pregnancy
PAC	Post Abortion Care
PICOS	Problem/ Patient Intervention/Indicator Comparison Outcome
PMs	Permanent Methods
RHRU	Reproductive Health Research Unit
RN	Registered Nurse
SA	South Africa
SAMRC	South African Medical Research Council
SANC	South African Nursing Council
SANDoH	South Africa, the National Department of Health
SDG	Sustainable Development Goal
SMR	Saving Mothers Report
SOP	Standard Operational Guideline
SPSS	Statistical Package for Social Sciences
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
TL	Tubal Ligation
TOP	Termination of Pregnancy
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCEDW	United Nations Convention on the Elimination of All Forms of Discrimination against Women
UNDESAPD	United Nations Department of Economic and Social Affairs, Population Division
UNFPA	United Nation Population Fund
UNIVEN	University of Venda
WCG	Women Care Global
WHO	World Health Organisation
VCAT	Values Clarification and Attitudinal Transformation
VSC	Voluntary Surgical Contraceptives

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CHAPTER 1

Overview of the Study

1.1 Introduction

The results of unsafe abortion complications depend on the accessibility and quality of Post Abortion Care (PAC) guidelines and the capability of women to seek care (Rolnick and Vorhies, 2012:348). When comparing death due to pregnancy complications with death due to accidents and other illness, it has been shown that death and injury due to unsafe abortion can be entirely preventable if the health care workers can provide adequate care based on the PAC management guidelines (Lopoo and Raissian, 2012:907).

According to (Adinma, 2012:151), PAC is a package of services offered to women after incomplete abortion due to spontaneous or induced abortion. When the guidelines are implemented for the provision of quality PAC to women and young girls, we can significantly reduce maternal death due to poor management of PAC (WHO, 2011:18). Post abortion care guidelines for management of unsafe and induced abortion complications could improve the life expectancy of women and present a significant path for preventing maternal deaths. Despite different interventions to curb unwanted pregnancies and repositioning of Family Planning (FP) as a key priority in health program in KwaZulu Natal (KZN), women are still admitted with induced abortion complications (KZN DoH, 2017).

Globally, maternal mortality and morbidity due to complications of unsafe abortions have increasingly taken a high toll (Haddad and Nawal, 2009:124). Furthermore, induced or spontaneous abortions result in complications (Alan Guttmacher Institute, 2012:78). The complications occurring after unsafe abortions are regarded as one of the main cause of maternal mortality and morbidity worldwide (Shah and Ahman, 2009:1148). Statistics indicate that the 22 million unsafe abortions seen globally

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result in 47,000 abortion-related deaths, 5 million women are disabled annually (WHO, 2012:20), and about 220,000 children are left motherless (WHO, 2012:19).

According to WHO (2011:28), Sub-Saharan Africa is the most affected region by risk of death due to unsafe abortion, with about 90 maternal deaths per 100,000 births compared to the least developed country in the world at 80 per 100, 000 lives birth. In South Africa, there is high number of mortality resulting from complications of unsafe abortion and poor PAC management (40 deaths per 100,000), and the epidemic is expected to rise (WHO, 2011:28). Due to the stigma and sensitivity around abortions, it is difficult to gather accurate data; however this number could be higher than what is being recorded. The epidemic around sub-standard post abortion care brings about changes in the demographic structure of households, a heavy toll on resources and assets, and an impact on economic activities.

The International Conference on Population and Development (ICPD), (2004:67) has helped many countries for the past decades in addressing the public health issues surrounding unsafe abortion, including awareness campaigns, identification of priority areas of intervention, prevention of unsafe abortion through provision of family planning information, safe PAC services, and training of health workers. Meyers (2010:57) stated that organizing and managing safe and legal abortion care must be implemented, regardless of whether it is in the public sector or the private sector. This health systems approach means carefully developing abortion and PAC guidelines, planning and managing policies, developing training programs, efficient and accessible services (WHO, 2012:64). However PAC is regarded as the main strategy for managing the complications of incomplete or induced abortion (Adinma et al., 2012:172). In some cases, a health systems approach may involve establishing pilot or small-scale services first, then assessing lessons learned and following up on plans to scale-up quality abortion services in order to increase access for PAC for women and young girls living in under-resourced areas.

There is much to learn about how best to provide PAC services to women. There is limited focus on the implementation of effective five essential components of PAC to ensure that high quality PAC is available whenever or wherever a woman seeks

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treatment for complications of abortions (Consortium Community Task Team, 2002:13).

Furthermore, essential components of PAC can be achieved through competency-based training, supportive supervision, monitoring, evaluation and other performance quality improvement processes (WHO, 2012:64). A systematic approach to policy and programme development is needed to achieve careful introduction of small scale improvement efforts, followed by scaling-up of successful interventions so as to benefit women and young girls (WHO, 2010:63). However, additional research to explore this phenomenon is important. Failure to implement the PAC guidelines effectively is a failure in combatting maternal mortality due to unsafe abortion complications. The overall goal of PAC guideline management is to reduce maternal morbidity and mortality due to abortion complications and increase life expectancy of women and young girls (Adinma et al., 2012:135). Therefore, this study seeks to develop post abortion care guidelines that can be useful in managing abortion at selected hospitals in KZN Province, South Africa.

1.2. Background of the Study

The term “Post Abortion Care (PAC)” was first uttered as a critical component of women’s health initiatives in 1991, as “the integration of post abortion care family planning services in health care system”. This was a way of preventing unwanted or unplanned pregnancies and improving the overall health status of women in the developing world (Ipas 1991:125). Subsequently, linking PAC with comprehensive reproductive health services was considered essential.

Post abortion care has five major elements, namely: (i) treatment and management of incomplete abortion and complications that are potentially life-threatening; (ii) counselling in order to identify and respond to women's emotional and physical health needs and other concerns; (iii) contraceptive and family planning services to help women prevent an unwanted pregnancy or practice fertility planning; (iv) reproductive and other health services that are preferably provided on-site or via referrals to other accessible facilities; (v) community and service provider

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partnerships to prevent complications of unwanted pregnancies, unsafe abortion, mobilization of resources to help women receive appropriate and timely care for complications from abortion, and ensuring that health services reflect and meet community expectations and needs (Corbett and Turner, 2010:65).

Globally, approximately 85 million pregnancies are unwanted annually (WHO: 2012:19). In the developing world, half of these unwanted pregnancies end in abortion (Sedgh, Singh, Shah, Ahman, Henshaw, Bankole, and Akinrinola 2012:379). Worldwide, it is estimated that 21.9 million unsafe abortions are performed and about 6.4 million unsafe abortions are performed in Africa (Sedgh et al, 2012:379; WHO, 2012:71).

Statistically, about 97% of abortions recorded in Africa are unsafe, thereby making it the continent with highest unsafe abortion rate in the world. In the year 2009, statistics on total legal abortion in South Africa was about 43 000, with over 5000 (12%) abortions recorded for young women under the age of 20; 30 000 (66%) between 20 – 30 years and over 9 000 (22%) were over 30 years; 4 620 (11%) of the total abortions were performed in the Province of KZN.

A contributing factor to the high incidence, is that abortion laws of many countries are restrictive, leaving women no choice other than to procure unsafe abortion (Grimes, Benson, Singh, Romero, Ganatra, Okonofua and Shah, 2006: 41). Data from DHIS show high incidence in number of septic and incomplete abortions. In the year 2016, 391 women were admitted due to septic abortion and 10 078 were admitted due to incomplete abortions. In the year 2018, 1455 women were admitted due to septic abortion and 12031 were admitted due to incomplete abortion, In addition, access to and use of contraceptive methods is limited, and the low status of women prevents them from making independent decisions on their own sexual and reproductive health (Berer 2004:8).

The WHO (2012:64), defines abortion as the termination of a pregnancy, whether spontaneous or induced, before 22 weeks of gestation. Unsafe abortion is defined as any procedure with purpose of terminating a pregnancy by persons lacking the proper skills and/or is performed in an unhygienic, non-medical setting (WHO, 2012:23). To address the complications related to incomplete, spontaneous or

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unsafely-induced abortions, Post Abortion Care (PAC) needs to be introduced effectively. The National Contraceptives and Fertility Planning Policy and Service Delivery Guidelines of 2012, Choice on Termination of Pregnancy Act (CTOPA), no92 of 1996 and Choice on Termination of Pregnancy Amendment Act, no1, 2008, indicate that PAC is implemented in South Africa for treatment of incomplete abortion caused by spontaneous or induced abortion. In addition, the policy enables a variety of providers such as midwife/nurse, clinical officer, medical officer and gynaecologist to treat incomplete abortions.

The increasing death rate from abortions is believed to result from poor administration of post abortion care. Shortage of resources such as financial and human resources, infrastructures and equipment in the health care system are major contributing factors to poor PAC, especially in low-income countries. In terms of human resources, the strategic training and use of registered nurses in the provision of post abortion care has been identified to increase productivity and efficiency within the health care systems in providing quality post abortion care (Nabudere, Asiimwe and Mijumbi, 2011:173). Since the 1994 International Conference on Development and Population (ICDP) held in Cairo, the provision of PAC has been provided in South Africa, including KZN. To reduce maternal mortality related to abortion complications, the National Department of Health has increased access of contraceptives and scaled up the access to TOP services since 1996. However, the acceptability and perception of PAC among health care workers, women and young girls at the district level in KZN has not been adequately explored. Moreover, health care providers' need for training and the challenges they face in the provision of PAC needs to be better understood. PAC can then help to overcome the barriers on facility-level and better implement task sharing and, finally, improve quality PAC in KZN. Attending to the issue of unsafe abortion and PAC by developing guidelines to manage abortion complications is a crucial step towards decreasing the maternal mortality ratio in KZN, hence the study approach.

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Table1.1 Summary of the research approach

Study Phase	Method	Objectives	Respondence	Data collection	Data analysis
Phase 1	Qualitative enquiry	1. Explore perceptions of women who access post abortion care services and health care workers who provide PAC services 2. Explore the challenges experienced by health care professionals when managing abortion complications	women who access PAC services PAC providers	In-depth semi structured Interview Five Focus Group Discussion (FDG)	Tesch Open-coding method
	Quantitative study	3. Assess the hospitals and skills of health care workers providing post abortion care in in selected districts of KwaZulu Natal Province, South Africa.	Health care workers providing PAC services	Skills Observation tool	Statistical analysis, tables and graphs
Phase 2	PAC guidelines	4. Develop post abortion care management guidelines that will improve quality of care at selected hospitals in KwaZulu Natal Province, South Africa.	Data from nurses and doctors	PICO=Population, Intervention, Comparator and Outcomes & GRADE=Grading of recommendations, assessment, development and evaluation	WHO guidelines
	Quantitative methodology	5. Validate the developed post abortion complication guidelines	Managers, Doctors and Nurses	Criterion/merit checklist	Statistical analysis

1.2.1 Provision of PAC Programmes

Implementing PAC services is still an ongoing challenge in the developing world. There are environment challenges related to the implementation of PAC guidelines, including lack of supplies, equipment and drugs, as well as lack of supportive policies guidelines, treatment protocol, and training of health care workers, stigma, transportation and community referral system. Abortion is legalized in South Africa, including KZN province, but access is still limited and women are likely to develop abortion complications. The table below indicates that women in KZN still rely on self-induced abortion, rather than accessing Choice on Termination of Pregnancy

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(CTOP) from the trained health care workers (table 1.2). Furthermore, women who experience complications also face challenges in accessing post abortion care.

Table 1.2: Incomplete abortions versus septic abortions

	Districts	Incomplete abortions	Septic abortions
Urban	eThekwini	4 045	72
	uMgungundlovu	824	111
Rural	Harry Gwala	939	32
	uMzinyathi	753	22
	King Cetswayo	849	49

Source: KZN Districts Health Information System: 2017/18 Financial Year (FY)

Globally, authorities, and technical specialists have suggested a number of recommendations to improve and scale up post abortion care; these recommendations range from education to addressing stigma and providers, to developing medical guidelines on post abortion care and ensuring adequate and appropriate supplies and equipment. Without appropriate management guidelines, women will continue dying due to complications of unsafe abortions (WHO, 2012:97).

1.2.2 Causes of Induced Abortions

Barriers to accessing safe termination of pregnancy services include: limited number of trained and committed providers, limited number of online facilities, lack of provision of medical termination of pregnancy (MA) services, lack of surgical abortion (SA) consumables, negative attitude of some public health servants towards abortion (Haddad et al., 2009:124).

It is disappointing that over 25 years after the promulgation of the Choice of Termination of Pregnancy Act, introduced in 1996, there are still women being

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maimed and dying as a result of illegal and unsafe termination of pregnancies (Alan Guttmacher Institute, 2012:124).

It is deemed alarming that these illegal abortion providers are seen using poor people on the street corners to distribute their pamphlets and hanging up wall posters against city bylaws. The proliferation of these advertisements without any action being taken, in spite of the fact that they are breaking many laws, make many women believe they are accessing a legitimate service (Haddad and Nour, 20019:126). Women finding themselves in desperate situations with unwanted pregnancy and who see walls and lampposts plastered with advertisements claiming to offer 'safe', 'pain free', 'quick', and 'cheap' abortion believe they are accessing a legitimate service. Consequently, the women in this situation have little recourse and often turn to illegal abortion through ‘lamppost’ providers, referring to unlicensed abortion providers.

1.2.3 Incomplete Abortions (ICA’s)

As per the Saving Mothers 2011-2013 Sixth Report on the Confidential Enquiries into Maternal Deaths in South Africa, 61.6% of maternal deaths were due to septic abortions (Department of Health:2014). The extent to which the unscrupulous termination of pregnancy providers market their mushrooming services at the expense of the vulnerable women and girls, and thereafter expose them to unsafe termination of pregnancy which results in the huge number of women in public health services admitted with incomplete termination of pregnancy (ICA), is alarming. Increased number of ICAs leads to concomitant escalation of both the Maternal Mortality Rate (MMR) and Maternal Morbidity Rate. The Provincial Department of Health’s Maternal, Child, Women’s Health and Nutrition (MCWH&N) has tried to avert the unscrupulous providers; however, their services continue to increase.

South Africa has had a liberal CTOP law since 1996; however, 30% of South Africans are unaware of the liberalized law and the gestational age limits permitted in 2006. Fifty (50%) of terminations of pregnancy still occur outside designated health care facilities and only 7% of government designated facilities provide termination of

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pregnancy services. Furthermore, only a limited number of facilities offer second trimester termination of pregnancy (3) in KZN Province.

1.2.4 Maternal Mortality Associated with Abortion Complications

Induced abortions are a common problem, and remain one of the most common causes of death amongst women in KZN Province. Induced abortion is also a common reason for admission to female/gynaecology wards in hospitals. Many women bleed to death in hospitals; sub-standard care unsafe/illegal TOPs is the major contributor**.** In addition to the problem of mortality, the morbidity of these patients uses up significant resources due to long hospital stays and need for frequent blood transfusions. There is limited capacity in KZN for definitive management of post abortion care services (KZNDHIS, 2017).

Estimated maternal mortality related to self-induction still remains a big challenge due to illegality and stigmatization of abortion. Available data shows that in the 2016/17 Financial Year (FY), 261 early pregnancy deaths (37%) were reported (DHIS: 2016/17Fy). During the same period, data analysis of causes of early pregnancy death showed that 24% followed unsafe abortions, followed by 5% of 2nd trimester legal TOP complications of women who were admitted in the wards (KZNDHIS, 2017). In some settings, reducing unsafe abortions may be technically the easiest way to reduce maternal deaths as mandated by Sustainable Developmental Goal (SDG) 3. Unsafe abortion can be reduced through comprehensive sexual and reproductive health education, and high quality contraceptives services.

1.2.5 The Impact of Sub-standard PAC that Leads to Maternal Mortality on Families

When women die due to abortion complications, the event is emotionally distressing for the family. Parenting a baby without a mother is particularly stressful because each child needs a mother when growing up. Higher rates of psychological stress,

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depression, marital problems, and stressful daily life have been linked with maternal mortality. For underdeveloped countries, these stressors are multiplied due to limited resources, poverty, the absence of health insurance, and limited health facilities, particularly PAC clinics (Wisanskoonwong, Fahy and Hastie: 2012:6).

1.2.6 The Impact of Poor PAC on Health

The incidence of hospitalization is higher for those who are admitted with abortion complications than for those who come to request CTOP. The highest rate of hospitalization is associated with septic abortions. Women with septic abortions also have high rates of severe complications including Total Abdominal Hysterectomy (TAH). These women may also have physical and psychological distress. They can experience depression and poor socialization development because of lack of proper counselling (Wisanskoonwong, Fahy and Hastie, 2012:6). According to PAC framework, proper pre- and post-counselling should be done to identify and respond to women's emotional and physical health needs and other concerns. The implications of women who have not received proper PAC services after induced abortion face greater risks of serious health problems, including mental disorders, and isolation. This added dimension of lifelong depression exacts a high toll on individuals, their families and the communities in which they live (Blencowe et al., 2012:9).

1.2.7 Resources versus Quality Care Improve PAC

According to a WHO (2012:19) global report, lack of resources such as skilled PAC health care workers, few health facilities with limited equipment in rural areas and long travelling distances, many women – especially in low socio-economic states like South East Asia and African continent – are not receiving quality PAC services, and contraceptives are believed to play a great role in preventing unwanted pregnancies. Neglecting the role of contraceptives in such countries resulted in increases in unwanted pregnancies that lead to induced abortions (Blencowe et al., 2012:45).

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European countries are considered safest in the world in which the incidence of induced abortion is 2%, with death due to unsafe abortion at 0%. However, there are wide disparities in induced abortion for Asia at 49% and 36% death due to unsafe abortion; 62% of women who have abortion in remote and rural areas of Africa die annually due to unsafe abortion compared to other countries (Kildea et al. 2010:2). This area is characterized by poverty, increased burden of disease, unemployment, poor housing and reduced access to sexual and reproductive health services. Due to fewer resources, women from Africa experience a problem of unwanted pregnancies and end up with induced abortion like other poor countries. Therefore, there is a relationship between resources and saving lives of women after induced abortion with quality PAC services (Kildea et al., 2010: 2). According to the framework for PAC essential care, it is recommended that contraceptives and family planning services should be given to women of reproductive age to prevent an unwanted pregnancy or practice birth spacing.

The KwaZulu-Natal Department of Health also recognized the need for SRH and FP interventions to curb the high rates of the HIV/AIDS epidemic and to contribute to increasing life expectancy in the province and in South Africa. The province is therefore repositioning Family Planning as a key priority in its health program. It has recently commissioned the KZN Five-Point Contraceptive Strategy (FPCS), which was developed with UNFPA and MatCH. The Provincial Contraceptive Strategy is designed to guide Programmes across the KZN health services and other sectors in order to: revitalize interest in the utilization of the contraceptive program to increase awareness about and use of contraceptive services; assist women to time and space their pregnancies; reduce teenage pregnancies and unplanned and unwanted pregnancies, including among HIV positive women; increase contraceptive prevalence and improve contraceptive service delivery. One of the recommendations of the FP is to promote integration of contraceptive services into all service delivery points in order to maximize opportunities for access to contraception through appropriate services.

Despite efforts from the KZN PDOH to strengthen these services, the provision and uptake of FP in KZN continues to be low. The province is taking measures to reverse the situation. In 2012, NDoH released National Contraceptive and Fertility

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Guidelines. KZNDOH, in collaboration with other stakeholders, contracted to ascertain the situation of FP provision in hospital settings in KZN; and build the capacity of 100 service providers from KZN on IUCD insertion and removal and other FP methods. The purpose of these activities is to promote integration of contraception services into Reproductive Health and HIV services in order to maximize consistent and comprehensive delivery of FP services.

1.3 Problem Statement

A review of literature has indicated that there are no guidelines on post abortion care in South Africa. Globally, only two guidelines were found (High Impact Practices in Family Planning (HIP), 2012). This lack of guidelines is linked to sub-standard access to PAC services in health care institutions. The 2011-2013 National District Health Information System (NDHIS) recorded a total of 4 452 maternal deaths, of which 114 women were reported dead due to septic miscarriage, while 9 died after adopting legal CTOP. The National Committee for Confidential Maternal Death (NCCMD), 2011-2013:13) reported on the Saving Mothers Report (SMR) that the highest number of maternal deaths were documented in KwaZulu-Natal, 964, followed by Gauteng, 849, and Limpopo, 750.

The KZN DHIS reported that 35 women died during the same period due to septic abortion and 3 died after accessing legal TOP. One of the hospitals in King Cetswayo district reported 42 maternal deaths in 2017/18 Financial Year and of these, 16 died due to septic abortion (DHIS, 2017/18). Also, between 2013 and 2018, KZN DHIS reported 67,430 Incomplete Abortions (ICA) and 97,106 legal abortions from private and public facilities.

About 77% of the abortions treated in the public health system are self-induced (Mbonye, Asimwe, Kabarangira, Nanda & Orinda, 2007:220). Additionally, unsafe abortions account for almost 40% of admissions to emergency obstetrics care units, and they are responsible for significant morbidity and mortality among women in KwaZulu Natal District Health Services Pivot Tables (KZNDHISP) for financial year 2017/18. As indicated, the literature reviews reveal no guidelines on PAC in South

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Africa and in KZN. It is against this background that the researcher sought to develop guidelines for post abortion care management at selected hospitals in KwaZulu Natal Province, South Africa. These guidelines will subsequently be used to improve the quality of PAC and reduce maternal morbidity and mortality.

1.4 Purpose of the Study

The main purpose of the study is to develop guidelines for post abortion care management at selected hospitals in KwaZulu Natal Province, South Africa.

1.5 Objectives of the Study

The objectives that guided the study were divided into two phases:

1.5.1 Phase 1

- To explore perceptions of women who access post abortion care services.
- To explore the challenges experienced by health care professionals when managing abortion complications
- To assess the skills of health care workers providing post abortion care in selected districts of KwaZulu Natal Province, South Africa.

1.5.2 Phase 2

- To develop post abortion care management guidelines that will improve the quality of care at selected hospitals in KwaZulu-Natal Province, South Africa.
- To validate the developed post abortion complication guidelines.

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1.6 The Research Questions

The following questions guide the study:

- What are the perceptions of women who have accessed post abortion care service?
- What are the challenges experienced by the health care workers when providing post abortion care services?
- How can the data obtained be used to develop the management guidelines to improve and scale up quality post abortion care in KwaZulu-Natal Province, South Africa?

1.7 Significance of the Study

The researcher believes that the findings of the study may assist in improving and scaling up quality post abortion care. It is also assumed that implementation of the developed guidelines may contribute to reducing maternal mortality. The researcher also anticipates that this study may contribute to achieving Sustainable Development Goal (SDG) 3 that focuses on "ensuring healthy lives and promote well-being for all ages".

This responds to the SDG target that ensures universal health coverage and access to essential quality services and post abortion care and reduces preventable maternal mortality from abortion complications by 2030 by a third (The National Development Plan 2030 goals).

According to the National and Contraception and Family Planning Policy, 2012, deaths due to abortion complications can be avoided if women are given quality post abortion care including contraceptives. A study conducted by Okonofua, (2006:321), stated that deaths can be prevented if the women who suffered from abortion complications have knowledge about seeking help as soon as possible and receive

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quality care by trained health care providers when they reach the facility. Therefore, understanding challenges that women come across with when accessing PAC is very important. The knowledge about the challenges and skills of the health care providers when offering PAC can be used in improving the provision of PAC services in the province.

The need to comprehend the features of the women utilizing PAC in KZN is three-fold. Primary are individual factors such as age, marital status, parity; second are community factors signifying their perceptions. Lastly are community care system factors such as health care workers' competency and attitude (Anderson Model, 1995). Therefore, it is of importance to understand these features and how they can affect PAC services.

Kidder et al., (2004:11) reported that spontaneous or induced abortion is the issue for all women of child bearing age; however the consequences differ per individual between the groups of women in terms of their age or socio economic status. Groups of women may have some distinctive and particular challenges in assessing PAC services (WHO, 2013:67). Therefore, obtaining information on the characteristics of the women who access PAC services can be used to target women in need of PAC services. It can assist in developing the strategies to identify women in need of PAC services. Largely, rendering quality health care services guarantees the continuum of care.

Therefore, the assessment of the quality of health care providers' skills should be taken into consideration (Shaikh, 2005:241). Research on the challenges of the users of PAC services on quality of PAC is of importance in KZN. This can aid in providing the input in policy making and also addressing the challenges in using the service.

Health care workers play an important role in the provision of PAC services in KZN. Therefore, it is important to understand their challenges in provision of PAC services. Providers' challenges may have an influential impact on health-seeking behavior of the health care users. The providers with poor skills or inadequate knowledge related to PAC services may lead to women receiving poor quality services, may delay care seeking that again may lead to complications (Melkamu et al., 2010:241). The study

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findings should add to the existing body of knowledge on challenges experienced by women and health care workers on post abortion care. In addition, it is hoped that the study may provide the following:

- Guidance to provision of quality management of post abortion care;
- Expansion of emergency post abortion care, in other words increasing safety of women and young girls in seeking early post abortion care service;
- Closing the gap between health system capacity and service needed;
- Improvement of the full continuum of care required to treat and manage the range of complications which may result from an abortion.
- Guidance for educators to teach nurses various ways of reducing the impact of poor management of post abortion care;
- Improvement of standard of care for management of post abortion care through developing guidelines which aim to address challenges faced by women and health care workers in providing post abortion care;
- Offer guidance for policy makers when formulating health policies for health care workers for post abortion care;

The guidelines developed for post abortion care management could be applied in hospitals across the country and in those of other developing countries with modification to suit each organizational setting.

1.8 Theoretical Framework Influences

The researcher integrated the Anderson Model in this study. The Anderson Model components are associated with requirements to guide the health care workers in ensuring that quality PAC is provided. Choosing these frameworks was based on the literature review. The research revealed that there are three main categories of the Anderson model that are associated with the utilization of PAC services and these

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factors are interrelated. The categories are enabling factors, need factors and predisposing factors (figure 1.1)

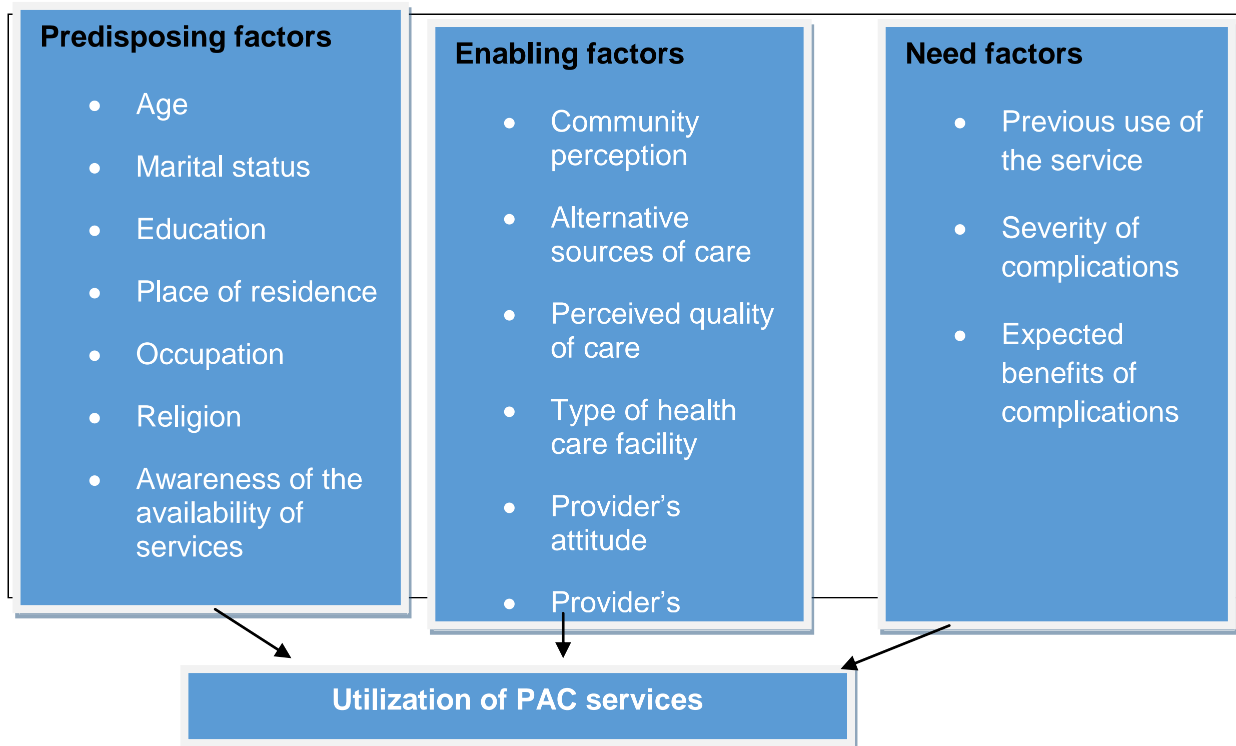

Figure 1.1: Anderson Model (Anderson: 1995)

The framework consists of three factors: enabling factors, predisposing factors, and need factors. The factors in Anderson's model as related to PAC are clarified as follows:

1. **Enabling factors -** enabling resources to include individual family, health care attitudes and the community in which the women live. Availability of the PAC services and the health care facility setting as well as the delivery of care available.

2. **Predisposing factors -** individuals' use of PAC health services is a function of their predisposition to use services, factors which enable or prevent use, and their need for care. Predisposing characteristics, enabling resources, and

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all contribute to individuals' use of healthcare (Anderson, 1995). Predisposing factors include demographics such as age, gender, religion, education, social structure and beliefs about the health and the medical industry.

3. **Needs factors -** this includes previous use of the service by the women and that encourages them to further seek the service, especially if they were treated well previously. It encourages women to continue seeking care before complications arise. Some women are encouraged or take the decision to seek PAC services based on their previous experience and recognizing that it was a benefit to them. Without the knowledge of PAC benefits, they tend to be reluctant to utilize PAC services.

Availability, type of health facility and quality of care rendered would encourage women to seek PAC services promptly before they have complications. Women's choices regarding seeking PAC would also be directed by competency of the health care workers regarding rendering quality PAC services. Also, the community perception and the family knowledge, beliefs and cultural background play a role on women's behavior regarding the utilization of PAC services. Health care workers' competency and attitude towards provision of PAC service also play a major role in women's utilizing PAC services.

Predisposing factors involve social structure, health beliefs and demographics of an individual that predispose them in seeking PAC services. Educational levels assist individuals in decision-making and care to which they choose to access the health services. Age also plays a role in decision making of an individual in seeking health services.

In this study, seeking PAC service was an individual behavior based on a number of inter-related factors (Berger, 2011:73). Individual, community or health care system factors could be barriers for the individual to seek PAC, but they could also encourage an individual to seek care. The researcher was to comprehensively analyze the study using factors influencing utilization of the PAC model focusing on challenges experienced by the health care workers and women during PAC services.

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Again, the conceptual framework is based in the belief that community perception influences individuals in accessing continuous care that includes five essential elements of PAC services (WHO, 2012:37).

Following abortion, the competent health care provider must be able to identify and respond to women's emotional, health and physical needs as well as other concerns. Health care facilities must have advanced medical abortion technology. Recent trends show that some clinicians offer quality care that contributes to significant alteration in human biological functioning and hold great promise for expanding women's reproductive health options (Berger, 2009:22). The utilization of PAC services must ensure that women are offered full counselling that can guide them in making future decisions about their future pregnancies. The women must have alternative sources of care that are easily accessible and they must not depend on unscrupulous doctors for termination of pregnancy. The nurse's moral integrity and attitude may affect the treatment given to women requesting PAC services, (Walker, et al., 2004).

In this study, utilization of a PAC model was used where individual; community and health care systems play an important role in influencing whether or not an individual with abortion complications makes use of PAC health services. The utilization of the PAC model was used to identify challenges encountered by health care workers and women during PAC care and act as a support system in provision of PAC services. The theory was used in this study for supporting and sustainability of PAC services as it was stated that PAC service is needed to prevent maternal mortality.

1.9 Definition of Concepts

For the purposes of this study, the following definitions were used for the terms in the research:

1.9.1 Abortion

Abortion may be defined as the intentional ending of pregnancy through evacuation of the uterus before the fetus has a reasonable chance of survival (Thapa and

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Sharma, 2014:270). In this study abortion refers to expulsion or removal of the products of conception from the uterus before the gestational age of 22 weeks.

1.9.2 Abortion Complications

Abortion complications are defined as the after effect that takes place after abortion regardless of whether an abortion is spontaneous or induced or whether the abortion is safe or unsafe (Harris & Grossman, 2011:79). In this study, abortion complications are any sign of complications that a woman presents with after having any type of abortion.

1.9.3 Post Abortion Care

Post abortion care is a strategic plan, which encouraged "the integration of post abortion care and family planning services in health care systems" as a means of breaking the cycle of repeated unwanted pregnancy and improving the overall health status of women in the developing world (Levels & Sluiter, 2014:104). In this study, post abortion care means care that is given to a woman after having induced abortion or spontaneous abortion before 22 weeks of gestational age.

1.9.4 Health Care Worker

Drabo (2013:431) defines health workers as all people engaged in the promotion, protection or improvement of the health of the population. In this study, health care workers refer to any professional who participate in direct clinical patient care.

1.9.5 Abortion Guidelines

The Royal College of Obstetricians and Gynaecologists (2010:29) defined abortion guidelines as systematically developed statements which assist clinicians and patients in making decisions about appropriate treatment for specific conditions.

In this study, abortion guidelines are a guide that promotes a consistent standard of post abortion care regardless of the facility in which an individual woman is managed.

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1.10 Ethical Considerations

Ethical clearance to conduct the study was obtained from the University of Venda - Research Ethics Committee. The permission to access the health facilities was obtained from KwaZulu-Natal Department of Health. Informed consent was obtained from the respondents. Confidentiality and voluntary participation was explained to the respondents and they were informed that they can withdraw at any given time if they feel uncomfortable or threatened, without punishment or victimization. Find details in Chapter 3.

1.11 Organization of the Thesis

1.11.1 Chapter 1: Overview of the Study

Chapter one comprises the overview, introduction and background of the study. It provides the relationship between abortion, maternal mortality and the need for PAC services. The chapter also covers the problem statement, purpose of the study, the research objectives, and research questions, significance of the study, scope of the study, conceptual framework, the definition of concepts and the research approach.

1.11.2 Chapter 2: Literature Review

This chapter covers the literature review which includes: The Choice on Termination of Pregnancy Act 92 of 1996 and the Amendment Act no.1 2008, circumstances and options for post abortion care, clinical care of women undergoing abortion, the concept of post abortion care – its origin and definition, post abortion care in South Africa, consequences of unsafe abortion, training of health care workers, roles and knowledge of health care workers in provision of quality post abortion care, perception of post abortion care by health care workers, factors affecting women's access to TOP availability services, perceptions of women who has access abortion and existing Guidelines/Strategic plans to promote quality post abortion care.

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1.11.3 Chapter 3: Research Design and Methodology for Phase 1

Chapter 3 presents and describes the research methodology employed in this study for Phase 1 of the study, which comprises a qualitative and a quantitative part. It includes the study design and the justification for the choice. Secondly it describes sampling procedure, study population and the sample size. The chapter then describes the data collection tool, methods used for data analysis.

1.11.4 Chapter 4: Results and Discussion of Phase 1

This chapter presents the findings of the study. The chapter also identifies and discusses the challenges faced by women when accessing PAC services, and the challenges and skills of the health care workers who provide PAC service..

1.11.5 Chapter 5: Development of Management of PAC Guidelines

This chapter covers the development of the management guidelines for PAC care givers. It starts with considerations including who should take part, and how the guidelines should be developed. The resulting guidelines are presented along with a section that describes the validation of the guidelines.

1.11.6 Chapter 6: Recommendations, Conclusions and Limitations of the study

The final chapter provides a critical discussion of the major findings that emerged based on the objectives, recommendations and conclusion, and recommendations for further research. The chapter ends with the summary and conclusion and limitation of the study.

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1.12 Summary

This chapter covers the overview of the study, background problem statement, purpose, research objectives, research questions, significance of the study, theoretical framework influences, definition of the terms research design, summary of research approach and organization of chapters.

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CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The previous chapter presented the overview of the study, background, problem statement, objectives of the study, theoretical frame work and organization of the thesis. This chapter covers a literature review, which focuses much more specifically on sources in the literature that are related to challenges affecting health care workers when rendering post abortion care, and women who have accessed post abortion care. As recognized earlier, research on the post abortion care management is limited; however, relevant literature was retrieved from databases, scientific articles, books, reports, guidelines and organizations. Gray (2013:709), defined a literature review as analyzing and synthesizing sources to come up with the picture of what is known and not known about the situation. One of the key issues of concern has been the lack of guidelines on post abortion care management for the health care workers. To focus on this knowledge gap, the current literature review aims to provide a comprehensive landscape of current thinking and existing research evidence, to determine points of view in the study area

According to the NCCMD (2011-2013), KZN has the highest burden of maternal death due to unsafe abortion in South Africa. In addressing this threat issue, SA focused its attention on addressing the poor post abortion care by legalising abortion in 1996. The SA government has a strong commitment to increasing the life expectancy of women (NCCMD, 2011-2013:9). Health care workers are the forefront of ensuring that these aspirations are met which, among other complexites, puts great demands on their roles as caregivers.

This section presents existing relevant literature on the following aspects:

- Demographic Size and Composition
- Sexual and Reproductive Health State

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- Context of Abortion in South Africa
- The Choice on Termination of pregnancy Act 92 of 1996 and the Amendment Act no.1 2008;
- Termination of Pregnancy in KwaZulu-Natal
- Circumstances and options for post abortion care
- Clinical care of women undergoing abortion
- The concept of post abortion care – origin and definition
- Post abortion care in South Africa
- Consequences of unsafe abortion
- Training of health care workers
- Roles and knowledge of health care workers in provision of quality post abortion care
- Perception of post abortion care by health care workers
- Factors affecting women's access to TOP availability services
- Perceptions of women who have accessed abortion
- Existing Guidelines/Strategic plans to promote quality post abortion care.

2.2 Demographic Size and Composition

KwaZulu-Natal province is the second most populated province in South Africa out of eleven provinces. The province comprises one metropolitan area, ten districts, fifty-one municipalities and eight hundred and twenty-eight wards. The 2016 SA statistics estimates that a total population of 11.1 million, which translates to 19.8% of the national population, resides in KZN; the annual growth rate is approximately 3.08%. About 58% of the populations are females while 42% are males. KZN population is

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divided into four racial groups, namely: Africans, Coloured, Indians and Whites. The majority of the population of KZN is dominated by Africans, who constitute 87.2%, followed by Indians, at 7.2%, Whites, at 4.2%, and Coloured, at 1.4% per cent. Approximately 54% of the population resides in the rural area and 46% live in the urban area. An estimated 34.8% of population is estimated to be less than 14 years, whereas 36.7% are the youth between 15-34 years. Only 28.5% are estimated to be adult from 35 and above. Women of reproduction age (15-45) constitute 45.6% (SA stat, 2016).

2.3 Sexual and Reproductive Health State

In South Africa, a survey conducted by Shisana, Rehle, Simbayi et al., (2014:143) revealed that adolescents continue to be vulnerable with the HIV prevalence of 7.3% for 15-25 year-olds. The same survey once more revealed that 19.2% of females aged 12-19 years had had at least one pregnancy, the majority of which were unplanned and unwanted pregnancies; meanwhile, the same age group of males had impregnated a girl. In terms of condom use, there was a massive drop from 85.2% to 49.8%. The IOM and UNAIDS, (2003) reported that 39.5% of females tested HIV positive, twice the national prevalence in South Africa. In the same study, HIV prevalence was significantly higher among females (40.7%) than males (30.9%). The province has reported the highest HIV prevalence rate amongst pregnant women with the prevalence rate of 40%. KZN projected to have the maternal mortality of 165 deaths per 1,000 in 2017. According to MoHSW et al., (2015), KZN failed to achieve the fifth millennium development goal which aimed at reducing the maternal mortality rate by two thirds by 2015.

The District Health Information system in 2017 indicated that KZN has a high fertility rate, 3.0, compared to national rates of 2.65. It is estimated that 17.6% of all pregnancies are unintended. The couple year protection rate is 46.5% and the unmet need for contraceptives is 46% among women of reproductive age. Social grants and low contraceptive use are the major contributing factors to the high fertility rate in KZN.

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The use of Long Acting Reversible Contraceptives (LARC's) is low (18%) amongst women of reproductive age, despite the intensive training of the health care workers and providing widespread information to the community (Fleming, 2009:86). LARC method is a recommended method because it is regarded as a high effective contraceptive which is easily reversible and it does not rely on compliances and correct use as oral pills, (Fleming, 2009:88) Other reasons for the poor uptake of contraceptives reported by women include misconceptions, side effects and poor acceptance due to poor counselling by the health care providers. However, educated women are more likely to have information about the contraceptives compared to the uneducated women. There are institutional challenges in the KZN with regards to the provision of contraceptives to women. It was noted that there are some health care centers were women queue for hours to receive a contraceptive option. There is a cutoff point after certain hours such that women are turned back home and told to come the following day.

Because of difficult living circumstances, poor access to services, low wages and high levels of substance abuse, as well as many other challenges, most community members are very vulnerable to gender based violence. It is revealed in different forms such as physical, sexual, psychological and economic violence. A study conducted by Branford, (2012:213) showed that a large proportion of females had poor knowledge about risk of having unintended pregnancy, and reported high levels of unsafe sexual practices. The same study revealed that transactional sex is taking place in daily lives, involving the exchange of money, clothing, gifts or food, because females are paid lower wages than men and they may also engage in sex with male in return for accommodation, permanent employment or other favors.

2.4 Context of Abortion in South Africa

Complications from spontaneous abortions and unsafe induced abortions have become one of the most devastating and far-reaching medical threats to women's life and productivity (Grimes, Benson, Singh, Romeo, Ganarata, and Okonofua, 2006:368).

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The effect of the pandemic is felt globally; it is estimated that 5 million women per year from the developing world are hospitalized for complications resulting from unsafe abortions, resulting in long and short-term health problems (Singh et al, 2006:368). No region appears to have been affected worse than sub-Saharan Africa where according to the WHO (2011:27) women's risk of death from unsafe abortion is up to 90 per 100 000 births.

It is estimated that, worldwide, an overwhelming 13% of maternal deaths resulted from unsafe abortions (Shah and Aham, 2009:1149). Unsafe abortion is defined by WHO as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimum medical standards, or both (WHO, 2012:7). It is also estimated that 38-68 of women treated for complications of abortions are under the age of 20 years (Orner & de Bruyn et al. 2010:49). It is also estimated that 10-50% of those who have unsafe abortions need medical care (WHO, 2012:21). The impact of complications of unsafe abortion cost health care systems a very great amount in terms of hospital space, provider's time, antibiotics, blood, and supplies (Shah and Ahman, 2009:31).

2.5 The Choice on Termination of Pregnancy Act 92 of 1996

The CTOP Act of 1996 was introduced to replace the Abortion and Sterilization Act of 1975. Again in 2008, there was a Choice on Termination of Pregnancy Amendment Act. The abortion and sterilization act was highly restrictive and the replacement was concerned with drawing attention to accessible post abortion care. The sterilization act led women to induce abortions themselves or use unskilled practitioners in unhygienic settings. The act failed the women on three accounts: it denied them their reproductive rights, it resulted in "back street abortion" creating a major public concern, and it denied South African women equal access to safe and legal termination of pregnancy (Alan Guttmacher Institute (AGI), 2013: 25). The South African Choice on Termination of Pregnancy (CTOP) Act 92 of 1996 was implemented in February 1997.

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A major factor leading to the acceptance of CTOP was the statistics with regard to 'backstreet abortions' and consequently morbidity and mortality. A national study undertaken in 1994 Department of Health (DoH), showed that 44 686 women with incomplete abortions were admitted to South African public hospitals each year with 34% of these showing signs of being unsafe abortions. Approximately 425 women, each year, died as a result of these unsafe procedures (Dickson-Tetteh and Rees, 2009:116).

Worldwide, the abortion Act (CTOP Act, no.92), was regarded as the most liberal law. The purpose of implementing the CTOP Act was to ensure that every woman in South Africa shall have access to good quality termination of pregnancy services when faced with an unwanted or unintended pregnancy, as well as access to other reproductive health services (CTOP Act, no 92:2). According to the CTOPA, abortion is legal on request by the pregnant woman. Pregnancy may be terminated by a medical doctor, or registered nurse or midwife who has completed CTOP training, until 12 weeks of gestational age. From 13 to 20 weeks, the pregnancy may be terminated by a medical doctor in consultation with another medical doctor, and the abortion may only be performed if the continued pregnancy would be a threat to the woman's mental or physical health or if there would be a risk of severe foetal physical or mental abnormalities. Abortion is also allowed if the pregnancy is a result of rape, sexual abuse or incest, or if the pregnancy would adversely affect the social and economic status of the woman.

In case of a minor, who is defined as a female person under the age of 18 years, shall be given termination of pregnancy upon their request after giving written consent; however minor must be encouraged to consult their parents, guardian or friends in their own free will. In the case of married women, no consent is required from the spouse before terminating their pregnancy. Regardless of age or situation, every woman or adolescent who is considering abortion should be provided with information that is clear, accurate, easily understood and easy to recall to allow her to make her own decisions about whether to have an abortion and, if so, what method to choose. For women who have not made a decision about whether to have an abortion, information can assist her in making the decision (Ipas, 2013:3).

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Clear, accurate information also helps the woman in selecting a desired method for the abortion. Women should be provided with the information so that they can give informed consent for the procedure. Women should also be offered counselling to assist in considering her options, if she so desires (Kapp, 2012:29).

The amendment act was then put in place in 2008 to increase access to termination of pregnancy. The act was amended in order to exempt a facility from offering 24-hour maternity service from having to obtain approval for termination of pregnancy services. The amendment act also includes registered midwives who have undergone prescribed training in terms of CTOPA to provide TOP services (Amendment Act, 2003:3). The CTOP Act recognizes the values of human dignity, achievement of equality, security of the person, non-racialism and non-sexism; and the advancement of human rights and freedoms which underlie a democratic South Africa (Dickson-Tetteh and Rees, 2009:67). It also ensures the right of the women to access safe, effective, acceptable methods of fertility regulation; women have the right to information, and women are given pre and post counselling about termination of pregnancy. The procedure takes place in a hygienic environment, the partner does not need to give consent for a woman to have a termination, women are given greater choice and empowerment by termination of pregnancy; and women are given a choice to have either medical or surgical termination of pregnancy (Walker, 2000:506). To legally restrict abortion does not necessarily reduce the number of abortions that occur in a country. Many people believe that if abortion services are made more available, safer abortions will take place. If we look at countries around the world, however, we see that this is generally not the case (Sedgh, 2012: 631). Abortion rates are much more likely to be linked to desired family size and availability and effectiveness of contraception. In fact, many countries with restrictive abortion laws also have high abortion rates (WHO, 2011:75).

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2.6 Termination of Pregnancy in KwaZulu Natal

Termination of Pregnancy (TOP) has been identified as a provincial priority in KwaZulu Natal (KZN) Province as well as in South Africa. In South Africa, before the implementation of the Termination of Pregnancy and Sterilization Act (Act 2 of 1975), there was no properly defined law on termination of pregnancy. The CTOPA of 1996 was introduced to replace the Termination of Pregnancy and Sterilization Act of 1975. The researcher identified a need for the KZN Department of health has recognized the need to extend termination of pregnancy services to include medical termination of pregnancy to increase access to all women in communities within the Province to reduce to morbidity and mortality associated with unsafe abortions. In order to mitigate the impact of illegal termination of pregnancy and improve access to termination of pregnancy, the province needs to implement a comprehensive policy TOP service in KZN.

This policy update takes the above strategies into account. It also recognises that, (i) All women requesting termination of pregnancy should have prompt access to a service that provides information, medical assessment and if necessary counseling; (ii) When the reasons for termination are within the grounds listed in the Termination of Pregnancy Act, safe, effective termination of pregnancy should be provided in circumstances that acknowledge women's physical, emotional and future contraceptive needs; (iii) The right of conscientious objectors, however should not be obstructive, once the termination of pregnancy process has started; and (iv) a comprehensive approach should be applied, (KZN CTOP Policy, 2013:10).

TOP policy is part of a broadly based Sexual and Reproductive Health (SRH) program implemented by the KZN DoH (KZN DoH, 2015). A number of concurrent health system interventions operating through other government priority programmes ensure that the necessary infrastructure, medical technology, competent health work-force, and other resources are provided to facilitate effective implementation and monitoring of these policy recommendations. In KZN only 86 providers and facilities offer TOP services (KZN DoH, 2015). It is recommended that the hospitals' and districts' managements support TOP provision at their facilities as per requirements stipulated in the CTOP Amendment Act no 1 2008.

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2.7 Circumstances and Options for Post Abortion Care

According to Paul (2009:28), health care providers can provide post abortion care surgically. It is of importance that the health care provider is well equipped with the knowledge of different choices of termination of pregnancy so that she gives the client the correct counselling (Izugbara and Egesa, 2014:112).

2.7.1 Manual Vacuum Aspiration (MVA)

Manual Vacuum Aspiration (MVA) is the recommended technique for management of complications of post abortion care. MVA is quick and is completed in a few minutes. It can be performed manually or with an electric vacuum aspirator. It is a widely used method for first trimester (Paul, 2009:291). MVA is widely recommended that it is safe in the provision of post abortion care by nurses. The documented success of nurse-led provision of PAC services led to the recommendation that nurses be trained to provide Comprehensive Abortion Care (CAC) services as well using MVA (Dickson-Tetteh, Kim and Billings, 2002:144).

2.8 Clinical Care of Women Undergoing Post Abortion Care

Facilities that provide induced abortion should have health staff trained to take medical histories and conduct bimanual pelvic examinations and abdominal examinations in order to determine gestational age. Staff should also be competent to provide counselling when necessary to help women to consider their options. If the facility does not have appropriate staff and equipment, the woman should be promptly referred to the nearest available services (Brahmi et al., 2012:73).

2.8.1 Pre-Abortion Care

Abortion services should meet the same high standards as other health services in terms of privacy, confidentiality, accessibility, promptness, affordability, and flexibility.

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There are number of critical aspects of pre- abortion care: determining gestational age, providing information and use of antibiotics at time of surgical abortion (Kapp & Nathalie, 2012: 68).

Regardless of age or situation, every woman or adolescent who is considering abortion should be given information of what is to be done before, during and after the procedure, what she is likely to experience for example, cramps or pain, how long the procedure was take, which pain management options she can choose, what side effects, risks and complications are associated with the method and what kind of aftercare and follow-up is needed (Kapp & Nathalie, 2012:29).

2.8.2 Inter-Abortion Care

All women having surgical abortion, regardless of their risk of pelvic inflammatory infection, should receive appropriate prophylactic antibiotics during pre-post abortion care. For women having medical abortion, routine use of prophylactic antibiotics is not recommended. All women should be routinely offered pain medication like diclofenac and ibuprofen. Prior to surgical abortion, cervical preparation is recommended for all women with a pregnancy over 12 to 14 weeks of gestation. Its use may be considered for women with a pregnancy of any gestational age (WHO, 2012:13). All women undergoing Dilatation and Evacuation (D&E) with a pregnancy over 14 weeks of gestation should receive cervical preparation prior to the procedure (WHO, 2014:92). During the procedure, infection prevention procedures are critical to prevent the transmission of infections, including Human Immunodeficiency Virus (HIV), to patients and health-care providers. Standard precautions include hand-washing and use of protective barriers such as gloves; proper cleaning of equipment's, linens and floors ; safe disposal of contaminated waste; safe handling and disposal of "sharps"; and safe cleaning of equipment after use.

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2.8.3 Post Abortion Care

Globally it was stated that Post Abortion Care (PAC) is one of the best practices that needs to be practiced in both private and public sector to minimize this public health problem (Alan Guttmacher Institute, 2012). PAC requires a health system approach that ensures access and high-quality services through planning and managing pre, intermediate and post abortion by a CTOP trained Registered Nurse (RN), midwife or a medical doctor. The WHO (2012:52) defines PAC as “an appropriate care that follows an induced or spontaneous abortion” and also a strategy to attenuate the morbidity and mortality associated with complications, including uterine aspiration for incomplete abortion, offer of contraceptives to prevent unintended pregnancies, and linking women with other services in the community.

During post abortion care, women should receive contraceptive information and, for those women who so desire, they should receive either a contraceptive method or a referral before they leave the facility (Singh & Darroch, 2012:98). Providers can also discuss and provide emergency contraception, as well as prevention of Sexually Transmitted Infections (STIs), including HIV. Contraceptive information and services are an essential part of post abortion care, as it helps the woman avoid unintended pregnancies in the future and thus reduces future complications and unsafe abortion. A woman must be given information to choose among several contraceptive methods, including long reversible methods like hormonal contraception for example: Intra Uterine Device (IUD) and Implants (WHO, 2012:52). Women must be adequately informed regarding complications that might show after management of the abortion complications like: symptoms of ongoing pregnancy and other medical reasons, such as prolonged heavy bleeding or fever, to return for follow-up for early management of abortions complications (Singh et al., 2012:114).

2.9 The Concept of Post Abortion Care Origin and Definition

Post abortion care is an approach for reducing morbidity and mortality from incomplete and unsafe abortion resulting in complications, and for improving women's sexual and reproductive health and lives (Greenslade, Harrison, Merill &

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McLaurin, 1994:4). The ICPD held in Mexico City, addressed the dangers of abortion-related risk, although no major decision was taken about addressing the problem According to (WHO, 2010:23).

In 1994, the World Conference on Women held in Nairobi, recognized the rights of the women to control their fertility. Both Cairo and Beijing recognized unsafe abortion as a major public health problem after having an International Conference on Women in 1994 and 1996, and emphasised health services related to abortion as an essential component of reproductive health care (Corbett & Turner, 2010:111). In 1996, WHO integrated post abortion care into community based family planning and reproductive health activities in many countries. In 1991, the term post abortion care was first articulated by IPAS as a critical element of women's health initiative in a strategic planning document, which encouraged the integration of post abortion care and family planning services in the health care system, International Post Abortion Services (IPAS) (2012:12). IPAS introduced the element as a means of breaking the cycle of repeating unwanted pregnancy and improving the overall health status of women in the developing world. In 1994, the ICPD Programme of Action 5 and the experience of various organizations and countries included additional elements in their PAC programs. Over the years, Actions 6,7,8 inspired the PAC/Community Task Force to expand and update the original PAC model to reflect progress and an expanded vision of high-quality and sustainable PAC services (Alan Guttmacher Institute (AGI), 2013).

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Table 2.1: Essential elements of PAC. (Post abortion care consortium: 2013)

Five Essential Elements of PAC
• Community and service provider partnerships
Prevention of unwanted pregnancies and unsafe abortion, mobilization of resources to help women receive appropriate and timely care for complications from abortion, and ensuring that health services reflect and meet community expectations and needs;
• Counselling
Identify and respond to women's emotional and physical health needs and other concerns;
• Treatment
Treat incomplete and unsafe abortion and complications that are potentially life-threatening;
• Contraceptive and family planning services
Help women prevent an unwanted pregnancy or practice birth spacing; and
• Reproductive and other health services
Preferably provided on-site or via referrals to other accessible facilities in providers' networks

It is important to focus on reducing the number and consequences of unsafe abortions by promoting post abortion care (PAC). PAC is expected to increase life expectancy of women and in turn help to overcome negative attitude and practices that encourages ill behavior of seeking unsafe abortions (Corbett et al., 2010:106).

2.10 Post Abortion Care in South Africa

South Africa has a high maternal mortality rate, especially among the African population. Septic abortion is a major contributor to maternal death incidence rates (Mhlanga, 2003:116). Various studies have shown the incidence, extent and terrible consequences of unsafe abortion.

During the time before the passing of the Abortion and Sterilization Act, 1975 (Act No.2 of 1975), the application of the prohibition of abortion was so severe that one

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eminent gynecologist and obstetrician was struck off the medical register. Because of the continued morbidity and mortality among women of all races, the National Party government of South Africa introduced a law in the 1970s, the Abortion and Sterilization Act, 1975 (Act No.2 of 1975). That Act sought to make abortion accessible under certain circumstances (Mhlanga, 2003:116). With the political liberation of South Africa in 1994, it was imperative that laws should start responding to the needs of the majority, and women were among those who needed their human rights respected, protected and promoted (CTOPA no. 92, Nov. 12, 1996, Act. 2(b).

In part, the government responded to national-level research conducted in 1993 indicating that approximately 425 women died each year in public hospitals while being treated for complications resulting from clandestine, unsafe abortions, (Ngwena, 2003:18). The research also showed that, of the nearly 45,000 women admitted to public hospitals with incomplete abortions each year, at least one-third had medical complications related to unsafe abortion (Rees et al., 1997:67). Therefore, South Africa started responding to the reproductive health needs of women by tackling one of the most contentious issues abortions. South Africa was responding to the recommendations of the ICPD and the United Nations Convention on the Elimination of All Forms of Discrimination against Women (UNCEDW) (Mhlanga, 2003:117).

After much debate and support from research institutions and academic institutions showing the burden of ill-health and death from septic abortion, and the need for legislative reform, the South African government passed the CTOPA, 1996 (Act No.92 of 1996). The PAC was included in the Act. The SA provinces have adopted the centralized approach to the scale-up of PAC services in the provinces, covering the district hospitals, with guidance flowing from the national levels with the support from partners like IPAS and Women Care Global (WCG) (RamaRao et al., 2008:3). Because the support was limited to provincial facilities, the non-covered facilities remained without the services.

Facing this problem, the province then signed the Memorandum of Understanding (MOU) with IPAS for the training of health care workers and supply of MVA kits

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(adid). In South Africa including KZN, registered nurses were trained as TOP provider's services through the TOP Act in 1997.

MVA has become the alternative to the standard surgical curettage, and has been introduced as a key component of PAC for the treatment of incomplete abortion (Solo, 2000:32). Using MVA for PAC instead of sharp curettage along with associated changes in protocols and an improved service delivery model, significantly reduced costs of care in most cases (Henshaw & Adewole, et al. 2008:43). MVA is safe method with few complications that is recommended for post abortion care especially when performed in the first trimester (WHO 2012:17). A study done by Duggal (2004:137) indicated success in 98 to 100% of cases, including for incomplete abortion. It is less costly when performed on outpatient basis under local anaesthesia. On top of this, attention is much focused on MVA rather than counselling and the linkage with other sexual and reproductive services. The main barrier that was reported associated with MVA was the procurement of MVA instrument because of high cost (Rasch & Sorensen, 2011:57). In addition, a study conducted in Nigeria challenged the assumptions according to which MVA is considered more cost effective than surgical curettage (Henshaw & Adewole, et al., 2008:48).

2.11 Consequences of Unsafe Abortion

Globally, there is a wide difference in the incidence of unsafe abortion and the laws, policies, and practices related to providing of safe and unsafe abortion services (Joffe, 2009:4). WHO (2011:52) indicated that when a woman is confronted with unwanted or unintended pregnancy, she can pursue her options of either to continue with the pregnancy, keeping the child in relationship or adoption or abortion (WHO 2011:32). There is no typical abortion seeker; abortions occur in all age groups among a wide range of women, both married and unmarried, and with or without children.

According to Saving Mothers report (2014-2016) and NDHIS (2011-2013:6), a wide range of women had abortions in South Africa between the years 2011 and 2013

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and a total of 4452 maternal deaths were documented in South Africa. The highest numbers were documented in KwaZulu-Natal (KZN), which was 964, followed closely by the provinces of Gauteng (849) and Limpopo (750) (NDHIS report, 2011-2013:5). Over the same period (2011-2013) it was reported by the National Department of Health that the underlying cause of death in 185 women was miscarriage. Of these, 114 were linked to septic miscarriage and another 9 to miscarriage following legal TOP. It is important to note that septic miscarriage is an indicator for illegal abortion. Hence these 123 maternal deaths related to the quality of care provided post abortion (NDHIS, 2011-2013:9).

A study by the South African Medical Research Council (SAMRC) (2010:62), reported that 49% of TOPs undergone by young people between the ages of 13 and 19 took place outside a hospital or clinic and were therefore likely to be unsafe. A study by SAMRC indicated that heightened stigma around TOP, cultural beliefs and healthcare workers' attitudes, could be some of the reasons why women chose TOP outside the formal health care sector. Alan Guttmacher Institute (2012:106), argued that women may wish to terminate planned (or intended) or unintended pregnancies. For example, even when a woman wants a child, she may feel the need to end the pregnancy because it is the result of rape, non-viable foetal abnormalities, and a risk to the woman's life. Therefore, family planning is an effective intervention to reduce unwanted pregnancy and induced abortion (WHO, 2012:22). Regardless of the progress, significant challenges remain. For instance, it is estimated that there are still 222 million women who do not want to become pregnant who are using either no contraceptive method or a traditional method which is more likely to fail than a modern contraceptive method United Nations Department of Economic and Social Affairs, Population Division (UNDESAPD) (UNDESAPD, 2012: 11). Again UNDESAPD reported that Africa has the highest proportion of women with unmet need for modern contraception at 31%, compared with 15% in Asia and 16% in Latin America. Unmet need for contraception exceeds use of contraception in West, Middle and East Africa.

Among those women who are using contraception, 33 million unintended pregnancies occur annually due to contraceptive failure. These unintended pregnancies result in unplanned births or legal and illegal abortions WHO (2012:17).

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Legal abortion is when abortion is performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions; induced abortion is a very safe medical procedure (WHO, 2012:21). Whereas, unsafe abortion is defined as a procedure to terminate a pregnancy that is performed by an individual lacking the necessary skills, and/or performed in an environment that does not meet minimum medical standards (WHO, 2011:22). However in South Africa, millions of unplanned pregnancies occur each year. Some factors that contribute to this situation include contraceptive methods that fail, many women experience forced or coerced sex and many women, men and adolescents do not have access to or use contraception (AGI, 2013:111).

South Africa has recently marked 18 years of the adoption of its progressive Termination of Pregnancy law, yet one can still walk down a busy city street and see adverts for back street abortion transforming pasted on the streetlight in the liberal classified advertisements. Tearing down these adverts gives some sense of satisfaction, but for every advert removed, several more are replaced. These illegal providers can also be seen on the street corners marketing themselves. Women finding themselves in a desperate situation with unwanted or unintended pregnancy and seeing walls and lamp posts plastered with advertisements claiming to offer 'safe', 'pain free', 'quick', and 'cheap' abortions. Consequently these women in this situation have little recourse and often turn to “illegal abortion through ‘lamppost’ providers”, referring to unlicensed abortion providers who advertise their services on the street or lampposts across the country. The proliferation of this advertising, and the fact that it is posted in public spaces such as taxi ranks and shopping centers make many women believe they are accessing a legitimate service (Marie Stopes, 2010:3). While the global rate of unsafe abortion remains unchanged since 2000 at about 14 per 1000 women (Sedgh, 2012:630) the trend globally has been an increase in the proportion of all abortions that are unsafe, with a rise from 44% of abortions being unsafe in 1995, 47% in 2003, to 49% in 2008 (Sedgh, 2012:19).

This means that almost half of all abortions worldwide, 40 million, are unsafe (Sedgh, 2012:632). The injustice is that 98% of unsafe abortions occur in developing countries and countries “in transition,” such as those in Eastern Europe and the

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former Soviet republics (Sedgh et al., 2012:2), which are up slightly from an estimated 95% by WHO (2011:3).

In Africa, 97% of all abortions are unsafe, and report the highest incidence of unsafe abortions in the world followed by Asia, Latin America at 95% WHO (2011:18). Sedgh et al., (2012: 635), indicated that globally, 75% of all induced abortions in developing countries are conducted in unsafe conditions. In terms of unwanted pregnancies among adolescents and young women, nearly 14% of all unsafe abortions in developing countries are among women under age 20. John Hopkins Corporation and University Center for Communications Programs (2011:14) stated that, adolescents are particularly vulnerable to unwanted pregnancy because they tend to have less information about sexuality and contraception, less access to services and fewer resources to manage their own health care. The estimated rate of death is 90 per 100 000 in Sub-Saharan, 80 per 100,000 in Least Developed Countries and 40 per 100 000, in Southern African due to poor post abortion care (WHO, 2011: 27). The consequences of unsafe abortion can be dire for a woman, her family and the community. Women who have abortion experience different problems including psychological, emotional, and social consequences. Peck and Marcus (1996:417) stated that women are grieved after abortion. De Puy and Dovich (1997:324) argued that women are traumatised by the process of abortion.

2.11.1. Psychological Consequences

A study conducted by the American Psychological Association (APA) (2006:18), showed that psychological trauma does not necessarily accompany an abortion but it is likely to occur if the woman is not supported in her decision or if the pregnancy was meaningful to her. Costa & Murray (2011:116) reported that a woman who has abortion at late gestational age is more likely to suffer from psychological distress.

Coast et al., (2014:645), after analysing the report by British Medical Journal findings, pointed out that women suffer from short term symptoms like grief and depression and they last for 8 weeks. Biggs & Gould, et al. (2013:29) argued that symptoms also include guilt, regret nervousness and not being able to sleep. The

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authors further stated that 10-30% of women suffered ongoing psychological problems. Adinma, et al. (2012:475), stated that in spite the fact that manifestation of psychological problems may not be instant; it may be visible at any stage of life and negatively affect people who were once traumatized in their lives. Other women might regret their decision and felt that they were supposed to decide differently (Dobkin & Gould et al., 2014:117). Once a week, women usually felt guilty and regret and feel sad when they think about their abortion experience (Adanu & Tweneboah, 2004:131).

2.11.2. Social Consequences

Though the termination of unwanted pregnancy was appreciated, the abortion process and procedure did cause regret, anxiety, grief and guilt, despair and anger. The researcher argues that even though different women react differently towards post abortion, they feel relieved. The role that society plays impacts women's lives from the decision-making process to the stigmatisation after the abortion. Guilt is experienced 'internally' leading to self-destructive behaviour or women just feeling awful about them. Major et al., (2000:671) and Trybulski (2006:82) argued that negative experiences become hidden in one's subconscious memory where they remain inactive. A trigger brings them into remembrance, at different times and in different situations, affecting one's moods and social interaction. This may continue in the long-term for several months or even years (Fergusson et al., 2009:63).

Davies (2002:214) stated that, when people experienced challenges in life, they always have people like partners/spouse, family, friends to turn to for comfort and support in life. For most of the women who are coerced with unwanted pregnancy it may not be easy to share with anyone.

Banerjee & Andersen et al. (2014:226) conducted a study that examined the attitudes, social networks and decision making process of women who had an abortion, and it was found that women consulted informal social networks when contemplating the route to pursue. Based on the level of trust that the women have for individuals, they choose different people (Banerjee & Andersen, et al., 2014:232).

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A similar study revealed that most of the people turned to their partner/spouse for support. Again it was interesting to find out that some women turn to their doctors and nurses for the support. It was concluded by Farria, Barret & Goodman (2006:8), that those women who did not receive support from their social networks turned to professionals for help, like psychologists.

2.12 Training of Health Care Workers

As is true with any new and progressive law, implementing the Choice on TOPA posed challenges to national and provincial authorities. A large demand for post abortion care services was identified after passing of the Act in the country (Alan Guttmacher Institute, 2012:42). The challenge of lack of health care personnel trained for provision of post abortion care services was also identified (Alan Guttmacher Institute, 2012:43). The Act stipulates that TOP trained registered nurses and the medical doctors are the people who can provide PAC in the health care facilities, particularly at the primary health care level. Thus, training and certification of registered nurses throughout South Africa was identified as a critical step toward making high-quality post abortion care services accessible to all women.

In 1997, authorities in all of the provinces reported difficulty in implementing the new Act because of the lack of health care providers trained to provide post abortion care. To ensure that providers would be trained in all provinces and in all types of facilities, in 1998 the government established the national Post Abortion Care

Programme, which encompassed the Midwifery post abortion care Training Programme.

The Reproductive Health Research Unit (RHRU) (2013:529) was responsible for coordinating the national program, which was carried out through partnership with the Maternal, Child and Women's Health Directorate (MCWH) of the Department of Health. To counteract resistance among health care workers, the Planned Parenthood Association of South Africa of the University of the Witwatersrand and the Reproductive Rights Alliance conducted workshops with more than 4,000 health

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care providers throughout the country during the year after the law was passed. The workshops addressed providers' feelings about abortion, educated them about the provisions of the law and encouraged them to approach abortion and post abortion in a non-judgmental way and to treat women seeking an abortion and post abortion care with dignity and respect (Jaldesa, 2014:16).

IPAS, an international nongovernmental organization in partnership with the department of health came on board to train and research on post abortion care, collaborated in the design of the training content and process as well as in the evaluation of midwives' skills. The curriculum was composed of three days of value clarification, three days of medical abortion and two weeks of surgical abortion. The main purpose of the program was to develop the capacity of public clinics and health centres to provide safe, high-quality and accessible abortion, post abortion care services, treatment and management of abortion complications, contraceptive services and counselling, and other reproductive health services abortion clients need. In doing so, the program was aiming to bring abortion and post abortion care services closer to the communities where women live, the disadvantaged women living in rural areas, (Wanjiru, Askew, Munguti, Ramarao, Kahando and Pile, 2007:387).

2.13 Roles and Knowledge of Health Care Workers in Provision of Quality Post Abortion Care

Health care workers are responsible for the provision of quality post abortion care services to the women who need it. The health care workers provide total quality care required to treat the range of complications that result from complications of abortion. Other nurses experience moral and ethical dilemma regarding the abortion procedure (Castaneda & Billings, et al., 2003:78). According to DHIS of KZN (2016), out of 72 hospitals only 41 facilities provide termination of pregnancy services and only 83 nurses have undergone CTOP training in the province and this few facilities leads to poor provision of PAC. A study done by Indira, (2013:36) in KZN at Lower Umfolozi Hospital, found that out of 300 nurses only 3 nurses agreed to assist in

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termination of pregnancy. There is a huge difference when comparing number of TOP done with the capacity of staff that renders abortion and PAC. The CTOP Act supports the woman to access quality post abortion care, hence it also protects the nurse's right to make the choice of either to participate or not to participate in termination of pregnancy, while being required to manage the women in case of emergency PAC or refer the women to another health care professional.

A study conducted by Walker (2011:118), found that even though nurses have the professional principle of care and empathy towards the patient, they are not in favour of the legislation of abortion in South Africa. A study done by Myburgh, Gmeiner, & van Wyk (2009:65) reported that even though the issues of abortion conflict with the personal beliefs of nurses, they have the responsibility of managing post abortion complications of abortion when the need arises. Another study conducted by Paul (2009: 83) upholds a similar belief that irrespective of the service provider's belief, regarding abortion, he/she has a professional duty to provide a woman with the necessary management of post abortion care complications.

2.14 Women's Empowerment: Education and Information

In some of the facilities there are Information Education Communication (IEC) materials such as pamphlets, posters, booklets, and models. A study conducted by UNFP (2014:78) revealed that only 12% of departments reported having Family Planning (FP) IEC material in a local language (Zulu). One interviewee from the (United Nations Population Funds (UNFPA) study mentioned that "it is hard to get IEC material in local languages". None of the departments has IEC material that caters to illiterate and disabled clients. As one interviewee indicates, "those who cannot read and write are provided with oral lesson". It was also reported that 50% of the departments offer TOP group information sessions in the morning, as part of general health education. The frequency of group information sessions ranges from department to department: daily, once weekly, and randomly. Again 38% of interviewees indicated that they conduct health campaigns that include FP.

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2.15 Post Abortion Care Challenges Posed by Health Care Workers in the Workplace

Post abortion care in South Africa is a noticeable health concern. Post abortion care is considered as an extended trend, with multifaceted challenges to both management and care reactions (Correa & Petchesky, 2013:47). In the countries hardest affected by the incidence of unwanted pregnancies, post abortion care increases workloads, professional frustration and burn-out. It affects health workers also directly, contributing to rising sick leave and absenteeism rates. The estimates of the incidence of abortion differ widely; it is clear that the health care workers are the main providers to care for women undergoing, or who have undergone abortion (Correa & Petchesky, 2013:49). This burden is borne by a health workforce debilitated already by poor training, turnover and retention of staff (Jewkes & Gumede, et al., 2005:1242). Reduction of the need for induced abortion and prevention of unsafe abortion through provision of family planning services should be an integral part of health care.

Health care providers, women and the community at large must understand the health risk of unsafe abortion and the advantages of contraception as a safer alternative. The incidence of unwanted pregnancy, induced abortion, and related maternal morbidity and mortality can be greatly reduced by increasing the availability of family planning services and providing accurate information to women, health care workers and the community. The full integration of family planning into maternal and child health services is a key component of WHO's strategy for providing improved primary health care for all people.

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2.16 Perceptions of Post Abortion Care by the Health Care Workers

According to (Correa & Petchesky, 2013:47) nurse's perceptions on post abortion care influence the rate of women seeking behaviour of post abortion care. An intervention in caring for women's sexual and reproductive health is to listen to the woman's experience and respect her legal and moral personhood; this implies her right to self-determination (Correa & Petchesky, 2013:49). Therefore it is important that the nurse treats the woman as a subject and takes the woman's desires and wishes seriously, may it be the wish to terminate a pregnancy (ibid). However, when the right to safe and legal abortion is denied, the respect for the woman's personhood is abused and at the same time the legal possibility of the nurse to provide care and support the woman in her right to self-determination is taken away (Correa & Petchesky, 2013:51). The nursing process ought to include the five phases of assessing, diagnosing, planning, implementing and evaluating (Florin, 2009:152). The process is interrupted as the nurse is left without legal means to provide the care that the patient is in need of. Concerning women's sexual and reproductive health, the nurse has an important role both in providing education on different contraceptive methods as well as contributing to safe post abortion care (Correa & Petchesky, 2013:63). Health care providers in sub-Saharan Africa and Southeast Asia have moral-, social- and gender-based reservations about induced abortion.

These reservations influence attitudes towards induced abortions and subsequently affect the relationship between the health care provider and the pregnant woman who wishes to have an abortion. A values clarification exercise among post abortion care providers is needed.

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2.17 Factors Affecting Women's Access to Post Abortion Care Services

Twenty-seven states have implemented laws setting stringent and medical requirements for abortion providers that go beyond what is necessary to ensure the safety of women getting the procedure (Alan Guttmacher Institute, 2013: 76). Women's access to abortion is determined by legal restrictions that vary across country as well as by the geographic availability of abortion clinics. In South Africa, new restrictions against the procedure were introduced in TOP Act, and most of these restrictions severely curtail women's access to the procedure by limiting women's ability to obtain the procedure and physicians' and clinics' ability to offer it (Alan Guttmacher Institute 2013: 80). Additional restrictions that do not allow the medical practitioners without accreditation are in place to discourage providers from opening the clinics and that makes it more difficult for women to access the procedure.

Table 2.2: Comparison of Abortion Restrictions on Service Providers and Patients

Abortion Restrictions on Providers	Abortion Restrictions on Patients
Abortion must be provided by the trained health care worker	According to conscious objection the health care provider has the right to offer abortion
Abortion must be performed in the facility that is accredited	Patient must undergo pre abortion counselling before the procedure
After twelve weeks of gestational age the second doctor and a nurse must be available (gestational age limit)	The women might fail if not meeting criteria of abortion beyond twelve weeks
Lack of resources in other facilities to provide abortion choice of the patient e.g. MVA or drug shortage	Abortion is prohibited at a certain gestational period

Source: CTOP Act no 92 of 1996

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Factors used by anti-abortion policymakers include mandating that a woman listen to medically biased information regarding abortion, gestational limits that restrict at what point a woman may have an abortion during pregnancy, parental notification requirements, and financial barriers related to Medicaid, and geographical barriers (Dennis and Blanchard 2013:236). These restrictions limit women's ability to choose reproductive healthcare and leads them to unsafe abortion which results with severe consequences that warrant quality post abortion care service. As restrictions are instituted, women find that they are geographically limited in accessing an abortion providers due to difficulty accessing transportation, poor economic status due to unemployment, and increased treatment costs for those who want to access safe abortion in private facilities (Kahane, 2000:464).

According to Andersen's healthcare utilization model (1995:3), people's use of health services is a function of their predisposition to use services, factors which enable or prevent use, and their need for care. Predisposing characteristics, enabling resources, and need all contribute to a person's use of abortion quality health care services (Andersen, 2005:230). Predisposing factors include demographics, such as age and gender, social services, and resources. Enabling resources include a person's family and the community in which they live and their understanding and beliefs to post abortion care services. Women perceive abortion in different ways within their community and that has an implication on access to safe post abortion care. For pregnant women, enabling resources include family members, friends, medical professionals, and their religious communities. All of these resources play a role in determining whether a woman will have a quality safe abortion or continue a pregnancy (Rolnick & Vorhies, 2012:348). Other factors from Andersen include age and gender. While a well-established woman in her late twenties may have greater resources to make a decision about her pregnancy, a teenage girl may not have those same resources (Ostrach, 2013:262). Lastly, distrust of abortion providers due to anti-choice campaigning and a history of distrust of the medical industry may also deter some women from accessing an abortion provider (Vasquez & Das Neves, et al., 2012:250).

Those who have access to technologies are better equipped to find post abortion care services and access them (Joyce, 2013:879). Internet access is also related to

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access to knowledge, since the internet gives women the necessary tools to learn about their options concerning their choice on termination of pregnancy and post abortion care. Limiting access to technology can significantly limit a woman's access to quality abortion and post abortion care services (Lafaurie & Grossman, et al., 2005:79).The topic of abortion is primarily seen as a women's issue, with men being removed from the discussion, and men are those involved in law making. Women have the most potential to benefit from access to the procedure, but also lose most if it is restricted (Ribot & Peluso, 2003:153). The discussion of access through social identity can further be dissected by membership in economic social groups.

For instance, abortion is primarily a women's topic, but access is enabled or disabled by a woman's race and ethnicity, economic status, and immigrant status (Oakley, 2003:472).

2.18 Existing Guidelines/Strategic Plan to Promote Quality Post Abortion Care

World Health Organization's technical support launched a managerial for prevention and treatment complication guidelines of abortion in 1995 at Geneva. The document was the first to give guidelines on management of complications of abortion globally (WHO, 2010:2). The primary purpose of the guidelines was to contribute to the reduction of maternal morbidity associated with abortion. The guidelines documented the usefulness to decision-makers, who are responsible for an individual health system, managers who oversee a group of service delivery points, and to the staff of individual health facility. The guidelines mentioned the significance of improving the quality and availability of care for abortion and its complications as part of a primary health care system. The guidelines also stated that prevention of unsafe abortion and its consequences in view of the significant role that abortion plays in maternal and morbidity. Lastly, the guidelines also assisted national and local managers in the collection and application of information useful in planning the location and content of emergency post abortion care at each level of the health care system.

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According to WHO (2012:1), clinical guidelines have been defined as systematically developed statements which assist clinicians and patients in making decisions about appropriate treatment for specific conditions. Most countries, including South Africa, have guidelines on maternal health; however, there are no guidelines on management of post abortion care. Few countries have guidelines on management of post abortion care. The World Health Assembly, in resolution WHO (2012:41), identified that abortion created a significant health problem for women in many countries including South Africa.

According to Moore and Kibombo, et al. (2013:8), magnitudes of unsafely done abortion account for a great part of maternal mortality and those who survive may suffer long-term consequences, including infertility. According to Safe Mother Initiative report (2014-2018), they discovered that there is a need to achieve substantial reductions in maternal morbidity. Activities within the initiative took many forms, for example: increasing awareness of the nature of the problem and the need for action; strengthening maternal health services, training health care workers and others, facilitating educational and economic opportunities for women, and research, particularly operational research. All these measures, which would help to reduce maternal mortality, would also exert at least equal effect on maternal morbidity which derives from the general poor health of women and girls and inadequate care during treatment for the complications of abortions this was initiated by (WHO, 2011:174). Each country, including South Africa, needs to have post abortion care guidelines that aim to ensure that all women considering abortion have access to service of consistently high quality (Blencowe et al., 2013:11). The guidelines must be applied across all pertinent healthcare sectors and promote a consistent standard irrespective of the sectors in which an individual woman is managed.

Safe Motherhood (2014-2016), provides practical guidelines on clinical management of abortion complications. The guidelines were produced after it was realized that abortion complications are responsible for around 14% of the approximately 500,000 maternal deaths that occur globally each year. The guidelines recommended that prevention of abortion-related maternal mortality is dependent on emergency post abortion care being integrated through the health care system of the country, from the most basic rural health post to the most sophisticated tertiary level facility, 24

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hours per day. Also health information and education, stabilization and referral, uterine evacuation or specialized care for the most severe abortion complications, at least some components of emergency post abortion care must be available at every service delivery site in health care system (WHO, 2012:114). The positive step which was again suggested was to provide lifesaving care at lowest possible level of the health system, in order to maximize the chances that the woman would reach the care before it is too late.

Beginning emergency services in the primary health care level is essential to achieving the goal. The first referral level must be able to build on the services provided at the primary level by providing live-saving surgical and medical procedures for all but the most serious complications (Grossman et al., 2010:205). Equally in South Africa, the TOP Act and Amendment Act specified that a registered nurse or midwife must give non-mandatory counselling to a pregnant woman to make an informed choice on termination of pregnancy and that the woman thereafter receives abortion and post abortion care (TOP Act, 1996: 2).

Henshaw and Adewole et al., (2008:50), stated that in some of the developing world, half of the admissions to hospital gynaecological wards are women needing treatment for management complication after unsafe abortions. Studies showed that hospitals in some developing countries do not have guidelines for management of post abortion care complications while the hospitals spend as much as 50% of their budgets to treat complications of unsafe abortion. International health organizations generally recognize post abortion care guidelines to include: Emergency treatment for complications of abortion or miscarriage, counselling to identify and respond to women's emotional and physical health needs and other concerns

In South Africa, the National Department of Health (SANDoH) in conjunction with IPAS developed the national strategic plan for the implementation of the choice of termination of pregnancy, as part of continued effort to fight against unsafe abortions and management of complications of abortions. Amongst others, it was developed in response to the inaccessibility and unavailability of termination of pregnancy services more especially rural areas. The strategy further advocates for TOP access, and also emphasizes the role of contraceptive services in the prevention of unwanted

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and unplanned pregnancies. The National Strategic Plan for Choice on Termination of Pregnancy (NSPCTOP, 2001) further recognized the importance of creating a favorable societal context for TOP provision, as well as addressing problems around health service managers who refuse to institute the TOP services in their institution.

SANDoH, with assistance of research from medical practitioners, outlined the strategic plan (NSPCTOP, 2001) to reduce abortion complications and improve quality of lives of women accessing abortion under five areas;

- Provide an enabling, supporting environment and infrastructure to ensure the availability, equality access and appropriate delivery of good quality TOP services

Competent management in each province is central to meeting the TOP services objective of optimal service delivery. Empowering women to take control of their sexual and reproductive rights require accessible, appropriate contraceptive services (NSPCTOP, 2001:21).

- Decentralizing TOP services provision

Decentralizing TOP services provision is central to reaching the TOP and upholding the values espoused in the CTOPA preamble. The decentralization of service was also make it possible to do more to ensure that the first trimester services are available and that the need for second trimester services, which have more complications, is reduced (NSPCTOP, 2001:22).

- Provide adequate resources to meet the national demand for TOP service

Adequate resources provision is critical to making access to safe, legal TOP an accessible option for all women in South Africa. The department recommended the provision of adequate staff, doctors, nurses, other health professional and support staff. The adequate supply of equipment, materials and other supplies should be maintained. Auditing and monitoring (NSPCTOP, 2001:23).

- Mainstreaming TOP training and in future in such a way that all health care providers in all existing clinical training Programmes receive training on TOP

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The process of mainstreaming was help remove the stigma attached to TOP service provision and contributes to alleviate the pressure on the present relatively small number of trained TOP service providers (NSPCTOP, 2001:28).

- Support health care providers to provide quality TOP services

Quality care service supervision requires the provision of support for these health care providers to help them deliver caring respectful services. To support TOP providers, the community must provide positive attitude and behavior towards them.

The literature focused on the values in South Africa that encourage the provision of quality post abortion care by health care workers. The gaps outlined by the literature include lack of proper support from the supervisors, lack of resources – both staff and equipment – to facilitate quality post abortion care.

2.19 Summary

The literature reviewed in this chapter covered important aspects of the phenomena under study both internationally and nationally. It outlined the Choice on Termination of Pregnancy Act, and existing guidelines and strategies to promote quality PAC services were also outlined. These included the origin of the concept Post Abortion Care, Post abortion care in South Africa and consequences of unsafe abortion. Important considerations were the perceptions of PAC services by health care workers and women who have accessed the service. These factors embodied challenges experienced by the health care workers and women during PAC services. Challenges affecting provision of PAC as perceived by health care workers and women, including lack of staff training and poor access to service by women. The next chapter provides an overview of the research methodology used in the study.

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CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

The scholarly work presented in the previous chapter provided a comprehensive picture of the current knowledge of abortion and post abortion care. The literature also provided clues to appropriate methodology and ways to refine the research instrument. The researchers agree that stigma around abortion makes it difficult to gather information in the community. Even though it has been more than 20 years since South Africa implemented one of the most liberal abortion laws in the world, abortion still carries stigma and discrimination around the community. Therefore, the plan to interview women who have accessed post abortion care service in the selected hospitals should include the sensitive interviewer and questions that are not intimidating and which are non-judgmental. This chapter will give an overview of the design and methodology used in obtaining data from women who were admitted with incomplete abortion, and health care workers rendering post abortion care services in 23 public health facilities in KZN Province.

The study was a cross-sectional study focusing on women with incomplete abortion who accessed post abortion care services, and on health care workers who provide post abortion care services in selected public hospitals in KZN province. The description leads to an explanation as to what are the challenges when accessing and providing post abortion care services. A research questionnaire with both closed and open-ended questions used in in-depth interviews were used to collect data from women who had accessed post abortion. Focus group discussion and observation were used to collect data from the health care workers.

The population was women who were admitted with incomplete abortion (spontaneous or induced) requesting post abortion care, and health care workers who provide post abortion care in the selected 23 public hospitals in selected 5 districts in KZN Province. The findings revealed that not all women were from the catchment area of the districts, while others came from other districts.

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3.2 Research Design for Phase 1

In this study, mixed methods that combined qualitative and quantitative research methods were used. Mixed methods research design is defined as a procedure of collecting, analyzing mixing both qualitative and quantitative research methods in a single study in order to understand a research problem (Klopper & Creswell, 2012:421). This study sought to understand perspectives associated with the challenges encountered during provision and accesses of post abortion care services. A cross-sectional study was identified as the most appropriate method. Cross-sectional studies are best suited for determining the prevalence of a phenomenon, a situation or attitude by taking a cross-section of the population (Babie, 1989 cited in Kumar, 2005:321). In this study, both qualitative and quantitative data were gathered using various research tools.

3.3 Convergent Parallel Mixed Method Design

In this study, convergent parallel mixed method design that combined qualitative and quantitative research method was used. According to De Vos et al. (2011:198), convergent parallel mixed method design is a design where the researcher collects and analyzes qualitative and quantitative data in the same phase, and merges findings; it is a side-by-side approach with comparison of data in the interpretation and discussion phase. The convergent parallel mixed method design, also called triangulation, is defined as the concurrent equal priority mixed method design in which different, but complimentary qualitative and quantitative data are gathered about the central study.

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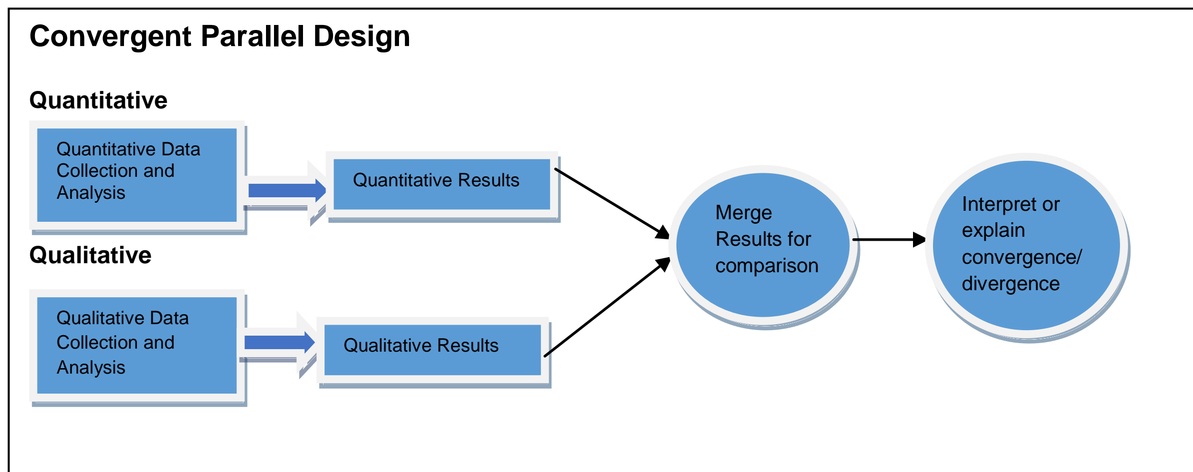

Adapted from Creswell & Clark (2011)

Figure 3.1 Convergent Parallel Mixed Method Design

In this study, the researcher used the convergent parallel mixed method design with the following benefits: (adapted from Creswell, 2013 and Creswell & Clark, 2015)

- It allowed the researcher to develop a life skill programme and instrument to measure its effectiveness based on the qualitative information
- The design was straightforward to describe, implement and report the phenomena
- Inclusion of the quantitative component allowed triangulation and made it acceptable to a quantitative-biased audience (Creswell & Clark, 2015:39).
- The combination contributed to seeing the problem from multiple angles and multiple perspectives (Creswell, 2013:48).
- The results from quantitative and qualitative databases could be merged to provide a different insight.
- The method made the researcher vigilant to potentials that concerns and allows multiple paradigms for a greater variety of perspectives.
- It combined inductive and inferential perspectives.

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3.4 Research Setting

The research setting refers to the specific place or places were the data was collected or physical location and condition in which data collection takes place in a study (Brink, van der Walt and Van Rensburg, 2013:131).

The KZN, formerly known as Natal province, is situated in the Southeastern portion of South Africa and shares borders with Swaziland, Mozambique and Lesotho. The province generally belongs to various ethnic groups. Most blacks are concentrated in rural areas consisting of broken, rugged country and most whites live along the coast. The province is divided into one metropolitan municipality (eThekwini metropolitan Municipality) and ten districts, namely: Amajuba, Harry Gwala, ILembe, King Cetswayo, Ugu, uMgungundlovu, Umkhanyakude, uMzinyathi, uThukela and Zululand. According to mid-year population estimates from 2018, the province is the second largest province, with an estimated population of 11.1 million. This study was carried out in five districts (eThekwini, Harry Gwala, King Cetswayo, uMgungundlovu and uMzinyathi) of KZN Province of South Africa from - September 2017- to November 2018.

The five mentioned districts were chosen for the following reasons: Firstly, during district quarterly meeting, data indicated that there is high number of women admitted due to incomplete abortions that need PAC services; in 23 hospitals in five above mentioned districts the number of women admitted for incomplete abortions ranged between 6 to 13 patients per day per hospital. This was approximately 540 to 1 620 cases per quarter per hospital. This was including the district, regional and tertiary hospital. It was difficult to collect data from the other hospitals in all eleven districts, for reason which was beyond the researcher’s control.

Secondly, eThekwini is a metropolitan municipality which shows alarmingly high statistics of incomplete abortions amongst women and young girls of different cultures (DHIS: 2017/18 FY). Thus, the district was an appropriate setting for gleaning information and shedding light on the challenges regarding post abortion care. UMgungundlovu is the peri urban district where the population is a combination of high, middle, and low socio-economic status.

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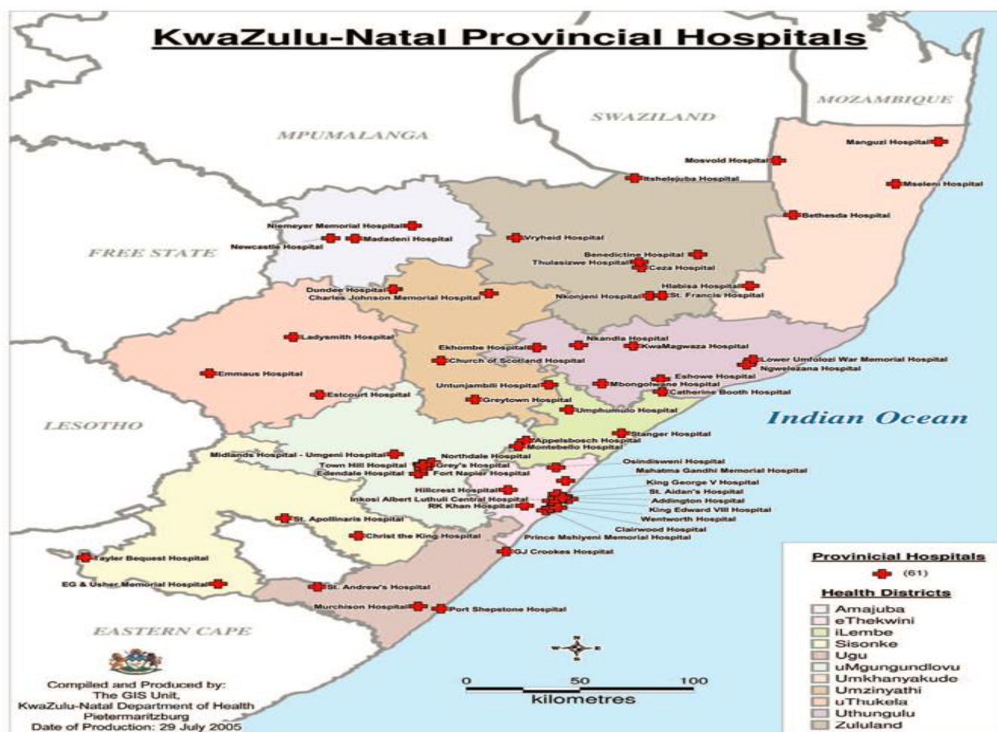
There is high number of teenage pregnancies reported at the district. The rest of the districts are in the rural areas where there is low level of education that leads to unwanted pregnancies.

Lastly, the districts that are chosen show that there is low uptake of contraception. Again due to the sensitivity of the topic it was also identified that there was no study that was ever done on post abortion care in those districts.



Source: GIS unit KZN DoH Pietermaritzburg: 29 July 2005.

Figure 3.2 KwaZulu Natal Province Districts and Hospitals

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3.5 Qualitative Research Design

3.5.1 Objective

Qualitative exploratory descriptive and contextual research was used for objectives 1 and 2 which are:

- To explore and describe the perceptions of women who have accessed post abortion care on the management of abortion at selected hospitals of KwaZulu Natal Province, South Africa.
- To identify the challenges faced by health care workers when providing post abortion care at selected districts of KwaZulu Natal Province, South Africa.

Qualitative research was used to investigate phenomena in a typically in-depth and holistic fashion, through collecting rich narrative material using flexible research design (Terre Blanche, Durrein and Painter, 2011:78). A qualitative research approach was appropriate for this study to identify challenges experienced by health care workers on management of post abortion care. Furthermore, the researcher desired to explore and describe the perceptions of women who have accessed abortion. The researcher was the key instrument for data collection.

A qualitative design takes on perspective that explores and describes the depth, richness and complexity of the subject of discussion which, in this study culminates in the development of guidelines for the management of complications of abortion. The researcher has a few preconceived ideas but stressed the importance of learning from health care professionals and from the interpretation of challenges experienced by health care professionals when managing complications of abortion and women when accessing abortion (Polit Beck, 2012: 146).

3.5.2 Exploratory Research Design

The intention of exploratory research design is to explore the dimensions of a phenomenon as it manifests itself, and as other factors relate to it (Polit & Beck,

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2012:148). This exploratory study helps to uncover a relatively unknown research area to gain new insight on the challenges phased by health care providers during the management of post abortion care in the facilities through focus group discussion.

In this study, detailed information was gathered by means of in-depth interviews in order to explore and describe perceptions of women who have accessed post abortion care. With exploratory design, a researcher aims to gain insight to develop new ideas, concepts and theories regarding a problem under review. Within the context of this study, exploration was used to gain insight into the views of participants regarding support from health care workers who manage post abortion care patients.

The study design was exploratory in character, especially considering that the study also intended to explore and determine the depth, richness and complexity of the knowledge of health care workers in KZN with regard to abortion management and post abortion care, and insight into the phenomenon. Again, the study identified the challenges faced by health care workers when providing abortion and management of complications of abortion and post abortion care needed by women who accessed post abortion care.

3.5.3 Descriptive Research Design

Descriptive suggests a precise account of the phenomenon being studied. Descriptive research aims toward accurately and completely describing phenomena in real life situations, discovering new meaning and determining frequencies with which something occurs (Burns and Brinks, 2013:32).

Through a descriptive design, concepts are described and discussed and relationships are identified to provide the basis for further research. It is important for the researcher to accurately describe the phenomenon under study (Polit and Beck, 2012:44).

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In this study, descriptive research also involves the collection of qualitative data through individual interviews with women regarding their perceptions on abortion and descriptions of the challenges faced by health care workers when providing management of complications of post abortion care. It is the health care workers' understanding of views and perceptions regarding challenges in the context of managing complications of abortions that can provide a relevant description.

In this study, the themes and sub-themes that emerged from interviews with women accessing post abortion care and from focus group discussions with health care workers provided a description of the current situation and could be used to develop guidelines for management of Post Abortion Care at selected districts in KwaZulu-Natal Province, South Africa. The information from quantitative data provided additional information for the description.

3.5.4 Research Population

Ranjit (2011:21) specified that research includes human subjects of a specific population from which information to answer the research questions are obtained. There is a clear distinction between a target population and an accessible population. Botma, Mulaudzi & Wright, (2010:123) define a target population as the entire set or aggregation of objects, persons, behavior or events, or any other single unit of a study sometimes called element of single unit that meet a sampling criteria. Accessible population is a portion of a target population to which the researcher has reasonable access (Grove et al., 2013:351).

In this study the accessible target population included two groups:

- **The first group**: Post abortion care users: This where the women who had access post abortion care services due to incomplete abortion-related complications from any of the 23 study selected hospitals during the study period. They form a group of analysis for the study. They provide information on the perceived challenges that they have experienced when they access post abortion care services at the study sites.

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- **The second group:** Health care workers: These are the health care workers that are responsible for providing post abortion care service in the study sites**.** The researcher was intended to have focus group discussion and observe the providers who were involved in providing post abortion care services in the study sites, however, only the health care workers who gave consent were involved in the study. They provide information on perceived challenges on rendering post abortion care services.

3.5.5 Sampling

Sampling refers to the process of choosing suitable participants or tests for inclusion in the study (Kumar, 2009:630). According to Haddad and Nour, (2009:176), abortion is a sensitive topic and it is regarded as a difficult topic to get information on. Only limited research has been conducted about post abortion care services because of its enormousness and consequences (Rasch and Kipiling: 2009:178).

Due to the difficulties of keeping the records of women who have accessed post abortion care services and retaining the staff at the unit where women are admitted, the researcher then decided to utilize convenience sampling technique to sample the participants.

The primary purpose of sampling is to obtain a representative or a small collection of units from a larger population that the researcher can study and produce accurate generalizations about the larger group (Neumann, 2006:113). A researcher usually works with samples as it is more economical and practical to implement and obtain reasonable information from a sample than from the whole populations (Polit and Beck, 2012:98). For this study, convenience sampling was done to select both hospitals and participants.

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3.5.5.1 Criterion Sampling

Criterion sampling is defined as a purposeful sampling where the researcher developed the preconceived criterion for purposeful sampling (Suri, 2011:62). In this study, the criterion sampling was used to select the study districts and hospitals, PAC providers (health care workers) and the PAC users (women).

3.5.5.2 Sampling of Health Hospitals

In this study, purposive sampling was used for selection of hospitals with high numbers of women admitted for PAC services. The hospital was selected if it provides PAC including comprehensive sexual and reproductive services, i.e. admission, treatment, counselling and contraceptives. Facilities that provide only one or two elements of SRH services were not included e.g. in other districts, there are specialized care facilities like TB hospital that provides only contraceptives, and they were not included.

The total number of patients admitted for incomplete abortion was considered and only facilities that are admitting high numbers were selected. The rating was counting from highest number of women admitted in a facility per quarter in a district down to the lowest number admitted and the 23 facilities were selected for the study in all five districts. The hospital must be a public hospital. The private hospital was not included since it was difficult to get ethical approval to gain entry. Therefore, 23 public facilities were selected for the study from five districts.

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Table 3.1: Districts and hospitals in KwaZulu Natal

eThekwini District (A)		
	Hospital Name	**Number of incomplete abortion admitted per quarter**
1.	Addington	1 619
2.	Wentworth	1 578
3.	Prince Mshiyeni	1 352
4.	King Dinizulu	841
5.	King Edward Viii	628
Total	**05**	**6 019**
Harry Gwala District (B)		
	Hospital Name	**Number of incomplete abortion admitted per quarter**
1.	Christ the King	852
2.	Rietvlei	650
3.	St Apollnaris	639
4.	St Margret's	629
5.	E.G & Asher	543
Total	**05**	**3 313**
uMgungundlovu District (C)		
	Hospital Name	**Number of incomplete abortion admitted per quarter**
1.	Northdale	1 342
2.	Edendale	1 060
3.	Greys	562
4.	Appelbosch	549
Total	**04**	**3 513**
uMzinyathi District (D)		
	Hospital Name	**Number of incomplete abortion admitted per quarter**
1.	Greytown	995
2.	Dundee	751
3.	Charles Johnson	722
4.	Church of Scotland,	631
Total	**04**	**3 099**
King Cetswayo District (E)		
	Hospital Name	**Number of incomplete abortion admitted per quarter**
1.	Lower Umfolozi	1 620
2.	Eshowe	1 326
3.	Mbongolwane,	688
4.	Kwamagwaza,	542
5.	Nkandla	531
Total	**05**	**4 707**
	Total	11 320

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3.5.5.2 Sampling of women

According to Groove et al., (2013:123) sampling is a process of selecting a group of people, events, behavior or other elements to conduct a study. Though abortion is still stigmatized in South Africa, reducing the morbidity and mortality of women due to mismanagement of incomplete abortions is still the number one priority. The majority of women who have gone through induced or spontaneous abortion often hide themselves from the community at large and arrive at the hospital late with complications. For this reason the researcher decided that it is important to know the perspectives from women to identify the challenges that women came across when accessing post abortion care services. The researcher felt that it was not possible to separate the women who have illegal and legal induced abortions. Therefore, the researcher decided that the woman is eligible to participate in the study if she is admitted in one of the hospital study sites with incomplete abortion. Women were not questioned about the cause of incomplete abortion. The women were recruited for interview by the researcher on discharge. Convenience sampling was employed and women were recruited irrespective of age. Women who refused to participate in the study were excluded from the study.

3.5.5.3 Sampling Size of Women who have accessed PAC Services

According to Polit and Beck (2008:76), sample size refers to a subset of population, selected by the researcher to participate in a research study. In qualitative research, when purposive sampling is used, the researcher did know in advance how many participants were being needed (Brink: 2011:217).

A total of 66 women were recruited for the study. About 34.8% (23) of the recruited women participated in the study from the 23 facilities in five districts. One participant was interviewed in each facility. One month was spent in each facility for recruitment and interview.

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In district A, 19 (28.7%) women who accessed post abortion care were recruited to the study. 5 (26.3%) of the recruited women were interviewed and 14 (73.6%) declined to participate in the interview. In district B, 9 (13.6%) women were recruited, of which 5 (55.5%) agreed to participate in the interview. 4 (44.5%) declined to participate in the interview. In district C, 13 (19.6%) women were recruited to participate in the study and out of these, 4 (30.7%) agreed to participate in the study and 9 (69.2%) declined to participate. In district D, 14 (21%) were recruited to participate in the interview for the study and only 4 (28.5%) agreed to participate in the interview and 10 (71.4%) declined to be interviewed. In district E, 11 (16.6%) women were recruited to participate in the study and 5 (45.4%) agree to participate, while 6 (54.6%) declined.

Table 3.2: The response rate among the women who access PAC services

District	Successfully interviewed, one woman per facility		Refused	
	N	%	N	%
A	5	26.3	14	73.6
B	5	55.5	4	44.4
C	4	30.7	9	69.2
D	4	28.5	10	71.4
E	5	45.4	6	54.6
Total	23		43	
N= 66				

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3.5.5.5 Sampling of Health Care Workers (Doctors, Registered Nurses or Registered Midwives)

Convenient sampling method was used in the selection of fifty health care workers involved in providing post abortion care services. In convenience sampling, also called accidental sampling, participants are included in the study because they are available at the time when invited for participation in a focus group. Convenient sampling is inexpensive, accessible and usually requires less time than other types of sampling (Burns and Groove, 2011:165). Health care workers who were involved in providing post abortion care services in the study site during the period of data collection were included in the study. Health care workers who were either doctors and registered with Health Professional Council South Africa (HPCSA) or registered midwifes or registered nurses registered with South African Nursing Council (SANC) were eligible for participation if they also had at least 6 months' experience or more caring for women seeking post abortion care. Health care workers who were working in the admitting award at the public selected hospital and those who agreed to participate in the study were included in the study. The health care workers were given an information leaflet prior to data collection. Contact information of the health care workers were taken and later used to request them to be in focus group discussion. A total of ninety-two (92) out of 376 health care providers from 23 selected facilities were approached for participation in the study. However, only fifty agreed to participate in the study.

3.6 Data Collection

Data collection refers to systematic gathering of information relevant to the research purpose or specific objective, question or hypothesis of the study (Burns and Groove, 2011. This study employed a range of data collection instruments. The data collection tool is determined by the purpose of the research, the resources, the skills and study site (Kumar, 2005:36). In-depth interview, focus group discussion and observation checklist were the main data collection instrument in this study. Data collection tool can be found in Annexa 11 and 12.

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The following objectives were covered:

- To explore perceptions of women who access post abortion care services.
- To explore the challenges experienced by health care professional when managing abortion complications.

3.6.1 Data Collection Method

3.6.1.2 In-Depth One-One Interview for Women who had Accessed PAC Services

In-depth one-to-one interviews were used because they are focused, discursive and allow the researcher to determine individual's perception, opinions, facts and forecasts and their reactions to initial findings and potential solutions (Speziale and Carpenter, 2007;403). In-depth interview was chosen as the data collection tool to gather a broad range of information from women on their understanding on post abortion care.

A questionnaire was administered to the participants on the day of the discharge before they left the facility after receiving post abortion care in the study site. The data collection tool collected the information on their demographic characteristics, and their perceptions on challenges when accessing post abortion care services. Only women who agreed and signed the consent form were interviewed. Women who were not psychological stable and those who refuse to sign the consent form were not included in the study.

The interview guide included three major sections. The first section collected personnel information of the participants. The second part asked information on socio-economic, demographic and reproductive issues of the participants. The third part gathered the information about the interview discussion. The interview was initiated by asking the women the following probing questions: How was it for you when attending/accessing the post abortion care services at this hospital? Kindly

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share with me the challenges you have experienced and the support that you have received when accessing post abortion care service. How long did you take to arrive at this facility?

On the day of data collection, the researcher requested the unit manager to allocate a quiet room in order to ensure comfort and privacy during the interview. The Interview session lasts for 40 to 45 minutes per interview. The researcher established relationship by paying attention to what the respondents were saying. Discussions were led by a spontaneous chat in a comfortable relaxed way. Listening and interviewing skills were used by listening attentively to the respondents' stories (see Polit & Beck, 2005). An audio recorder was used by the researcher after obtaining consent from the participants.

During the recorded interviews, the researcher also took field notes. Non-verbal communications/gestures were also observed when coding the interview and jotted down in the field notes. In order to encourage the respondents to produce more in-depth information about the study, the research probed with extra questions. Furthermore, the researcher asked some respondents to elaborate on some of their statements in order to get clarity and avoid misunderstanding (see Henning et al., 2004). At the end of the interview, the researcher strove for a positive closure to the interview, by summing up interview, giving the respondent an opportunity to clarify, refine or correct the interviewer's summary (see Pilot and Hungler, 2006).

3.6.1.3 Focus Group Discussion with the Health Care Workers

Data was collected through Focus Group Discussion (FGD) interview (see de Vos et al., 2011) in order to gather information and understand perceptions and views with regards to challenges on post abortion care. A focus group is similar to one-on-one interviews; the main difference is that it is done with a group of people, exploring and stimulating ideas based on shared perceptions of the world rather than individual.

In this study to cover the second objectives from the health care workers, 5 FGDs were conducted, and each group has one session per day, which lasted for one

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hour. Participants were recruited with the assistance from the MCWH coordinators from each district at the study sites. For each discussion a group, a maximum of 10 participants were recruited to participate in the group discussion, the selection took into consideration the various positions in the unit, demographic backgrounds, and race and work experience. After the recruitment, the FGD participants were contacted regarding the date, time and the venue of the discussion. Participants from the same district formed a one discussion group. Having participants from same district in one discussion group ensures that the participants talk freely and share the same sentiments. The venue for the FGD was identified with the help from District MWCH Coordinator in each district.

The FGDs were conducted during day off of all the participants to avoid disruption during working hours. The FGDs were conducted out of the hospital setting at an accessible central venue at each district e.g. eThekwini (Addington Hospital), Harry Gwala (Christ the King Hospital) uMgungundlovu (Northdale Hospital), uMzinyathi (CJM Hospital), King Cetswayo (Lower Umfolozi Hospital). The venues were chosen considering accessibility and privacy during the discussion.

The discussion focused on health care workers' perceptions on challenges when providing post abortion care. The discussion was conducted in English which is a medium of instruction is KwaZulu-Natal. The participants were asked to sign the consent form before the discussion. The researcher was accompanied by the moderator and the scriber on the day of data collection and tape recorder was also used to record the discussion. The discussion was recorded and transcribe verbatim at the end of each discussion. Permission to use voice recorder was obtained from the respondents.

The purpose of the group discussions was explained to the respondents by the researcher to ensure that ethical consideration such as assurances of beneficence and the rights to withdraw from the research were applied. The researcher created an accepted atmosphere amongst the group and encouraged participants to share discernments, opinions, experiences, desires and concerns without coercing respondents to reach agreement (see Monett et al., 2005 cited in de Vos et al., 2011). This technique was useful in allowing participants to share their opinions with

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one another. The researcher created a favorable setting for discussion by warmly appreciating the participants for their enthusiasm to participate in the study. The discussion lasted between one to one and half hours.

3.7 Data Analysis

The analysis of data was started at the time of data collection and not at the end of data collection, as qualitative analysis begins early in a research project, while the data is still being collected. This is conducted to reduce, organize and give meaning to data. Qualitative researchers look for patterns or relationships. In this study, qualitative data were analyzed with non-numerical assessment of observations made through in-depth interview and focus group. Tesch's eight steps of systematically analyzing textual data were used (Creswell, 2009:317).

8 Steps of Tesch's inductive, descriptive open coding technique Creswell (2014) was used by following the steps below:

- **Step 1 – Reading through the data**

The researcher carefully and repeatedly read the transcripts of all the participants. Reading through all the verbatim transcriptions gave the researcher a sense of the whole, and triggered ideas about the data segments and how they look like/mean. The meanings that emerged during reading were written down. An uninterrupted period of time to digest and think about the data in totality was created. The researcher could then engage in data analysis and write notes and impressions as they came to mind.

- **Step 2 – Reduction of the collected data**

The researcher scaled down the data collected to codes based on the existence and/or frequency of concepts used in the verbatim transcriptions. The researcher then listed all topics or themes that emerged during the scaling down. The researcher grouped similar topics together, and those that did not have association

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were clustered separately. The researcher started recording thoughts about the data in the margins of the paper where the verbatim transcripts were written.

- **Step 3 – Asking questions about the meaning of the collected data**

The researcher read through the transcriptions again and analysed them. This time the researcher asked herself questions about the transcriptions of the interview, based on the codes (mental picture codes when reading through) which existed from the frequency of the concepts. The questions were “Which words describe it?” “What is this about?” and “What is the underlying meaning”?

- **Step 4 – Abbreviation of topics to codes**

The researcher started to abbreviate the topics that emerged as codes. These codes were written next to the appropriate segments of the transcription. Differentiation of the codes by including all meaningful instances of a specific code’s data was done. All codes were written on the margins of the paper against the data they represent with a different pen colour than the one in Step 3.

- **Step 5 – Development of themes and sub-themes**

The researcher developed themes and sub-themes from coded data and the associated texts and reduced the total list by grouping topics that relate to one another to create meaning of the themes and sub-themes.

- **Step 6 – Comparing the codes, topics and themes for duplication**

The researcher reworked from the beginning, to check the work for duplication and to refine codes, topics and themes where necessary. The researcher grouped similar codes and recoded others where necessary so that they fit in the description.

- **Step 7 – Initial grouping of all themes and sub-themes**

The data belonging to each theme were assembled in one column and preliminary analysis was performed, which was followed by the meeting between the researcher

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and co-coder to reach consensus on themes and sub-themes that each one has come up with independently.

- **Step 8 – Recoding if necessary**

Recoding was done with the existing data to allow for consensus on themes and sub-themes.

3.8 Trustworthiness of the qualitative study

The root of trustworthiness was first outlined and published by Guba in (1979:29) who raised four (4) concerns that any researcher carrying out qualitative studies needs to address (Anney 2014 : 275). Trustworthiness is concerned with how the researcher establishes confidence and what makes the findings genuine – what is the true value. How does the researcher determine applicability or transfer the findings to other settings/participants? How would one achieve consistency or repeat the study with the same participants and get the same results.

3.8.1 Credibility

Credibility refers to the value, believability and the degree to which the findings and research study methods used to generate research findings can be trusted (Houghton et al., 2013:17). Credibility alludes to confidence in the truth of the data and the interpretation thereof (Speziale and Carpenter, 2007:309).

One strategy to establish credibility is through prolonged engagement with the participants during data collection and with the data during data analysis. In this study, the researcher engaged with the participants when informing them about the study, when they signed an informed consent form, during the interview and also during guideline validation. The researcher collected and analyzed the data in such a way that the findings reflected the state of affairs regarding the phenomenon. The

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interviews were recorded on audiotapes to capture the original responses and were transcribed in order to maintain the original meanings.

Bracketing was employed where the researcher had to put a way what she knew about the topic to allow data to convey undistorted information. The health care workers who participated in the study were given the opportunity to validate that the reported findings represented their own words that they have shared with the researcher. The discussion was conducted in English and IsiZulu.

3.8.2 Dependability

Dependability of qualitative data refers to the stability of data over time and over various conditions (Polit and Beck, 2012:119). The researcher ensures that dependability was achieved by applying strategies to enhance credibility of the study with an audit trial established to enable others to judge the study.

To meet the criteria for dependability in this study, the researcher engaged a consultant to do independent data analysis for each individual interview and discussion. The collected data and analysis was then checked for comparability and discrepancies and was resolved through member checking with the participants. In order to enhance objectivity, the researcher shared the transcript with other experienced researchers who independently did the analysis and compared notes.

3.8.3 Conformability

This refers to the objectivity, the potential for congruency between two or more independent people about the data accuracy, relevance or meaning. This is also concerned with establishing that the data represent the information provided by participants and not researcher's imagination (Lincoln & Guba 2010: 421). To ensure conformability, the researcher used audit trial, in which approaches to data collection, decisions about what data to collect, and decisions about the interpretation of data were carefully documented so that another knowledgeable

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researcher could arrive at the same conclusions about the data and for protection of human subjects as required by institutional review boards.

3.8.4 Transferability

Transferability refers to whether the findings of a qualitative study can be transferred to other similar contexts or settings. Transferability of the findings rests with the potential users and with not the researcher (Polit & Beck, 2012:178). In this study, the researcher spent sufficient time in the field and gave a rich description of the context and assumptions that guided the research process and findings. The guidelines that were developed were applied to management of post abortion care.

3.9 Quantitative Research Design

A quantitative empirical study was designed to objective number 3.

3.9.1 Objective 3

Assess the hospitals and skills of health care workers providing post abortion care in selected districts of KwaZulu Natal Province, South Africa.

3.9.2 Non-Experimental Descriptive Design

Quantitative descriptive observation design was used for objective 3, which was to assess the skills of health care workers providing PAC at selected districts. According to the literature (Creswell, 2009:327; Burns & Groove, 2009:181), quantitative research is a means of testing objective theories by examining the relationship among variables and these variables can in turn be measured, typically on instruments, so that numbered data can be analyzed using statistical procedures. Furthermore, Creswell (2009:265) explains that those who are involved in this form of analysis have assumptions about testing theories deductively, building in

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protections against bias, controlling for alternative explanations, and being able to generalize and replace the findings.

3.9.3 Observation

Observations took place in the participants' work place while the participants were offering post abortion care services. Observation technique was used because it helps the researcher to observe and describe important changes in human interactions and behaviour. The researcher was able to document health care providers and patients interactions, quality delivery of post abortion care services. The observations were without physical participation with the participants, as recommended by Merriam (2009:631). Permission was granted to enter the consultation room and this was in line with Sapsford and Juppe (2006:234) who stated that the researcher has to negotiate access to gain entry to conduct observational research. According to de Vos et al., (2005:294), it is recommended that the observer study the natural and daily activities of the subject under investigation with regard to the field under investigation. The aim of observation study is to get to know the participants and hear and see what they do and say.

3.9.4 Population

Convenient sampling method was used in selection of ninety-two (92) health care workers involved in providing post abortion care services. Four health care workers (3 nurses and 1 doctor) were selected from each of twenty-three hospitals in five districts. In convenience sampling, also called accidental sampling, participants are included in the study because they are available at the time when skill observations were assessed. Convenient sampling is inexpensive, accessible and usually require less time that other types of sampling (Burns and Grove, 2011:165).

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3.9.5 Sampling

3.9.5.1 Sampling of Facilities

The 23 mentioned hospitals were due to high number of women admitted due to incomplete abortions that need PAC services (range between 540 to 1 620) cases). Out of the total number of 72 hospitals in KZN; 23 hospitals were selected in five districts and the number of women admitted for incomplete abortion ranged from 6 to 13 per day per hospital. This was approximately 540 to 1 620 cases per quarter per hospital. This was including the district, regional and tertiary hospitals. It was difficult to collect data from other hospitals in all eleven districts, for reason was beyond the researcher's control.

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Table 3.3: Districts and hospitals in KwaZulu Natal number of Incomplete Abortion Admitted per quarter (2017/18 Financial year)

eThekwini District (A)			
Total number of hospitals		Selected Hospital Name	Number of incomplete abortion admitted per quarter
Addington Hosp Charles James Hosp Clairwood Hosp Don McKenzie Hosp Ekurhuleni Care Centre Hosp FOSA Hosp Hillcrest R K Khan Hosp St. Aidan's Hosp	Inkosi Albert Luthuli Hosp King Dinuzulu Hosp King Edward VIII Hosp KZN Children Hosp Mahatma Gandhi Hosp McCord Hosp Osindisiwe Hosp Prince Mshiyeni Hosp Wentworth Hosp	Addington Wentworth Prince Mshiyeni King Dinizulu King Edward Viii	1 619 1 578 1 352 841 628
Total= 18		05	6 019

Harry Gwala District (B)		
Total number of hospitals	Selected Hospital Name	Number of incomplete abortion admitted per quarter
Christ the King Hosp E.G & Usher Hosp Rietvlei Hosp St. Apollinaris Hosp St. Margret's Hosp uMzimkhulu Hosp	Christ the King	852
	Rietvlei	650
	St Apollnaris	639
	St Margret's	629
	E.G & Asher	543
Total=6	05	3 313

uMgungundlovu District (C)		
Total number of hospitals	Selected Hospital Name	Number of incomplete abortion admitted per quarter
Appelsbosch Hosp Edendale Hosp Doris Goodwin Hosp Fort Napier Hops Grey's Hosp Northdale Hosp Richmond Hosp Townhill Hosp UMngeni Hosp	Northdale	1 342
	Edendale	1 060
	Greys	562
	Appelbosch	549
Total=9	04	3 513

uMzinyathi District (D)		
Total number of hospitals	Selected Hospital Name	Number of incomplete abortion admitted per quarter
Charles Jonson Hosp Church of Scotland Hosp Dundee Hosp Greytown Hosp	Greytown	995
	Dundee	751
	Charles Johnson	722
	Church of Scotland,	631
Total=4	04	3 099

King Cetswayo District (E)		
Total number of hospitals	**Selected Hospital Name**	**Number of incomplete abortion admitted per quarter**
Catharine Booth Hosp Ekhombe Hosp Eshowe Hosp Lower Umfolozi War Memorial Hosp Mbongolwane Hosp Ngwelezane Hosp Nkandla Hosp Kwamagwaza Hosp	Lower Umfolozi	1 620
	Eshowe	1 326
	Mbongolwane,	688
	Kwamagwaza,	542
	Nkandla	531
Total= 9	**05**	**4 707**

ILembe District (F)		
Total number of hospitals	**Selected Hospital Name**	**Number of incomplete abortion admitted per quarter**
Montebello Hosp	None	275
Stanger Hosp		625
Umphumulo Hosp		532
Untumjambili Hosp		688
Total= 4		**2 120**

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uMkhanyakude District (G)		
Total number of hospitals	**Selected Hospital Name**	**Number of incomplete abortion admitted per quarter**
Bethesda Hosp	None	275
Hlabisa Hosp		76
Manguzi Hosp		119
Mosvold Hosp		218
Mseleni Hosp		391
Total= 5		**1 079**
Ugu District (H)		
Total number of hospitals	**Selected Hospital Name**	**Number of incomplete abortion admitted per quarter**
Dunstall Farrell Hosp	None	197
G.J Crookes Hosp		421
Murchison Hosp		219
Port Shepstone Hosp		165
St. Andrews Hosp		208
Total= 5		**1 210**
UThukela District (I)		
Total number of hospitals	**Selected Hospital Name**	**Number of incomplete abortion admitted per quarter**
Emmaus Hosp	None	175
Estcourt Hosp		321
Ladysmith Hosp		487
Total= 3		**983**
Amajuba District (J)		
Total number of hospitals	**Selected Hospital Name**	**Number of incomplete abortion admitted per quarter**
Madadeni	None	14
Newcastle		979
Niemeyer		271
Total= 3		**1 264**
Zululand District (K)		
Total number of hospitals	**Selected Hospital Name**	**Number of incomplete abortion admitted per quarter**
Benedictine Hosp	None	193
Ceza Hosp		197
Itshelejuba Hosp		221
Nkojeni Hosp		376
Vryheid Hosp		467
Total= 5		**1 454**
Total=70	**23**	**28 761**

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3.9.5.2 Sampling of the Health Care Workers

Convenience sampling (Brink et al., 2012) was used to select the population as described under section 3.5.5 of the qualitative study. In each facility, the researcher visited the units where women were admitted due to incomplete abortion. In each unit, 3 nurses and 1 doctor, in other words 4 respondents per hospital (23 hospitals) making it a total of 92 participants selected out of the total of 265 health care workers whose skills were observed during provision of PAC services.

Table 3.3: Sampling of Health care workers per hospital

eThekwini District	
1. Addington	4
2. King Dinizulu	4
3. Prince Mshiyeni	4
4. Wentworth	4
5. King Edward Viii	4
Total	**20**
Harry Gwala District	
1. Christ the King	4
2. Rietvlei	4
3. St Apollnaris	4
4. St Margret's	4
5. E.G & Asher	4
Total	**20**
uMgungundlovu District	
1. Northdale	4
2. Appelbosch	4
3. Greys	4
4. Edendale	4
Total	**16**
uMzinyathi District	
1. Greytown	4
2. Dundee	4
3. Charles Johnson	4
4. Church of Scotland,	4
Total	**16**
King Cetswayo District	
1. Nkandla	4
2. Kwamagwaza,	4
3. Mbongolwane,	4
4. Lower Umfolozi	4
5. Eshowe	4
6. **Total**	**20**
Total 23 facilities	**92 health care workers**

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3.9.5.3 Inclusion Criteria

Inclusion criteria were done as described under qualitative design (Brink et al., 2012). All respondents who agreed to participate in the study were given the informed consent form to sign. The sample comprised both doctors and nurses from the selected hospitals. Health care workers who were involved in providing post abortion care services in the study site during the period of data collection were included in the study. Health care workers who were either doctors and registered with Health Professional Council South Africa (HPCSA) or registered midwifes or registered nurses registered with South African Nursing Council (SANC) were eligible for participation if they also had at least 6 months' experience or more caring for women seeking post abortion care. Health care workers who were working in the admitting award at the public selected hospital and those who agreed to participate in the study were included in the study. The health care workers were given an information leaflet prior to data collection. Contact information of the health care workers were taken and later used to request them to be in focus group discussion.

3.9.6 Data Collection

Observations were done using observation techniques at the participants' natural areas of work to assess their competency skills in rendering PAC services. According to Yosritzal (2014: 291), observation is a method of data collection in which researchers observe within a specific field. It is sometimes referred to as an obstructive method. In this study, data was collected using observation competency skills checklist (see Kerkvliet and Spithoff). The basic objective of the competency tool was to obtain facts about the phenomenon from the people who are informed on the particular issue (de Vos et al., 2012:265).

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Four key questions were considered when conducting observation:

Where to observe? The observation took place in the 23 selected hospitals of KZN province South Africa where the researcher had carried out the in-depth interviews with the women who had accessed post abortion care. The researcher requested permission to be in the consultation room with the health care worker and the woman who was given post abortion care services. In each hospital, 3 nurses and 1 doctor were assessed in GOPD, Gynae ward or TOP ward.

When to observe? Data was collected by the researcher and the research assistant observed one person each, at one hospital per day, from the 13th May to 3rd July 2018, from 08h00 in the morning to 16h00 late afternoon.

Who to observe? Four health care workers per institution were observed with the maximum of 92 health care workers in total in all 23 facilities.

What to observe? The researcher used a checklist to tick “yes” if the respondent did an activity and tick “no” if the activity was not done and comments were written if the respondent explained some activities without actually doing them (Annexa 9).

3.9.7 Data Analysis

Analysis of quantitative data involved the third objective of the study, to assess the hospitals and skills of health care workers providing post abortion care services. The dependent variable of interest was skills observation of the health care workers when rendering PAC at the time of the study. The primary independent variable, each health care worker was observed on the following skills: Demographic data, infection control activities, guidelines availability in 23 facilities, client interaction activities, pre abortion care activities, contraceptives offered, surgical abortion (MVA) services, post abortion care services and continuation of care.

The researcher examined descriptive statistics to explore dependant and independent variables of interest. Data were entered and analysed using Statistical Package for Social Science Statistical (SPSS) 20 for Windows (SPSS Inc. version 20). Data

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cleaning was done by running frequencies; cross-tabulation and shortcoming reported variables.

3.9.8 Validity and Reliability

Validity refers to the degree to which an instrument measures what it is supposed to be measuring (Polit and Hungler, 2016:279). In order to ensure validity of the Checklist Agree Reporting (CAR) instrument used for this quantitative observation study, the main basis of evidence used during the design of CAR included face and content validity. According to Allen et al., (2007), face validity evidence implies a casual examination of the instrument items to determine whether they cover the content that the instrument claims to measure, as viewed by layperson, users, or experts. The researcher therefore, established the content validity, including the identification of the domain of the content through review of relevant literature, generating the pool of items accordingly, and developing the CAR checklist. During this phase, the preliminary pool of sections was written, the CAR checklist was constructed, and the expect review form was developed.

The development of the items and the construction of the CAR checklist by the researcher was based and guided primarily by: (1) review of literature and instruments from similar studies conducted locally and internationally; (2) the review of literature review regarding internal evaluation in health facilities with the emphasis in PAC services, to provide a solid bases on the sections a here point rating scale (yes. Some extent no) was developed to rate each of the items of the CAR checklist. The observation instrument tool was used. The instrument contains nine sections: demographic data, infection control activities, guidelines availability in 23 facilities, client interaction activities, pre abortion care activities, contraceptives methods, surgical abortion, post abortion care services and continuation of care.

The instrument was critically reviewed and corrected by the potential expects in the content area who were purposively selected by the researcher. The expect reviewed if the wording and format of the checklist was appropriate and identify ways in which

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CAR checklist could be improved (e.g., clarity and readability of items), in order to include further recommendations into it prior to its application.

3.9.9 Dissemination of the Study Findings

The final study report document was given to audiences including research subjects, health care providers, policy makers and community groups. Dissemination of the guidelines developed were broad-based as much as possible including, national and international distribution through journals and website for publications.

3.10 Ethical Considerations

Scientific studies are to be done with respect for person, beneficence, and justice (Polit & Beck, 2008:170). In this study, the research was carried out in a way that fostered autonomy, justice, beneficence and non-maleficence.

The study was conducted in South Africa where abortion is legal and there was no attempt to differentiate between patients who had spontaneous abortion, and who had induced abortion – legal or illegal. Such differentiation could put the subjects of study at some risk of social retribution, ostracism or penalty. The researcher's aim was to show a link to improved health and safer clinical care and not to justify attempts to categorize women with induced abortion.

3.11 Ethical Clearance

Ethical clearance to conduct research on developing guidelines of post abortion care management in KwaZulu-Natal was granted by the University of Venda Health, Safety and Research Ethics Committee. Furthermore, the Department of Health in the KwaZulu-Natal province granted permission to utilize the hospitals and the participants who in this case were health care workers and the women who had accessed abortion. A letter outlining the purpose and study methods was sent to the

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prospective districts and hospitals inviting health care workers and women to participate in the study.

3.12 Informed Consent

Informed consent means that the participants should have adequate information regarding the research: the purpose and scope of the study, types of questions that might be asked, how the results will be used and how their anonymity will be protected (Polit and Beck, 2012:176). After getting permission to conduct the study, arrangements were made for data gathering from the health care workers and the women at selected hospitals. The letter of information about the research was accompanied by the informed consent form (annexure 2a), explaining the purpose of the study, procedure, potential benefit, assurance of confidentiality, description of risks, alternatives to participation and subjects right to withdrawal.

3.13 Privacy and Confidentiality

The identity of the participants was protected in various ways. The information reflected in the communication of the research results was presented in a way that it could not be connected to a specific individual and institution (Kaiser, 2009:87).

3.14 Freedom from Harm (Protection from Exploitation)

The participants were informed to feel free to withdraw at any stage from the study and that they should not have to give prior notice about withdrawal or provide any explanation (see Kaiser, 2009:88).

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3.15 Protection of Human Rights

The researcher and reviewers have ethical responsibility to uphold and protect the rights of human research subjects in order to preserve their self-respect, dignity and health (see Burns & Groove, 2009:97). The researcher employed the major ethical principles, namely, beneficence, respect for human dignity and justice.

3.16 Summary

This chapter addressed the design and the methods of Phase 1, the qualitative and quantitative parts of the study. It described the setting, population, sampling, inclusion criteria and analysis. The design and methodology of Phase 1 focused on achieving the following objectives: To identify the challenges that are encountered by women when accessing PAC, challenges in provision of PAC services by the health care workers, and to observe and assess the facilities and the skills of the health care workers.

The next chapter, Chapter 4, presents the findings of the studies of Phase 1.

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CHAPTER 4

PRESENTATION AND DISCUSSION OF THE FINDINGS

4.1 Introduction

The previous chapter presented and discussed research methods and design, including measures to ensure validity and reliability, trustworthiness and ethical considerations. This chapter presents the quantitative and qualitative results of the study and discusses these findings for phase 1 of the study.

The objectives were to:

1. Explore challenges experienced by women who access post abortion care services in selected districts of KwaZulu-Natal Province, South Africa.
2. Explore the challenges experienced by health care professionals when managing abortion complications in selected districts of KwaZulu-Natal Province, South Africa.
3. Assess the skills of health care workers providing post abortion care in selected districts of KwaZulu-Natal Province, South Africa.
4. Develop guidelines to improve and scale up quality Post Abortion Care management of abortions complications at selected hospitals in KwaZulu Natal Province, South Africa.
5. Validate the developed post abortion complication guidelines.

The study was conducted in two phases: Phase 1: The first objective in Phase 1 was to use qualitative research to explore challenges faced by the women who have accessed post-abortion care. The second objective in Phase 1 was to explore the challenges experienced by health care professionals when managing the care of abortion complications in selected districts of KwaZulu Natal Province, South Africa.

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The third objective was to assess the skills of health care workers providing post abortion care in selected districts of KwaZulu-Natal Province, South Africa. Both qualitative and quantitative approaches were used to merge these objectives, i.e., the parallel convergent mixed method. Phase 2: To reach the fourth objective, guidelines were developed to improve and scale up quality Post Abortion Care management of abortions complications at selected hospitals in KwaZulu-Natal Province, South Africa. To reach the fifth objective, the developed post abortion complication guidelines were validated.

Data collection was done using both qualitative and quantitative approaches. The qualitative data was analyzed using Tech's eight steps of open-coding (See section 3.4.7). The quantitative data were analyzed through the computerized Statistical Package for the Social Science (SPSS) version 20. Pie charts, graphs and tables were used to present demographic variables and observation variables.

In this chapter, Phase 1, covering objectives 1, 2 and 3 is presented. In chapter 5, details of Phases 2 and 3, covering the fourth and the fifth objectives are presented and discussed.

3.10 Qualitative Approach

4.2.1 Overview of field Activities in the Qualitative Approach

In-depth one-to-one interviews were conducted to explore perceptions of women who access post abortion care services. The objective was to: Explore challenges experienced by women who access post abortion care services in selected districts of KwaZulu-Natal Province, South Africa.

Two questions (see below) were asked in order to probe answers from 23 women through a semi-structured interview. The interview session was conducted in both English and IsiZulu, their local language, in order to promote quality in the process of obtaining data from the respondents. The responses were later translated into English by language experts.

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The in-depth one-to-one interviews were conducted in 5 selected districts namely: eThekwini, Harry Gwala, uMgungundlovu, uMzinyathi and King Cetswayo, with 23 facilities. The data was collected from August 2017 to December 2017. Tech's eight steps to open-coding were used to analyze data.

The study was directed by the following questions:

- In your own views, how was it for you when accessing post abortion care services at this hospital?
- Could you describe the challenges you experienced when accessing post abortion care services?

Secondly, focus group discussions were conducted to explore challenges experienced by the health care workers. The objective was to explore the challenges experienced by health care professionals when managing post abortion complications in selected districts of KwaZulu-Natal Province, South Africa.

Four questions (see below) were used to elicit answers from the total of 50 health care workers who took part in focus group discussions. The focus group discussions were conducted in English as it was the workers' medium of instruction in the work place. Therefore, there was no need to translate the probing questions. Data was collected from the same districts as mentioned above and during the same time period.

The following directed the focus group discussions:

- Can you explain what are you doing as a health care worker to reduce maternal death due to post abortion complications?
- Can you share the challenges you are facing that affect your role of saving women who have accessed abortion?
- Can you outline the resources available in the unit that assists you in the management of post abortion care, for emergency resuscitation equipment/ medicine available, access to an emergency referral center or facility and a private counselling space, private space to conduct TOP procedures and enough staff/beds to meet client demand?
- Explain what contraceptive methods that are offered during post abortion care.

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4.2.2 Presentation of Demographic Findings

4.2.3 Demographic Profile of the women

Table 4.1 Distribution of women who accessed PAC services per District

District	Code	Frequency (n)	%
Ethekwini	A	5	22%
Harry Gwala	B	5	22%
UMgungundlovu	C	4	17%
uMzinyathi	D	4	17%
King Cetswayo	E	5	22%
Total		**23**	**100%**

Source: Primary analysis of the survey

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Table 4.2 Demographic profile of women (n=23) who accessed PAC according to their characteristics, according to district.

eThekwini district (A): Women who accessed post abortion care service (n=5)								
Name	**Age**	**Parity**	**Marital status**	**Employment status**	**Educational level**	**Previous TOP**	**Method of contraceptive**	**Youngest child**
Respondent 1	17	0	Single	Schooler	Grade 11	None	None	1 year
Respondent 2	31	P2G3	Single	Unemployed	Grade 12	One	Oral	3 years
Respondent 3	46	P5G6	Divorced	Employed	Tertiary	None	Injectable	14 years
Respondent 4	29	P3G4	Married	Unemployed	Grade 12	None	Injectable	3 months
Respondent 5	34	P3G4	Single	Employed	Tertiary	None	None	11 years
Harry Gwala district (B): Women who accessed post abortion care service (n=5)								
Name	**Age**	**Parity**	**Marital status**	**Employment status**	**Educational level**	**Previous TOP**	**Method of contraceptive**	**Youngest child**
Respondent 1	38	P4G6	Widower	Self-employed	Grade 10	None	injectable	7 years
Respondent 2	40	P3G4	Single	Employed	Tertiary	None	IUCD	9 years
Respondent 3	33	P2G3	Married	Unemployed	Grade 9	None	injectable	9 months
Respondent 4	42	P1G2	Single	Employed	Grade 8	None	Injectable	14 years
Respondent 5	34	P2G4	Married	Unemployed	Grade 11	One	None	2 years
uMungundlovu district (C): Women who accessed post abortion care service (n=4)								
Name	**Age**	**Parity**	**Marital status**	**Employment status**	**Educational level**	**Previous TOP**	**Method of contraceptive**	**Youngest child**
Respondent 1	38	P4G5	Married	Unemployed	Grade 7	None	None	6 months
Respondent 2	28	P3G4	Married	Unemployed	Grade 12	None	Injectable	4 years
Respondent 3	33	P2G3	Married	Unemployed	Tertiary	One	None	6 years
Respondent 4	20	P0	Single	Schooler	Grade 11	None	Injectable	None
uMzinyathi district (D): Women who accessed post abortion care service (n=4)								
Name	**Age**	**Parity**	**Marital status**	**Employment status**	**Educational level**	**Previous TOP**	**Method of contraceptive**	**Youngest child**
Respondent 1	18	P2G3	Single	Unemployed	Grade 12	None	None	2 years
Respondent 2	49	P5G6	Divorced	Employed	Tertiary	None	None	14 years
Respondent 3	39	P3G4	Married	Unemployed	Grade 6	None	Injectable	3 years
Respondent 4	36	P2G3	Single	Schooler	Grade 11	None	None	6 years
King Cetswayo district (E): Women who accessed post abortion care service (n=5)								
Name	**Age**	**Parity**	**Marital status**	**Employment status**	**Educational level**	**Previous TOP**	**Method of contraceptive**	**Youngest child**
Respondent 1	31	P2G3	Single	Unemployed	Grade 12	One	None	3 years
Respondent 2	41	P4G3	Single	Unemployed	Grade 10	One	Oral	14 years
Respondent 3	36	P4G5	Single	Employed	Grade 8	None	None	11 years
Respondent 4	27	P3G4	Married	Unemployed	Grade 12	None	Injectable	3 months
Respondent 5	48	P5G6	Single	Unemployed	Grade 9	None	None	19 years

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4.3 Description of Demographic Profile of Health Care Workers (FGD)

The demographic profile of the health care workers (n=50) who participated in the study are reflected in Figures 4.1 to 4.4. The respondents were health care workers: 26% doctors and 74% nurses, both males and females. The presentation of biographical data is presented in a narrative-like form, the respondents' race, type of facility visited, and occupation, years in position, and districts within which hospitals were situated is stated.

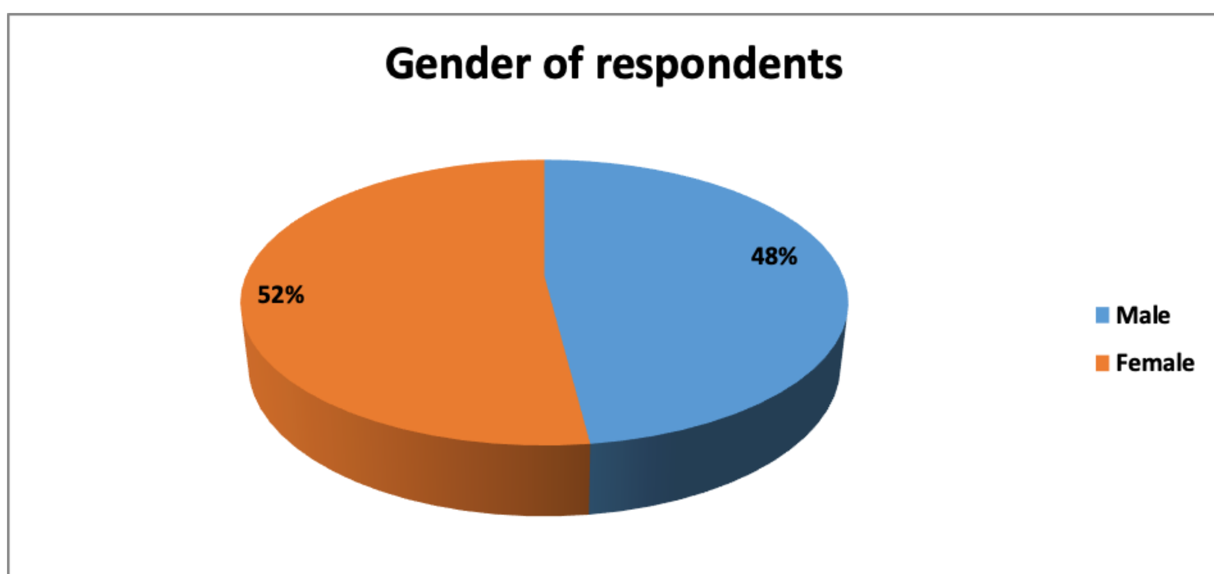

Figure 4.1: Gender of health care workers

As illustrated in the above figure 4.1, there were more females health care workers constituted the majority 26 (52%) of the respondents very much in keeping with demographics of the nursing profession which is predominantly females in South Africa. Out of 26 female health care workers, 24 were nurses, while 2 were doctors. The male counterparts constituted the remaining 24 (48%). Out of 24, 13 were male nurses, while 11 males were doctors. This is because male health care workers were reluctant to participate in the PAC services; hence gender sensitive PAC services are needed.

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The study finding shows that more Africans (78%) render PAC services than Coloured (14% and Indians (8%). Data also shows that there are no whites who render PAC services at the study sites.

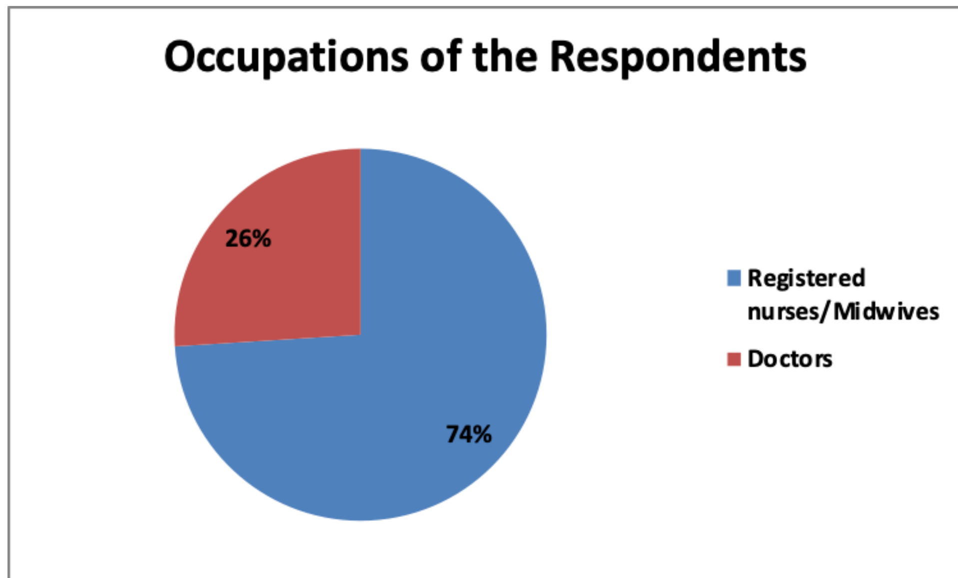

Figure 4.2 Occupation of the health care workers

The above figure 4.2 illustrates that 74% of health care workers who provide PAC from the study sites were registered nurses/midwives and 26% were doctors.

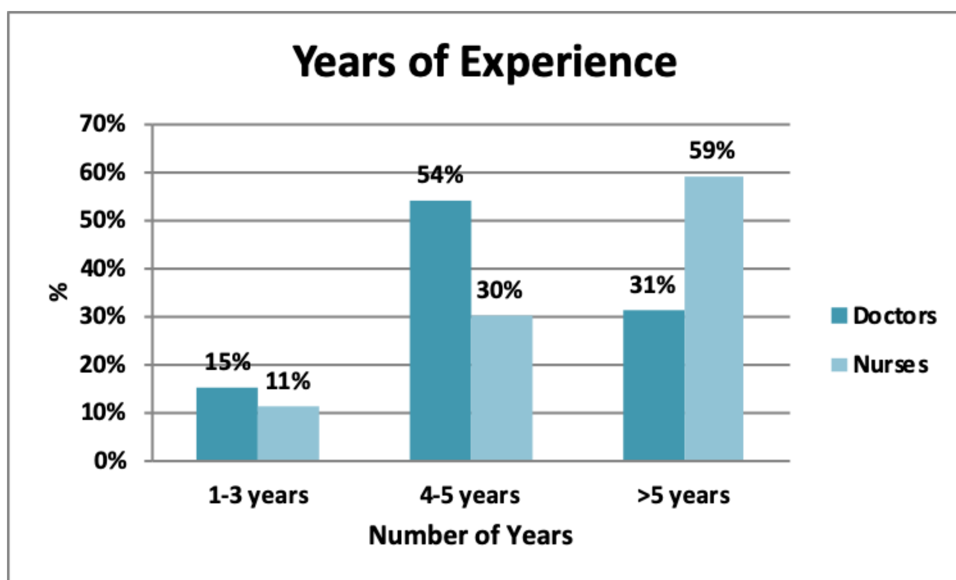

Figure 4.3 Years of experience of health care workers

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In the above figure 4.3, it is illustrated that more than 50% of health care workers with more than 5 years of experience were nurses/midwives and in terms of experience between 54% were doctors.

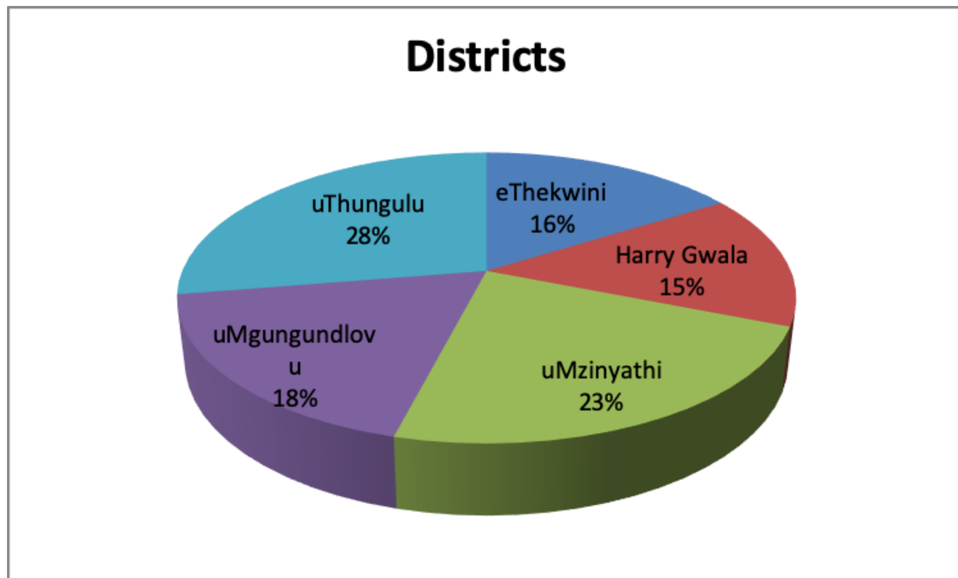

Figure 4.4 Districts within which the hospitals were situated

Figure 4.4 show that 24% of the study sites were drawn from the King Cetswayo district, where 13% of hospitals were drawn from the Harry Gwala district.

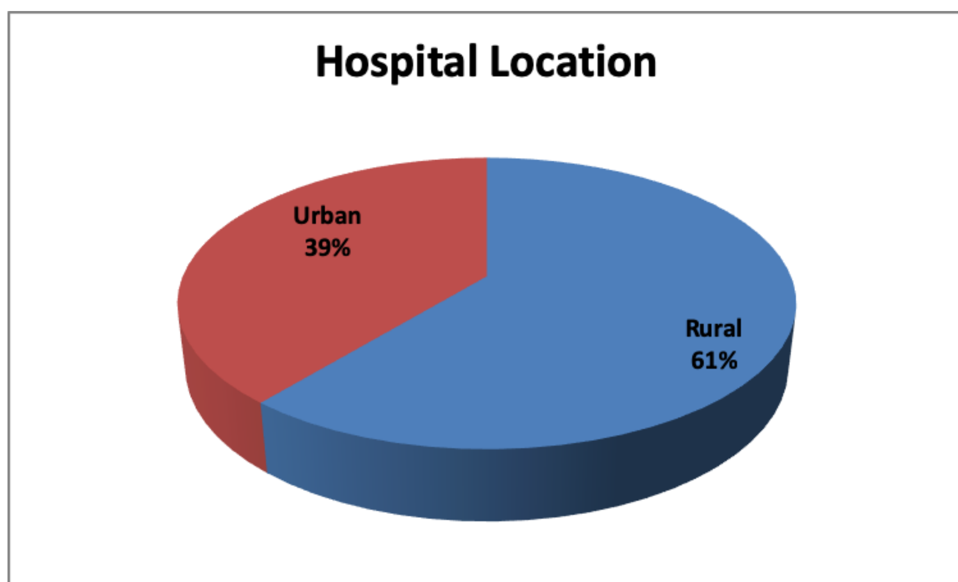

Figure 4.5 Location of hospitals from which respondents were drawn

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Figure 4.5 shows that 61% of hospitals were located in the rural areas and 39% were located in the urban area.

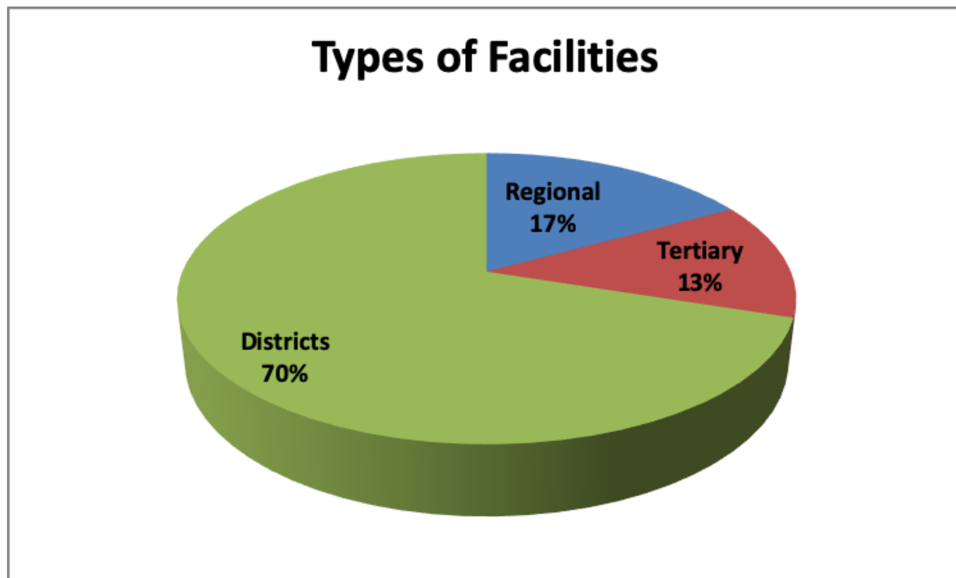

Figure 4.6 Types of facilities in different districts

Figure 4.6 illustrates that 70% of selected hospitals were district hospitals, 17% were tertiary hospitals, and 13% were regional hospitals.

Table 4.3 Average distance for women to travel to access abortion service in KZN

Demographic	Distance travelled in Kilometres
Urban area	20 km
Rural area	165 km
From rural district hospital to urban Regional hospital	**263 km**

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4.4 Presentation and Discussion of Findings

4.4.1 Introduction

The findings are divided into two perspectives. The first perspective provides a view of the challenges experienced by women in accessing post abortion care services. The second perspective comprises challenges experienced by health care professionals when providing PAC services. Eight main themes and twenty-six sub-themes emerged from the raw data (Table 4.4). To authenticate the discussion of each theme, appropriate citations from the raw data are presented, and compared with findings in the literature and discussed. In addition, the quantitative research strand results were included.

Convergent method and thus triangulation were used to analyses the data, therefore the data was analyzed side-by-side (parallel). The themes that emerged from the qualitative data were confirmed by the findings from the statistical data, therefore merging both qualitative and quantitative aspects. In the discussion of the findings, the researcher integrates the findings from both qualitative and quantitative data.

In this study, by merging the outcomes of qualitative and quantitative data, problems could be identified from different perspectives and from numerous standpoints and provided insight and created more complete view of the problem. Various narratives were provided by the participants. Excerpts from some of these narratives are presented here to illustrate the findings.

The side-by-side method served to enhance the development of clinical guidelines presented in Chapter 5 (Creswell, 2017:49).

4.4.2 Main Themes and Sub-themes

The qualitative data were divided into two main perspectives: 1) challenges experienced by women in accessing post abortion care services, and 2) challenges experienced by health care professionals when proving PAC services. These two perspectives revealed eight main themes: barriers related to seeking PAC, stories

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related to seeking PAC, expectations during PAC, problems experienced during the process of PAC, barriers to providing quality accessible PAC services, deficits in knowledge and unwillingness to provide PAC, logistics system, material resources and infrastructural barriers, and suggestions for provision of quality and accessible PAC care services. Lastly, twenty-six sub-themes emerged that were related to the themes.

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Table 4.4: Themes and sub-themes reflecting challenges from the perspectives of women accessing post abortion care and of health care professionals who provide post abortion care service

Perspectives	Themes	Sub-themes
1. CHALLENGES EXPERIENCED BY WOMEN ACCESSING POST ABORTION CARE SERVICES	**1 Barriers related to seeking PAC**	1.1 Accessibility of Post Abortion Care
		1.2 Refusal of health care providers to provide PAC services
		1.3 Transport problems caused by referral
		1.4 Long waiting periods due to shortage of health care workers at the referral sites
		1.5 Stigma from health care workers at the facilities
	2 Experiences related to seeking PAC	2.1 Motives to seek PAC
		2.2 Motives for not requesting PAC especially after illegal abortion
		2.3 Suffering and mismanagement experienced during PAC process caused by health care workers
	3 Expectations during PAC	3.1 Intolerable pain experienced during PAC/expectations to be provided with strong analgesics and antibiotics
		3.2 Insufficient time with the health care professional
		3.3 An expectation that contraceptives initiation were done before discharge
	4 Problems experienced during the process of PAC	4.1 Utterances experienced by women from health care professionals
		4.2 Problems due to early discharge after PAC – leading to complications
		4.3 Feeling of guilt experienced post PAC

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Main Theme	Themes	Sub-themes
2. CHALLENGES EXPERIENCED BY HEALTH CARE PROFESSIONALS WHEN PROVING PAC SERVICES	**5 Barriers to providing quality accessible PAC services**	5.1 Shortage of human resources leads to provision of sub-standard post-abortion care
		5.2 Shortage of skilled health care workers
		5.3 Increased attrition rate due to increased workload
		5.4 Moral views towards abortion
		5.5 Stigma attached to the provision of abortion care
		5.6 Low staff morale and burnout
	6 Deficits in knowledge to provide PAC	6.1 Lack of competency in provision of post abortion care resulting to insufficient providers' skills
		6.2 Explanation related to management of women seeking Post Abortion Care Services
	7 Logistics system, material resources and infrastructural barriers	7.1 Limited proper facilities and necessary resources to provide PAC
		7.2 Time constraints
		7.3 Insufficient management and administrative support
	8 Suggestions for provision of quality and accessible PAC care services	8.1 Ensuring operation management and administrative support
		8.2 Providing more PAC and post abortion trained nurses

Source: Primary analysis of the transcription of information

4.5. PERSPECTIVE 1: CHALLENGES EXPERIENCED BY WOMEN WHEN ACCESSING POST ABORTION CARE SERVICE

The first perspective comprises challenges that women have when they try to access post abortion care (PAC). As a background for this perspective, it should be noted that there are higher rates of unintended or unwanted pregnancies for poor women due to lack of education and lack availability of birth control. These unintended pregnancies have negative financial effects on both the mothers, children, family and the community. The increased financial hardships of an unplanned pregnancy perpetuate the cycle of poverty within the already poor families. Therefore proper

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and consistent usage of contraception greatly affects its effectiveness. The majority of women have a problem on improving their health outcomes regarding birth control, and educating women about reproductive health and proper long term birth control usage would be of great value (WHO, 2012:19).

Though abortion is legalized in South Africa, there is still poor and/or lack of adequate abortion care services and this leaves women and young girls with no other choice than to resort to unsafe abortion, thus placing a great burden on the South African health system and making unsafe abortion one of the major contributors to maternal mortality in South Africa including KZN (NCCMD, 2011-2013:34). It has been noted that an increased demand for services and a concomitant lack of infrastructure, physical space and trained personnel to respond to these demands sometimes results in fragmented barriers to quality post abortion care services. Travelling long distances in order to access abortion and post abortion care services is regarded as one of the major factors that impacts abortion services.

Every woman is expected to be treated with dignity and respect irrespective of whether they have an induced or spontaneous abortion. However, women are reporting that the health care workers that are rendering PAC services are maltreating them, which predisposes the women to psychological trauma and later higher risk of psychological distress especially if the women do not have a support system from home during the process. Health care workers who are rendering PAC services were reported to offer pre and post counselling. However, women are still at risk of experiencing “post abortion syndrome” the symptoms of which are guilt, depression, and anger, social and sexual dysfunction. These may be the result of treatment that they receive at PAC services (Coast and Murray, 2014:187).

This study revealed various narratives that the women related about their experiences when seeking PAC services. Complications that occur after induced or spontaneous abortion may cause death if the woman does not seek help before further complications. Due to lack of information about abortion services, women reported that they seek PAC service late – after heavy bleeding – and that is when they think that the pregnancy is terminated and the bleeding will stop without any complications. Women are not aware that PAC is the key strategy to treat the

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complications of unsafe abortion (Adinma, 2012:312). Women who seek abortion expect to be treated holistically with knowledgeable health care workers at all times.

The discussion reflects how barriers expose women to unsafe and post abortion complications. Barriers related to seeking PAC services were identified and discussed. These include accessibility and transport availability, stigma from health care workers that predisposed women to the risk of not accessing PAC, waiting periods, and referral from one facility to another was found to add to the barrier of accessing PAC services. Table 4.5 presents theme 1 and its sub-themes

4.5.1.1 Theme 1: Descriptions of Barriers Related to Seeking PAC

Women and young girls are expected to know and practice their right to sexual and reproductive health. Health care workers are regarded as having knowledge, experience, and full responsibility to help and teach the community about health care services including safe abortion care services and also about seeking care before complications of abortion arise. There are various factors that expose women to engaging in unsafe abortion practises, such as buying cytotec from illegal doctors for self-induction or using traditional medicines to abort the pregnancy. Barriers and lack of knowledge about safe abortion care services expose the women to the risk of resorting to illegal or unsafe abortions that lead to complications and even death to women. During data collection women were complaining about geographical and health care attitude barriers as the main impact barriers to accessing abortion and post abortion care services.

Table 4.5: Theme 1: Description of barriers related to seeking PAC

Themes	Sub-themes
1 Barriers related to seeking PAC	1.1 Accessibility of Post Abortion Care
	1.2 Refusal of health care providers to provide PAC services
	1.3 Transport problems caused by referral
	1.4 Long waiting periods due to shortage of health care workers at the referral sites
	1.5 Stigma from health care workers at the facilities

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4.5.1.1.1 Sub-Theme 1.1: Accessibility of Post Abortion Care

Women at all study sites reported that post abortion care service are not easily accessible to those women who need it. It was reported the service is not available on a daily basis and is not available in all facilities. Women were often referred from one facility to another; they also reported transport problems caused by the referrals. The challenge of waiting periods at the referral sites due to shortage of staff at referral site was another theme. Respondents reported that in some of facilities that are accessible to them there are issues of stigma from health care workers who pushed them away from seeking PAC in those particular facilities.

The findings indicate that women always present at the health facilities late. One of the main challenges faced by women who accessed PAC services is the long distance they have to travel to access proper care in the hospital; this is further complicated by poor transportation in their areas. This was supported by several respondents, as shown in the following:

Respondent 2 from district E:

I went to the clinic from where I stay and the nurse told me that I was three months five days pregnant. I told her that I don't want to keep this pregnancy and she told me that I was late to do abortion. I took some herbs and started bleeding after a day and I thought the bleeding would stop. Bleeding went on for four days. I went back to the clinic and I was told to go to the hospital. I had to travel 259 km to come to this hospital and when I was here I was given another date to come back again.

Respondent 5 from district A:

Getting to the hospital took a toll on me and it was awful. It was raining that day, of all the days it's raining. I had to take two buses just to get to that appointment. It was the longest day that I can remember having for a long time.

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Respondent 1 from district D:

I started bleeding while at home early in the morning. I stay very far from the clinic. My mother-in-law called an ambulance. The ambulance took 3 hours to arrive and I felt like I am almost dead because I lost too much blood.

Respondent 4 from district D:

I had to travel and change three taxis to come to this hospital and when I was here I was given another date to come back again.

The literature indicates that though abortion is legalized in some developing countries, lack of access to abortion services leaves women and young girls no other choice than unsafe abortion, thus placing a great burden on the South African health system and making unsafe abortion one of the major contributors to maternal mortality in South Africa including KZN (Finer and Fine, 2013:5).

It was noted that an increased demand for services and a concomitant lack of infrastructure, physical space and personnel to respond to these demands sometimes results in fragmented or poor quality post abortion care services. Varkey (2000:231) examined the impact of distance on women's abilities to obtain abortion services. Geography and geographical barriers have various impacts on access to post abortion services. More women have greater access to physicians and the posters on the street poles advertising abortion services than they do to clinics, yet few doctors perform the procedure due to lack of training, disinterest, and controversy surrounding the topic. In the world overall, 97% of non-metropolitan counties and 69% of metropolitan counties lacked a provider in 2011 (Jones and Kooistra, 2011:45). While finding an abortion provider is a challenge, finding one that does the procedure at a specific gestational age is another barrier.

Jones and Kooistra (20011:49) found that of those who provided abortion services, 96% so at eight weeks. However, only 40% of the providers provide abortion services at four weeks (or earlier). At various stages of the second trimester of pregnancy, 67% provided services, but only 8% offered the service at 24 weeks or later In general, accessing an abortion provider is a challenge to many women, which may be one

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reason why abortion rates have declined. Literature shows that increased distance to health facilities and poor local transportation impedes accessibility to the primary and secondary health care services (Jonston, Ved, and Agarwal, 2003:29), and that delayed health care provision can worsen people's health (Peters, Yazbeck, Sharma, Pritchett, and Wagstaff, 2002:194). Consistent with these study findings, poor transportation is identified as a barrier to post abortion care in Uganda (Bacon et al., 2014). In the light of this, decentralisation of health facilities and availability of emergency and quality PAC services in remote and rural areas is a necessity for improvement in women health and reduction in maternal morbidity and mortality, especially in developing countries (Greenslade et al., 1994:271).

One of the main challenges faced by women who accessed PAC services in KZN is the long distances they have to travel to access proper care in the hospital; this is further complicated by poor transportation in their areas.

As shown in Table 4.3, women from the rural areas travel long distances to access PAC service compared to women from the urban areas. The long distance estimated from the rural to urban area is 300 km in case of emergency when a woman needs tertiary service. The literature shows that increased distance to health facilities and poor local transportation impedes accessibility to the primary and secondary health care services (Peters et al., 2002:199) and that delayed health care provision can worsen people's health (Peters et al., 2002:173). Consistent with our findings, poor transportation is identified as a barrier to posting abortion in Uganda (Vlassoff et al., 2012:261). In the light of this, decentralization of health facilities and availability of emergency and quality PAC services in remote and rural areas is a considered a necessity for improvement in women's health and reduction in maternal morbidity and mortality, especially in developing countries (Greenslade et al., 1994:287).

The researcher concluded that there are aspects that need to be addressed in order to improve access to quality provision of post abortion care across the province including the rural areas based on the experiences of women from their facilities that they have visited. There is a need for increased knowledge about contraceptives and where women can access TOP services to eradicate the risks of unwanted or unplanned pregnancies that lead to unsafe abortion. The researcher established that there is a

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lack of knowledge with regard to where to access safe TOP services. This highlights the need of KZN DoH to create a data base that consists of facilities that are offering TOP services.

4.5.1.1.2 Sub-Theme 1.2: Refusal of Health Care Providers to Provide PAC Services

The interviews with the women indicated the perception that the majority of health care providers refuse to offer TOP including post abortion care services, stating their religious beliefs or conscientious objections. They indicated that health care workers including other staff like security officers at the gate of the health facility refuse to give them information pertaining to abortion services and this lack of information leads to women to fail to access safe services, and limited access contributes to delays that lead to complications.

The women indicated that most of the health care workers reported that they are not trained to offer the post abortion care services. They reported that they were made to wait all day long, waiting for a health care worker who is looking after so many patients while other health care workers are saying that they do not offer the abortion services. The following are some of the quotes from the respondents:

> **Respondent 1 from district C:**
>
> The health care worker at the clinic told me that I was not supposed to have an abortion at home because legal abortion is offered for free at the hospital and backstreet abortion is not legal. She even threatened to call the police to come and arrest me. “It is a sin. I can’t help you because backstreet abortion is against the law.”

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Respondent 3 from district B:

> When I arrived at the hospital, I was in pain and I told the man at the reception that I am here for post abortion care and he told me that I must go to the next window to get the file, because he doesn't deal with abortion women who are killers.

Demtsu, Bugssa and Alemu (2014:4) reported that there is an association between provision of PAC services, religious, cultural, beliefs, morals and values in terms of care of women seeking PAC services. Again it was reported that conscientious objection limits provision of care for many women and affects the referrals to those who need it. The majority of health care workers demonstrated negative perception on PAC services. They were mostly Muslims. From all the study sites, the oldest health care workers were the ones who showed a negative attitude about rendering the PAC services.

The main reason why the respondents were not offered PAC services was that they were supposed to be consistently using contraceptives, or any other birth control, that could have prevented them from falling pregnant. The majority of the women indicated that it is difficult to use contraceptives consistently because of the side effects. Others reported that their partners did not support their use of contraceptives. From the demographic data of the health care workers, it appears that male health care workers were most reluctant to participate in the PAC services; hence gender-sensitive PAC services are needed. Quantitative data shows that the majority of unsafe abortions take place during the 2nd trimester because second-trimester abortion services are not readily available due to lack of trained health care workers (doctors). Doctors are said to refuse to participate in provision of abortion services due to conscientious objection and their religious status.

The study found that both women and health care workers play a major role in providing post abortion care services. Their religious and cultural beliefs play an important role in preventing safe abortion services. Post abortion care services should be available and provided to all women who have suffered from complications of abortion. Health care workers must have positive attitudes towards provision of post

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abortion care services because absence of PAC services can lead to death (Wariki et al., 2015: 184).

4.5.1.1.3 Sub-Theme 1.3: Transport Problems Caused by Referral

The study findings indicated that transport availability caused the women to seek PAC early or late. Referring patients from one facility to the next facility to improve the management is of importance. The study was done in both rural and urban settings. In rural settings it was found that transport was not available. In addition, majority of the respondents were from rural areas (61%), while 39% were from urban areas. Thus, the availability of transport – both in the rural area or urban area – affected the women's seeking of care. A study conducted by (Vlassoff et al., 2012:4) showed that women from rural areas are more likely to face transport problems in accessing PAC services early before complications. The following quotes are the respondents' experiences:

Respondent 3 from district E:

I was transferred from the local clinic to this hospital and it was so difficult to get here, I had to wait for three hours for an ambulance to come and collect me.

Respondent 4 from district C

I had to borrow money first for traveling, because this hospital is very far from where I am coming from I had to take two taxis to get here and I was so scared that people would see that I am bleeding, because I was having heavy bleeding.

Care for the post abortion services must be extended throughout the health care system, particularly at the primary health care level and in the rural areas for the care of women when complications of unsafe abortion or spontaneous miscarriages arise. According to Fetters, Akiode & Oji (2004:143), women are more likely to reach facilities earlier before the complications arise if the PAC services are decentralized and there are reliable transport services. However, women who need PAC services may feel

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discouraged if they know that they will be transferred from one facility to the other for PAC services (Melkamu, Betre & Tesfaye, 2010:129).

At the moment, most of the rural areas and many primary health centres do not offer any emergency stabilization or intervention for women with abortion complication prior to referral to the next level of care. Decentralization of PAC services is essential, bringing with it immediate life-saving care and preventing unnecessary deterioration of the woman's condition when referral and transport are required. Expanding access of PAC services in all facilities is the critical step in the creation of continuous chain of care, with providers in each level of care understanding their role guided by the PAC management guideline. The health care workers must receive the training which clearly identifies their essential role in the prevention and management of maternal mortality and morbidity from post abortion complications.

In conclusion, the researcher finds that PAC can have significant consequences to women and community at large. Post abortion care service is regarded as a critical component of skill services. It was identified that there is no uniformity in the access of PAC services in the province. Out of 72 hospitals, only 45 facilities are providing abortion services and only 7 CHC's out of 22 provide the service.

During data collection, it was identified that the women who live in the rural areas are more likely to travel long distances than those in the urban areas. PAC services need to be integrated with other emergency obstetric care at all levels of the health system and delivery service.

4.5.1.1.4 Sub-Theme 1.4: Long Waiting Periods due to Shortage of Health Care Workers at the Referral Sites

Seeking post abortion care services was reported as a challenge by the majority of the PAC users due to referral from one facility to the other and then long waiting periods at the referral sites. Some of the users at the study sites from district E reported that they came to district B because the waiting time is shorter. At their own facility, the waiting period is too long and if you are not bleeding much you can also

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be booked to come back on the other day. The following are some of the quotations from the respondents:

Respondent 4 from district E:

I came here because i don't like the services from the district that I am coming from. I have been waiting for a long time. I have decided to come here even though the e hospital is overcrowded and I have to queue first to open the file at the reception

Respondent 4 from district A:

The shortage of health care workers in this facility is too much. Only one nurse was working today and the ward has been so full since morning.

Respondent 1 from district E:

Sometimes when you go to our nearest hospital you are made to spend all day there and at the end of the day you are told to come back because the nurse is alone she cannot see all of us today.

Government health facilities are associated with long waiting hours due to long queues (Wariki et al., (2015:186). During the study, the researcher found that long waiting periods are one of the factors that hinder the utilization of PAC services. In addition, there is a shortage of skilled health care workers with good attitudes to provide quality service is lacking in or public facilities.

4.5.1.1.5 Sub-Theme 1.5: Stigma from Health Care Workers at the Facilities

Stigma related to abortion care services has been identified as a major driver for women to keep silent and avoid seeking PAC services. Although abortion is legalized in many developed countries, including South Africa, during data collection from the study sites, women expressed various ways in which they were being stigmatized for seeking the service in the health institutions. Women have reported

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that they are being labelled as killers, sinners and mothers of devils. They are told they are a bad influence on the young girls in the community. The following are some of the quotations from the respondents:

Respondent 5 from district A:

I was told that I would never have kids in my life because of the abortion that I have done and when I die the baby will be waiting for me in heaven crying.

Respondent 5 from district B:

They see me as a bad girl and they say that I always sleep around with married men. The other nurse told me I must not associate myself with other young girls because I would teach them how to do an abortion. I felt that I was neglected at the hospital and I feel like dirt.

Respondent 3 from district A:

I was told that I am a useless and terrible person and she made me hate myself.

At all study sites, women reported being maltreated by the health care workers when seeking the PAC service. Stigma was reported as what keeps women away from the facility and drives them to seek abortion services from the traditional birth attendants and bogus doctors who offer them unsafe abortions that lead to abortion related complications and increasing morbidity and mortality. Women reported a lack of supportive environment that provides guidance on correct information on how to prevent further unwanted pregnancies and where to get help. In terms of women's decisions on whether they should have a safe or unsafe abortion, stigma plays a major role. Due to high stigma in the facilities, women and young girls feel that they should not go to the facilities to seek PAC service; instead, they resort to seeking other services and taking care of themselves until they get complications.

Stigma creates a predominant obstruction for post abortion service. It affects women who seek the service and health care providers who render the service. Values Clarification and Attitudinal Transformation (VCAT) might be useful to health care

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providers to explore questions, clarify and affirm their values and beliefs about abortion and related Sexual and Reproductive Health (SRH) services. Broader introduction to VCAT can influence attitude awareness and comfort with the provision of increased comprehensive, women-cantered SRH care. Appropriate distribution of PAC guidelines and obvious institutional support for provision of safe post abortion care services also need to be rolled out.

4.5.1.2 Theme 2: Experiences Related to Seeking Post Abortion Care

Women also reported to lack knowledge of the risk of unsafe abortion, as most women were reported to have undergone unsafe abortion practices in this study. For most of the women, having an abortion is a lonely experience due to stigma attached to it. Rasch and Sorensen (2014:419) reported that there are so many issues related to why women fail to seek post abortion services. Women are regarded as being not knowledgeable with the matters that involve preventing unwanted pregnancies, and they also lack knowledge on where to access abortion care services.

The sub-themes that emerged from theme 2 are presented in Table 4.6

Table 4.6: Theme 2: Description of experiences related to seeking Post Abortion Care by women

Theme	Sub-themes
2 Experiences related to seeking Post Abortion care	2.1 Motives to seek PAC
	2.2 Motives of not requesting PAC especially after illegal abortion
	2.3 PAC process causes suffering and mismanagement experienced from health care workers

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This study found that women tend to be reluctant in seeking post abortion care due to fear of ill treatment from the health care workers, especially if they have undergone an illegal abortion. According to Gebreselassie, (2012:11), Women have fear about the procedure by itself, because they lack knowledge of MVA procedure and as a result they do not go to the facility early to seek PAC services and they put themselves at risk of abortion complications. In this study, women reported that they did not disclose their pregnancies to their family or friends. Lack of self-motivation regarding seeking post abortion care services is regarded as a risk towards one's wellbeing. Lack of knowledge about safer sex practices and availability of safe abortion care services including to PAC, predisposes the women to the risk of complications and even death.

4.5.1.2.1 Sub-Theme 2.1 Motives to Seek PAC

A survey study conducted by Koster (2009:1792) revealed that 12% of abortions in the world reported were undoubtedly illegally induced. The study also revealed that there are three factors that are possibly associated with women having induced abortion. Koster reported that majority of women report that their pregnancy was unwanted, 30.4 % reported that they are not married or they have cheated on their husband and fallen pregnant. The decision to go for post abortion care services after illegal abortion is complex, where one needs to consider psychological impact and social stigma. Each individual has to take decisions looking at their own circumstances around their lives. This study shows that 75% of women who participated in the study have had illegal abortion; one respondent said:

Respondent 1 from district A:

I have to abort this pregnancy, because I am young and I still need to continue with school.

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Respondent 4 from district C:

When I told my boyfriend about the pregnancy he was angry and told me that he is leaving because he is in a relationship with someone else.

Respondent 2 from district E:

I was afraid when I found out that I was pregnant, then I decided to do abortion and when I started bleeding I rushed to the hospital and reported that I had a miscarriage.

Respondent 2 from district B:

I have a three month old baby and I am unemployed, and currently writing my grade twelve so that I get my grade 12 certificate. I had a problem with my husband; he is having affairs in the village. I told my husband's aunt about my pregnancy that it tested positive. Aunty always says that if one of her children does abortion she would disown them. What would my husband say if someone saw me at the clinic requesting TOP? I went and had a back street abortion and lied to them and told them that I had miscarriages and they took me to the hospital for PAC because I was bleeding.

Respondent 1 from district C:

My mother said I had to go for post abortion care because I performed illegal abortion because my partner has rejected me and I feel very bad about it because I suffered a miscarriage after I engaged in a fight with the other girl at school, "tearful and looked depressed". I feel so sad and angry and keep quiet because she was just shouting and not listening to me.

Respondent 3 from district D:

I have a problem with my in-laws. With the previous pregnancy she asked questions why I was not breastfeeding the baby. When I fell pregnant again, I decided to induce the pregnancy in fear of discrimination from my in-law. She always talks bad about people who are HIV positive.

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Respondent 1 from district D:

After my sister found out that I am having heavy bleeding after missing periods for two months, she suddenly took me to the hospital for PAC services.

Respondent 3 from district C:

My grandmother suggested that I should go to the nearest hospital for PAC services after she gave me liquid that I took to induce the pregnancy because they were saying that I have bled a lot.

Respondent 2 from district D:

When I found out that I was pregnant, I was already divorced from my husband and I felt embarrassed. I drank a mixture of cleaning detergents and aborted the pregnancy and I started bleeding and I decided to go to the hospital for post abortion care.

Respondents reported their reasons for seeking post abortion care services as pressure from the family members who interfered with their choices of keeping their pregnancies; they also reported their concerns for their future and the questions about the unborn baby. This is how the respondents verbalised the pressure they have about seeking post abortion care.

The findings by Morell and Ritcher (2006:112) revealed that men are more likely to abandon pregnant women and leave them to look after the baby by themselves (Morell et al., 2006:2). HIV status can influence women to take decisions to terminate their pregnancy due to fear of transmitting the HIV to their unborn babies. One of the respondents reported that she was afraid of keeping the pregnancy because of her HIV status, then she decided to induce the pregnancy herself and later, when she fell sick, she went to seek PAC services. The study also revealed that few respondents are influenced by others to seek PAC. A feeling of shame from the family can lead women to seek PAC, especially if a person has unexplained bleeding. Having a child after divorce in some communities is a taboo and it can lead people to speculate that a woman was already having an affair while she was still married.

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The respondents indicated that relatives were placing pressure on them by asking them about their pregnancies and not showing any support over their situation. One respondent was so upset and she felt that her sister was supposed to show support to her and even guide her through the process of her pregnancy. The power of cultural diversity contributes to the influence of relatives or providers over all matters in the homestead, including abortion. Relatives have shown that they feel they have authority over the reproductive health or the right to interfere with the pregnancy of their siblings which then leads to the pregnant women resorting to abortion.

Sida studies, (2001:24) explain that relatives' oppressive authority over their siblings that was found in South Asian culture, was a result of internalizing their own lower status in the society, and thus resulting in discrimination. The above is supported by the conceptual framework that is based on that human behaviour to seek the health care need due to predicted factor that can either be biological, psychological or social.

4.5.1.2.2 Sub-Theme 2.2: Motives for not Requesting PAC Especially after illegal Abortion

In South Africa, 30% of adolescents who seek termination of pregnancy use legal termination of pregnancy services and the rest use illegal abortion, (Alan Guttmacher Institute, 2013:25). Failure to use legal services is associated with lack of information about the stage of which pregnancy can be terminated as well as stigma associated with pregnancy and abortion generated in the community; this is replicated by the health system. Illegal abortion is a major cause of maternal death and injury to adolescents, especially if there is a delay in seeking PAC service. There are dangers and complications associated with illegal abortion, such as: severe bleeding, uterine perforation, tearing of the cervix, all of which can lead to death in the absence of PAC. Reasons for not requesting the services were cited by respondents:

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Respondent 1 from district D:

I did not go to the hospital immediately when I found out that I was bleeding because I was afraid that the nurses are going to shout at me that I have done an illegal abortion

Respondent 3 from district A:

I went to the private doctor to get the pill because I am old and the hospital – its young nurses and doctors who are working there – and I was afraid that they would look at me in a bad way and insult me.

Respondent 4 from district A:

Though I did not have money for transport, I decided to go to the furthest hospital to seek PAC, because I heard that health care workers from the nearest hospital does not maintain privacy if they suspect that you have done an illegal abortion.

Respondent 2 from district D:

When I found out that I was bleeding after inducing the pregnancy, I decided to go to the traditional healer, because I was afraid that if I go to the nearest hospital for abortion, people might see me and tell my children. And both "muti" and the traditional doctor told me to douche it in my vagina and it would be quick and painless.

Respondent 2 from district E:

My grandmother is full time at church and she is a chairperson at one of the communities. When she found out that I was pregnant she told me she is not going to embarrass herself, I got an abortion pill and I started bleeding while at home, when I was weak and sick, then she decided to take me to the hospital for PAC service.

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Respondent 3 from district B:

I wanted a baby with my whole heart. My husband said he did not want the baby, because he can't afford to take care of him/her since he is supporting other three kids from outside the marriage.

Respondent 4 from district B:

I was forced to do abortion. Since I was refusing to do abortion he threatened to leave me for another woman. I pleaded with him to keep the baby and it did not work. That night he forced me to sleep with him and he put a crochet hook inside my vagina and poked me until I started bleeding. I felt like dying and he refused to take me to the hospital saying that I would be arrested because I have done an abortion. He finally took me to the hospital after five days and he reported to the doctor that I was having a miscarriage. It was like a nightmare to me.

Respondent 2 from district B:

When I found out that I was pregnant, I went to the hospital for abortion and the nurse told me that I am late because I am above three months. I then went to the pharmacist to buy the tablets. I started having severe pains and bleeding after taking the pills, I was afraid that if I went back the same nurse who turned me away would see me and report me to the police.

During the study, one of the respondents told that she went to seek PAC from a private doctor because she was scared of being shouted at. She also illustrated the reason why she decided to go to the traditional healer before going to the hospital to seek PAC service. The study also found that some of the women delayed seeking PAC service even though they are aware of its availability, due to fear of stigma and discrimination from the health care workers and the community. The study showed that amongst the women who access PAC service, only 52% go straight to the hospital for seeking PAC and others either start at the private doctors or traditional healers. The excerpts illustrated how they delay seeking PAC due to illegal abortion.

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Women in South Africa are mostly affected by unwanted pregnancies which lead to illegal abortion (Harries et al., 2011:78). In South Africa, induced abortion is permitted on medical or on broader socio-economic grounds; however women still resort to abortion performed by unskilled providers or in unsafe conditions as a result of barriers that impede access to safe abortion. Such barriers include lack of information, distance, economic constraints, and lack of confidentiality. Women discuss their unwanted pregnancies with relatives and friends and always receive support for obtaining illegal abortions.

Substantial challenges still exist in making information and quality services for safe abortion accessible, despite the considerable advances that have taken place in KZN in the last years. The advances include: evidence supporting the importance of both safe abortion in cases of unwanted pregnancy and contraception to prevent unintended pregnancies, medical technologies, empowerment of women and community involvement to demand and help ensure access to information and services, and strengthening of the health system to provide services based on the CTOP Act (Alan Guttmacher Institute, 2012:2).

4.5.1.2.3 Sub-theme 2.3 Suffering and Mismanagement experienced during the process caused by Health Care Workers

All the respondents perceived that they had been stigmatised by the health care providers. One of the respondents gave a detailed account of the health care providers' negative attitudes and behaviours towards one of the women who was admitted for post-abortion treatment in her ward. The respondent lamented over the maltreatment and the death of her fellow patient. The following excerpt illustrates how the women experience suffering from the hands of the health care workers.

Respondent 3 from district A:

I was admitted in the ward with Jabu, who began to bleed profusely. After some hesitation, I called the nurse to come and help. Jabu openly told her that she had wanted to get rid of her pregnancy, because she wanted to finish

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her studies. The health care worker left her, and never returned to her bedside. Jabu continued screaming from pain and saying “God help me”, a health care provider heard about her fear of “death” and said: "you kill and then said but you are afraid of death...”. The following day I was then discharged. I came back to the hospital after three days to check on Jabu, but when I went to her bed she was not there. I then asked the sister in charge and she informed me that she died in two days back, while waiting for a manual vacuum aspiration to be done. At the hospital she faced negligence because of health care workers that are anti-abortionists.

Respondent 1 from district C:

I started feeling sick and I was bleeding and I went to a private doctor and he gave me medication to stop the bleeding; I continued to lose blood for an entire week and had to go to the hospital. When I told the hospital that I went to the private doctor they showed discrimination and provided inappropriate care –they were thinking that abortion was induced, inferring pre-judgment. Ah, it was the worst for me because they thought it was an abortion, and not a miscarriage, you know? So they did not treat me well thinking that I had an illegal abortion.

Respondent 4 from district E:

I was admitted with the women who delivered their babies and the attitude with the health care worker was very bad. She was shouting at me saying that other women are having babies and I have aborted mine. Her words are still haunting me till today.

According to the CTOP Act health care, workers are to treat patients who request the abortion services with dignity and respect. The above findings are not uncommon in the literature. Abortion stigma is defined by Kumar et al. (2009:625) as a negative attribute ascribed to women who seek pregnancy termination and/or post abortion treatment. Discrimination against women seeking post-abortion care (PAC) was identified as one of the major barriers in accessing PAC services in most developing countries; South Africa not excluded (WHO, 2012:98).

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The literature shows that two out of three women experienced stigma following abortion, thus most women prefer to keep their abortion secret (Shellenberg, 2010:11). Despite the legalization of abortion in South Africa, the negative attitudes and judgemental behaviours surrounding abortion are enormous and call for urgent actions.

4.5.1.3. Theme 3 Expectations during Post Abortion Care

All PAC patients should be given clear and accurate information that allows them to give full informed consent for the procedure. Before the procedure, pre and post counselling and full physical examination, including neurological system, vital signs before the procedure. Cervical preparation should be done to any women of any gestational age prior the procedure (WHO, 2012). Women must be informed about the duration of the procedure, what they are likely to expect during and after the procedure e.g. bleeding and cramping, pain management, risks, when to resume sexual intercourse and any follow up care. Contraceptives information and services must be provided as this helps the woman to avoid unintended pregnancies in the future and reduces the need for illegal abortion. A woman must be given several contraceptive methods to choose from.

Table 4.7 Theme 3: Expectations during PAC

Theme	Sub-themes
3 Expectations during PAC	3.1 Intolerable pain experienced during PAC/expectations to be provided with strong analgesics and antibiotics
	3.2 Insufficient time with the health care professional
	3.3 An expectation that contraceptives initiation was done before discharge

In this study, the results revealed no evidence that any thorough assessment, examination or counselling had been implemented as part of PAC. This could be attributed to PAC health care workers' lack of knowledge and skills, guidelines or facility protocols with regard to management of PAC patients (see also section on

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Main Perspective 2: Challenges experienced by health care professionals when providing PAC services). As illustrated in figure 4.14, only one of the study sites had PAC guidelines or had a program for in-service training on PAC although such training would allow the health care workers to provide quality management care of PAC patients and care that meets both the psychological and physical needs of the patients (Adanu and Tweneboah, 2004:215).

4.5.1.3.1 Sub-Theme 3.1: Intolerable Pain Experienced during PAC/Expectations to be Provided with Strong Analgesics and Antibiotics

The majority of women complained that they received no medication for managing the pain they experienced during the uterine evacuation and they identified the lack of analgesics to be major problem. About 86% of women who received PAC services repeatedly called for improved pain relief. The health care workers also reported that they could do better if they had adequate pain management. Women also verbalized there is a need for better hygiene and infection prevention at the hospital where they were treated. For example, they objected to the fact that they had to share a bed with other clients and that bloody floors were not cleaned between procedures.

Respondent 4 from district E:

When I was asked to come in for the procedure, the nurse did not explain anything to me or tell me what she was going to do. She only asked my age and if I have had an abortion before. No medication was given to me; instead she put an instrument inside and start cleaning me up. I was screaming and she kept saying scream like the time when you were sleeping with your boyfriend.

Respondent 1 from district E:

I felt horrible pain when the doctor started cleaning my womb, when I told him that I am in pain, he told me you deserve it.

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Respondent 3 from district C:

When I arrived at the hospital, I was admitted to the ward. The nurse told me the doctor would come and clean me later – he is still busy with emergency. I was bleeding heavily. After seven minutes the doctor left me with the nurse to clean me up. I was asked to get out of bed and it was not easy for me to walk out, the pain was too much. I was told to go home and come back after two weeks.

Respondent 2 from district E:

When I arrived in the ward I was seen by the female doctor and she was very cold to me and that made me to feel uncomfortable. The nurse that was with the doctor was busy calling me names and how evil I am by having an abortion. I felt that the health care workers were judgmental, because they did not even ask me the reason for the abortion. I felt guilt and regret why I came to the hospital.

Respondent 4 from district D:

When I was admitted I was scared thinking that they are going to take my uterus out. I was taken to theatre and I was so scared. The doctor gave me an injection for pain, but still the pain was there. The procedure lasted for fifteen minutes. I was taken back to the ward for observation but the nurse's attitude was not good. I was discharged home the following morning while still bleeding.

In the above quotes, instances of emotional, physical and psychological traumas are reported. The respondents reported that they were verbally abused by health care workers and in some instances they were abused by the doctors. The respondents were not given pre or post counselling, they just got into the procedure room without knowing what was going to happen to them. According to the CTOP Act no 92 0f 1996, every woman, regardless of age, race or background who considers post abortion care service needs non-directive professional pre- and post-counselling. One of the respondents from District D indicated that she was told to go home after

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the procedure, without being told what to expect at home. Some of the respondents also expressed that they were not given any analgesics before the procedure and that makes the procedure painful. One respondent reported that she was told to lie still on the bed during the procedure. According to WHO (2012:17) recommendations, with regards to analgesics, all women should be routinely offered pain medication for example NSAIDs like diclofenac 25mg thirty minutes before the procedure and ibuprofen 200mg tds post abortion care.

After suffering from labour pains due to abortion or spontaneous miscarriages, all women expect to be offered appropriate non-pharmacological and pharmacological pain management before initiation of post abortion care through surgical intervention. Respondents were concerned about the medication – that it must be timed so that it is in full effect when the procedure starts. The only respondents who were not expecting to be given any analgesics before and after the procedure were Mphe, Linda and Zandile. These respondents reported that they got information either from a relative or friend that there is no pain medication given during and after the procedure. Although there are reported clashes of interest in protection of the women known to have gone through abortion and the desperation of fear of death after abortion, most opted not to raise the issue of not having been given analgesics to anyone in fear of stigma and discrimination related to abortion. Therefore they opted to be silent about those experiences.

Respondent 2 from district C:

I thought I was going to die when I started bleeding at home with the severe cramps that were in my lower abdomen.

Respondent 4 from district A:

When I arrived at the hospital, I felt as if my womb was falling out between my thighs and I was shivering and sweating.

Respondent 3 from district C:

After the nurse had cleaned me, I felt like I was dying due to pain and I called for help and no one came to assist me (tearful and wanted to cry).

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The majority of the respondents mentioned that all they wanted to protect themselves was from dying due to bleeding since they knew that abortion complications can take their lives. The goal and objective of post abortion care services is to ensure that women and girls have access to safe and free abortion services without fear and harm. The respondents' reports were clearly not in line with those of the programme.

Quinn & Chaudior (2009:649) found that the reason why women delay seeking post abortion care is often because abortion is stigmatized and women always try to protect themselves from being the victims of discrimination. Many women believe that seeking abortion services may lead to social ostracism or rejection by family members. To avoid this rejection, women were often delaying seeking care, even to the point of death. Women also believe that health care workers also contribute to this judgement because of the negative attitude towards them. Although women voiced their belief that health care providers must provide care which is accessible and supportive encouraging them to seek, rather than hide from, medical help. Phillis looked depressed, tearful and crying when talking about this. She mentioned that she blamed herself for not complying with contraceptives and ended up with unwanted pregnancy that led her to have an illegal abortion. She mentioned that she hates it that she is feeling guilty for having an abortion.

Every woman who undergoes abortion care suffers from anxiety and the anxiety is affected by the level of perception of pain. However, no pharmacological pain management may address the level of anxiety. Non-pharmacological methods included physical and verbal reassurance to the women. The technique is important because it makes a woman feel comfortable and relax during the procedure. Therefore, it is important for the health care provider to make sure that she asks the woman the method of preference in terms of support during PAC care.

During observation it was identified that women are more likely to be offered injectable Voltaren 25mg before manual vacuum aspiration and Ibuprofen 400mg orally post procedure. Pre-medication with non-steroidal analgesics such as above has shown to decrease pain pre- and post-procedure.

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PAC respondents are supposed to be provided with antibiotics regardless of their risk of pelvic inflammatory infection, and they should receive appropriate prophylactic antibiotics pre- or post-abortion care to prevent infection. Health care workers should provide information and issue antibiotics during counselling and education session. Most of the respondents indicated that they were not offered antibiotics during pre- and post-procedure. Antibiotics played a vital role on infection prevention during post abortion care services. It emerged that in certain cases respondents were offered antibiotics before the procedure, but others stated that they were not offered any at all. This was confirmed by the following excerpts:

Respondent 4 from district E:

The nurse sat down with me and talked about the dangers of not taking antibiotics and the importance of finishing them to protect myself from the infection. The way the nurse advised me I should finish the antibiotic, even if I have no pain or no longer bleeding, I then decided to tell myself that I really need to finish the treatment.

Respondent 2 from district C:

After the procedure I explain to the nurse that I did not tell anyone at home that I am coming to the hospital. I ask if there is any medication that I need to take. She did not give me any clear answer, but she just said it’s your choice to take treatment or not, then I was discharged with no medication.

Respondent 2 from District E:

I was surprised when I was discharged from the hospital without any antibiotics. When I tried to ask the nurse, she told me that everything was done for me, I can go home.

The wording in the above quotes indicates that antibiotics were not considered as important for the women during pre- and post-abortion care. One health care provider advised and recommended antibiotics. From observations of the health care workers’ skills it was identified that the use of antibiotics in pre-abortion care was a matter of uncertainty for many health care workers. Data indicate that only 30% of

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health care providers offered antibiotics for cervical preparation before the procedure. This confusion has resulted in misuse and overuse of antibiotics in many settings. Lack of cervical preparation by antibiotics increases the risk of infection to women. The administration of prophylactic antibiotics to all women undergoing vacuum aspiration is recommended. The development of a scoring system to determine who should be given antibiotics would give concrete guidance to health care workers in making these clinical decisions. It should be noted that lack of antibiotics should never be a barrier to providing abortion services.

4.5.1.3.2 Sub-Theme 3.2: Insufficient Time with the Health Care Professionals

Many of the respondents reported that the services providers do not spend sufficient time with them. Some of the women felt they were only given attention when their conditions were critical. The excerpts below confirmed this:

> **Respondent 2 from district E:**
>
> I feel that our PAC's supply is limited to the management of emergencies. I came with bleeding and a manual vacuum aspiration was done. Then after the procedure I was sent home by the health care worker – she did not have time to see me again.
>
> **Respondent 2 from district A:**
>
> The health care provider who was helping me managed to give me the injection contraceptive, though I had requested to be given the IUCD. She told me that she is busy and alone and she doesn't have time for IUCD. She told me to go to the nearest clinic for IUCD.

According to KZN CTOP policy, health care workers are supposed to spend thirty minutes with the women during provision of PAC. Depending on their clinical condition, the women are supposed to remain in the ward at least minimum of two days while receiving antibiotics, especially those who come with sepsis. Accessibility

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to contraception is an integral part of PAC, so as to prevent unwanted pregnancy and future induced or unsafe abortions (Harries et al., 2006:78). However, this study shows that PAC services providers do not have adequate time to provide such services. Not surprisingly, the above may be as a result of general shortages in the health workforce in most countries including South Africa; subsequently there is an increase in health care providers' workload, coupled with discrimination and low priority of abortion services (WHO, 2015:38). PAC services users may definitely benefit from more trained staffing in the hospital.

4.5.1.3.3 Sub-Theme 3.3: An Expectation that Contraceptives Initiation Would Be Done before Discharge

Adherence by the health care workers to issuing post-abortion contraceptive care can reduce the morbidity and mortality associated with complications of either miscarriage or incomplete abortion (including abortion that was performed unsafely). Post abortion contraceptives remain a challenge to the respondents who have experienced complications of unsafe abortion; when they reach a health facility for treatment, they often receive no contraceptives information or services. Of the 20 respondents who had received post abortion services, 8 were not given any form of contraceptives. The remaining 12 received contraceptives. The following respondents reported how they felt after leaving the facility without contraceptives:

Respondent 2 from district B:

I was told that "I have completed your abortion; go, leave go! I have a lot to do." I was not given any counselling about family planning. I am working alone. I decided to go to the nearest clinic after three months because I was scared to fall pregnant again, I am now on injectable.

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Respondent 1 from district D:

She told me, "I am not trained for contraceptives, the nurse who was trained some time back has left the unit, and she is no longer working here"…hmm I was transferred to the maternity ward and there was no one to help me there.

Respondent 1 from district C:

I was on injectable contraceptives, then I started having vaginal bleeding, I went to the hospital and a pregnancy test was done and I was told that I was pregnant. I was shocked and in pain. I was taken to the theatre for cleaning the following day. The following day I was cleaned and discharged home. No one ever talked to me about contraceptives, though I was expecting the nurse to explain to me why I fell pregnant while I was on injection.

Respondent 3 from District D:

I requested to be given Loop and the nurse told me that she didn't know how to insert it and even if she called someone for insertion, it is out of stock because it was not ordered.

The reason for participant 2 from district B to opt to go to the nearest clinic was because she is afraid of falling pregnant again; it was not the nurse's recommendation that she went for contraceptive. Participant 4 from district D had a different experience; she discovered that she was pregnant while she was bleeding; she was on contraceptives. Her pregnancy could have been caused by the contraceptive failure. Contraceptives in relation to PAC were regarded as an important aspect to avoid unwanted pregnancies and induced abortions. However, health care workers were not providing PAC and contraceptives in the same unit or in the same facilities; and patients would be transferred to other units or other facilities for contraceptives counselling. Patients complain that health care workers do not have enough time to provide PAC counselling, including contraceptives counselling.

Health care workers do not have the resources to provide PAC services including contraceptives and they do not do follow up to ensure that the women are provided

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with the contraceptives. According to the respondents, there is no proper counselling given about contraceptives; those who were provided with contraceptives reported that they were not given proper choice of contraceptives, and not enough information. The pressure between the contending concern of contraceptives and the high risk of unwanted pregnancies involved in the PAC includes the facts that health care workers sometimes fail to provide appropriate contraceptive methods and sometimes no methods at all.

4.5.1.3.4 Theme 3.4: Problems Experienced During the Process of PAC

Women's problems related to their experiences during the process of PAC are discussed. Women have the right to their reproductive health, but they do not have full control to over their body and their choice in terms of reproductive health and rights.

The majority of the women (65%) reported that health care workers have shown bad attitudes towards women seeking PAC services. Patronizing and judgemental behaviour was said to be more common towards women with suspected induced abortion and that affected the quality of care they received and the duration of stay in the hospital. Women reported that they were not treated equally, that there was an issue of discrimination which leads to early discharge that exposed women to complications. Women who reported spontaneous abortion (miscarriage) were given preference and that make women with induced abortion to delay seeking PAC services.

Table 4.8: Theme 4: Problems experienced during the process of PAC

Theme	Sub-themes
4 Problems experienced during the process of PAC	4.1 Utterances experienced by women from health care professionals
	4.2 Problems due to early discharge after PAC – leading to complications
	4.3 Feeling of guilt experienced post PAC

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During the study, some women verbalized that their husbands and their in-laws are the decision makers in terms of child bearing. Culturally, women have no say in terms of the number of children they want to have (Mahbubuo et al., 2012). The department of health is doing its best with regard to providing information on the dangers of illegal abortion and educating women to access PAC services early before complications arise. However, women still access the PAC services late – after complications have arisen that expose them to serious challenges when accessing the services.

4.5.1.4.1. Sub-Theme 4.1: Utterances Experienced by Women from Health Care Professionals

Many of the respondents voiced their grievances about how they had been abused by the health care providers. One of the women explained that she was left in pain to suffer as a punishment for her decision to have an abortion. The statements are confirmed by the following quotes:

Respondent 1 from District C:

They gave me three pills and then immediately after I swallowed, I started having cramping and heavy bleeding and everything. So seeing as though I was commuting, it was about like an hour and 45 minutes from my house, they told me that I needed to go back home because I was having cramping and bleeding and just be very uncomfortable. And they said that abortion would take place at home. They did not say anything about me coming back to the hospital for post-abortion care.

Respondent 3 from District B:

I got really sick, I thought I'd die. I went to the hospital and the nurse put plastic on my bed and I stayed there the entire night, she used a speculum and put on a rubber, and a probe and tied it, I slept with that, only that in the morning I lost too much blood and couldn't stand up, so I stayed there yelling

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for someone to help me go to the bathroom (...) some blood clots came out, some plaque together with the rubber. I lost blood for a week.

Respondent 3 from District A:

They left me suffering for days alone in pain.

Despite evidence that shows that post-abortion care reduces maternal morbidity and mortality and facilitates the use of contraceptives (Grimes et al., 2006:375), the findings of this study suggest that negative attitudes and discrimination of clients who are seeking post abortion care result in PAC providers offering services begrudgingly, if at all. A study by Harries et al. (2006) revealed that even with the legalization of abortion in South Africa in 1996, the opposition faced by the PAC users is one of the major barriers to accessing the services. The analysis of the interviewees' responses in the study by Bacon et al. (2014) showed that patients' abuse by health care providers stemmed from the providers' religious beliefs and personal stigma around abortion.

4.5.1.4.2 Sub-theme: 4.2 Problems due to Early Discharge after PAC Leading to Complications

CTOP Act (no 92 of 1996) stipulated that every woman has the right to universal access to quality reproductive health service including family planning, termination of pregnancy, as well as sexuality education and counselling programmes and services. Health care workers are expected to ensure that the women are given proper care before discharge as well as providing assessment and on-going referral for more specialist treatment if required. The majority of respondents reported that the hospital stay was not sufficient enough for them to recover before being discharged. The quotes below confirmed this:

Respondent 3 from District C:

Because of the shortage of beds I was discharged on the same day after receiving PAC service.

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Respondent 4 from District C:

I honestly think that I was supposed to be monitored further before being discharged to go home.

Respondent 2 from District C:

I was thinking that I would be sent to the psychologist for further counselling and know the ordeal of abortion is haunting me because I did not receive proper counselling.

The women were concerned that they had not being adequately treated. Generally they felt that they had a short 2-3 day stay before they got discharged. They complained about coping with bleeding and pain at home. The respondents felt that the process happened fast and they were not given time to internalize the whole process in order to process what had happened to them.

Accessibility to contraception is an integral part of PAC, so as to prevent unwanted pregnancy and future induced or unsafe abortions (Harries et al., 2006). However, this study shows that PAC services providers do not have time to provide such services. Not surprisingly, the above may be as a result of general shortages in the health workforce in most countries, including South Africa, and this subsequently increases health care providers' workload, coupled with discrimination and low priority of abortion services (WHO, 2015). PAC services users would definitely benefit from more trained staffing in the hospital.

4.5.1.4.3 Sub-Theme: 4.3 Feeling of Guilt Post PAC

The respondents showed that they have accepted and appreciated the PAC methods and they were even feeling better, because this way they were free from the risk of post abortion complications. The respondents reported that they are focusing on not having unwanted pregnancy and are looking forward to having good sexual and reproductive health, even choosing to ignore the stigma and shame of having abortion from family and community. A study done by Oladokun et al. (2015:50) also found that the major

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factor influencing the choice of seeking post abortion care was the desire to reduce post abortion complications, and therefore the women felt happy and relieved because they had protected themselves from complications or even death. There were five respondents that expressed positive emotions about PAC.

Respondent 3 from District E:

I feel fine, because I have protected myself from dying by going to the hospital and seeking PAC although people judge me somehow by concluding that you have had an abortion when they see you in the TOP clinic. I am alive today.

Respondent 3 from District A:

I accepted that I have had an illegal abortion and I have received PAC and I learnt to live with it.

Respondent 2 from District E:

I feel better knowing that I won't give birth to a baby that is deformed. I am ok, because the nurse who had helped me had advised me to go for TL and I am considering doing that.

Respondent 1 from District B:

When I arrived at the hospital, I was bleeding heavily and the nurses and doctors who were at the emergency room helped me so quickly and the following day I was taken to the theatre for cleaning.

Respondent 4 from District B:

I feel good, because the nurse who helped me gave me the pain medication before the procedure and she explained in detail what she was going to do to me.

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Respondent 1 from District E:

I was alone in the hospital since I did not tell anyone at home that I have had an abortion. However, I was not that alone – the health care worker who gave me PAC services was very good to me and she even gave me food. I felt so good that I have gone through PAC to save my life.

However, some respondents stated that they regret their choices of seeking post abortion care services, as can be seen in the following quotes:

Respondent 1 from District A:

It was very difficult because like any other woman I wanted to keep my pregnancy, as I would have if my grandmother had not forced me to have an abortion that led me to be discriminated by the health care workers calling me names when I was seeking PAC.

Respondent 1 from District D:

As a woman I always dreamed of getting married and having a family, and this was my first experience of having this pregnancy, but I wanted to protect my reputation of being a young mother with unplanned pregnancy. I opted to go for an illegal abortion that nearly caused me to lose my life because I was sick and maltreated at the hospital. I was even discharged with no contraceptive methods, because I was told I was too young to do adult things "crying and looking sad."

Respondent 3 from District D:

In fact I did not want to abort this pregnancy, but I wanted to keep the baby, but because of the HIV status and being scared of rejection I have done it and I was not happy with the PAC service that I have received at the hospital.

These three respondents opted for abortion and to seek PAC service but wished they had kept their babies; as women, they felt that they had failed their babies by aborting them, especially Linda who was pregnant for the first time. A study done by Lazarus, Struthers and Violari (2009:432) confirmed that most women who chose to have an

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abortion regretted not being able to keep their pregnancy and give birth. The findings provide pointers to shortcomings in health care workers' communication and suggest effective communication should take normative communication views into account and be more closely attuned to the needs and experiences of women seeking post abortion care services.

Certain respondents indicated that they were feeling pain and hurt about the PAC service that they have received.

Respondent 3 from district C:

I was depressed and stressed for days after receiving the PAC service. I was called names and I had the procedure without even being given pain medication. I was told to go home after the procedure and I was scared and concerned about what my family and partner would say when they saw me bleeding since I did not tell them that I was having an abortion.

Respondent 3 from district E:

It was a problem to me because I was treated like I had an illegal abortion. This was very painful to me especially when I hear babies across from where I was sleeping.

Respondent 4 from District E:

At first, it was not easy for me because all my other kids were from my husband and this baby was out of wedlock because I cheated. I tried to explain the reason for me to have an abortion to the nurse but she did not sympathize with me, instead she screamed at me.

Respondent 3 from District D:

I have accepted it, but when I was in the hospital, the attitude that I got from the health care workers was not good. They were telling me that I am not educated and unemployed all I know is how to make babies at home.

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Respondent 4 from District B:

It was difficult for me and my heart was very painful and there was nothing that I could do in that ward where I was.

Respondent 2 from District B:

The presence of that nurse was awful. She had just finished doing the procedure on one of the women who was screaming since she started and she went through it and did not feel good or nice and I just went through it because I had no choice.

Respondents expressed pain and hurt as they were unable to change the situation that they are in and they had no control over it, since they had already had the abortion. It was a difficult situation that they believed they could not change. Gugu even mentioned that initially, when she heard the other woman screaming, she had doubts if she would continue. These kinds of negative feelings about seeking PAC were also found by Lazarus et al. (2009:543), who state that the expression of such feelings indicates emotional and psychological strain in the choice of seeking PAC services, and suggests that there is a need for continued psychological and emotional support of women who access post abortion care service.

4.5.1.5 Summary of Main Perspective 1

The women's level of education, age, parity, and marital status, religious and cultural beliefs all influence their decision towards post abortion care services. Their place of residence also plays an important role in terms of accessing PAC services; it depends on the availability of services in their area, as well as the accessibility of PAC services. The availability of transport from one referral facility to the other also worsens the accessibility of PAC services. Lack of knowledge about the importance of seeking PAC early also predisposes women to severe complications that can lead to death. Poor service delivery and lack of decentralization of PAC services in all facilities and all districts increase poor accessibility.

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The referral system is not in place in some of the study sites. In some of the study sites that do not offer the service, it was found that some of the health care workers do not even know where to refer the patients for further management. The facilities are expected to render the emergency services before referring the patients; and that was also found to be lacking at the study sites. According to the National Contraceptive and Fertility Planning policy, SRH services are supposed to be integrated with other medical services including HIV and TB.

Treatment of PAC complications was found to be inadequate from all study sites due to few trained health care workers, despite TOP annual provincial training. The majority of women seeking PAC services reported that they had aborted on the floor or alone in the toilet. They reported that the wards are overcrowded and there is a massive shortage of health care workers in the facilities that they visited. They reported that health care workers that are anti-TOP not only refrain from giving attention to women seeking PAC services, but also show discrimination towards these women. Some women from the study sites reported that they were not given food during the time that they spent in the hospital. Other women reported that they slept on the floor and they were always treated last, especially if they reported that they had undergone a backstreet abortion.

The findings indicated that more than 85% of the women who sought PAC services were younger than 25 years of age. Data also indicated that achieving quality progress in the provision of quality PAC services depends on the health care workers who are the implementers of the PAC services. From the data collected, it was reported that the health care workers were mismanaging and giving ill treatment to women seeking PAC services. In other instances, it was reported that even when the women arrived in time to seek PAC services, it was difficult for them to receive treatment on time and with dignity and respect by the health care workers.

Some women complained about the negative attitude of the health care workers; this made them wait to seek PAC services at a later stage when complications had already occurred and they could get treated as an emergency. It was reported that even if the women have a little knowledge about seeking PAC services early, their knowledge is shattered by health care workers' attitude towards them. Women reported that even if

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they call for pain medication while in the hospital, the health care workers do not consider their cry, and it is the health care workers who have the final decision on when to give medication to the women.

Women reported that their expectations were totally different from the treatment they received in the hospital. For example, they expected to be given contraceptives at the facility before they were discharged. However, instead of getting contraceptives at the facility, they were referred to another facility for contraceptives.

Women reported suffering, mismanagement and confusion regarding what to expect during PAC services. Because of this, the women delayed seeking PAC services and were thus predisposed to severe complications. In other words, women are experiencing lack of support from the health care workers with regards to quality PAC services. Lack of knowledge on illegal abortion and safe abortion were reported to cause problems for the women regarding prevention of abortion complications. This problem was exacerbated by fear of being victimized and stigmatized at the hospital by the health care workers. The women's narratives demonstrated that the limited access available makes it a real a challenge for the women to seek PAC services on time.

4.5.2 MAIN PERSPECTIVE 2: CHALLENGES EXPERIENCED BY HEALTH CARE WORKERS WHEN PROVIDING PAC SERVICES

In all the study sites, it was revealed that there are many barriers identified as challenges that lead to poor provision of PAC services by the health care providers. Lack of skills due to shortage of trained health care providers was identified as a diverse challenge influenced by the low number of health care workers providing post abortion care services. The impact of shortage of skills then results in physical and emotional exhaustion of the health care workers. Shortage of human resources is compounded by the high number of women who are reporting to the health facilities seeking post abortion care services. All participants providing PAC services mentioned that PAC provision is a burden because there is inadequate staff and that situation

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compromises the quality of care rendered to the women as they were unable to render comprehensive PAC care.

This was consistent with the findings of the interview where some of the health care providers indicated that they need in-service training education. Respondents have a general concern about the lack of training and support from the management. All participants have had basic training for providing TOP, but no training on post abortion care services. Their concern was specifically related to a lack of guidelines or facility protocols on PAC services, which leads to inadequate clinical assessment of the patients. During competency skills observation, it was revealed that none of the study sites had TOP guidelines and only three sites (13%) had CTOP facility protocols on how to manage the patients.

Health care providers address the challenges by using their own strategies, drawing upon their socio-cultural perspectives and religious beliefs. These affect their attitude towards women who need post abortion care and the service they provide. A study done by Bamisaiye (2014:175) documented that women are unwilling to seek care from health facilities that make them feel uncomfortable or where they have been treated badly. It is particularly important that all health care workers in different health facilities are aware of and sympathetic to cultural factors when women from diverse culture groups are cared for at the same time and in the same place.

4.5.2.1 Theme 2.1: Barriers to Providing Quality Accessible PAC Services

Health care providers face many barriers when providing PAC services. Health care providers also experience conflicts in their moral and religious values when it comes to the provision of PAC services. Health care providers also complain about a high work load that leads to burnout. Some are concerned about the stigma attached to abortion, the attitude of colleagues and the feeling of isolation

Table 4.9 presents theme 5 and its sub-themes developed from the data collected.

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Table 4.9: Theme 5: Barriers to provide quality accessible PAC services

Theme	Sub-Themes
5 Barriers to provide quality accessible PAC services	5.1 Shortage of human resources lead to sub-standard provision of post-abortion care
	5.2 Inadequate skilled health care workers
	5.3 Moral views towards abortion
	5.4 Stigma attached to the provision of abortion care
	5.5 Low staff morale and burnout

During the interview with health care workers, it was concluded that they are faced with many barriers when providing PAC services.

The following are quotations from the health care worker respondents who participated in the focus group discussions (FGD). They reflect the variety of needs and situations the health care workers face:

FGD 4 R2

Yes, we need training and updates and a mentor who updates us about the latest developments and who tells us or guides us on what is expected so that patients receive total quality nursing care. If you are inadequately trained you turn to mismanaging the women and the women end up coming back with life threatening complications.

FDG 3 R4

When people see us working in this room they start saying bad things about us in the community. They regard us as people who are responsible for killing their babies. Our community way of living is channelled either by religious or cultural beliefs. This work makes us have a bad relationship with the community.

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FDG 2 R1

> We cannot offer proper quality care to the patients, because they are too many for one health care worker. It affects us psychologically knowing that even if we complain to the management, they always say that there is shortage of staff, there is nothing that they can do.

FDG 1 R10

> I was employed and allocated to TOP clinic immediately after completing my four years training. I was expected to care for women who seek abortion and post abortion care services and I was not experienced. I was expecting to work under the supervision of the experienced professional nurse, but there was no one. I asked for the guidelines for the standard operational plan to follow when doing the procedure and there was none. I worked by myself through trial and error and I was terrified that I am risking the woman's life.

Health care providers view provision of PAC services as problematic due to the shortage of PAC trained personnel. In all study sites, the researcher found that there are few health care providers providing PAC services. If they are not there or are on leave, the services are not available, which then leads women to seek unsafe abortions, which again leads to complications and causes more need for PAC. The shortage barrier also leads to poor quality of post abortion care services. Socio-cultural characteristics of health care workers are also a predisposing factor that leads to barrier of PAC services. In some of the study sites, health care workers reported that their skilled colleagues are resigning due to burnout, stigma, and religious beliefs and even due to greener pastures. Health care workers reported that they do not want to provide the service because of fear of stigma and discrimination from the community members because, according to their cultural and religious beliefs, abortion services are forbidden.

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4.5.2.1.1 Sub-Theme 5.1: Shortage of Human Resources Leads to Provision of Sub-standard Post Abortion Care

Shortage of health care providers in provision of PAC services is a major challenge that leads to poor provision of care. Shortage of human resources is defined as lack of adequate number of trained health care workers, as seen worldwide. According to McIntosh and Stellenberg (2009:145), shortage of human resources in the South African health system means lack of adequate skills to provide quality care. The following were identified by participants as the major shortages of human resource for rendering PAC services: inadequate number of health care workers allocated to render PAC services, extent of management care required by women who need PAC services and staff turnover and resignation of health care workers.

All interviewed participants indicated that the shortage of staff (doctors and nurses) was the main factor contributing to sub-standard of care considering the inflow of patients on a daily basis. Shortage of staff was linked to non-replacement of health care workers who retired, resigned, those passed on, and those who went for higher positions; it was also linked to poor working conditions due to shortage of equipment and medical supply. Some of the respondents cited that unmet expectations on incentives, salaries or any benefits agreed upon (e.g. advanced training) attributed shortage of health care workers to absenteeism due to burn out, physical and emotional exhaustion. The above was supported by health care worker's perspectives, detailed in the quotations below:

FDG 3 R9

> Jaaa, we have serious challenge of shortage of staff, our managers do not consider us in the PAC unit, because other nurses were sent for training but we were never considered. Some of the nurses have resigned and they were never replaced. Another challenge is that you can have a patient who needs to be seen by the doctor and when you call for the doctor you don't find them, because some doctors have negative attitude toward abortion patients.

The quotation was supported by the study conducted by Mullaly; (2010:286) which indicated that there is still high rate of maternal mortality related to mismanagement

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during post abortion care, due to few doctors who are assisting the nurses. Significant challenges emphasized by the health care workers included: non-existence of speaking about staff shortage, working conditions; ensure staff skills and training; recruiting, sustaining and motivating staff concertation by the management Mullaly, (2010:221).

FGD 3 R8

> We do have shortage of staff, if I am on leave the service become offline, because there is no one trained. Patients who then came bleeding they are taken to theatre for evacuation by the doctors and those who are seen as not emergency are turned away and given another date to come back.

In support to the above sentiment, Sathar et al., 2013:145), indicated that there is a challenge to provide essential comprehensive PAC to prevent complications and deaths related to PAC patient management. The concept of essential comprehensive PAC was first proposed in 2013 since complications and death related to PAC still exist in high numbers. Shortage of personnel and lack of recognition leads to staff turnover, which then compromises the PAC service rendered to the women. Negative staff attitude towards PAC providers results in quick rotation or staff turnover. The results of this study show that junior employees who have no experience are always allocated to render PAC services. The study shows that more than 50% of the health care workers allocated in the unit have less than five years' experience in the health system.

Shortage of staff leads to poor thorough assessment and poor classification of women seeking post abortion care as high or low risk. Health care workers use a booking system because of the shortage, and that leads to missed opportunity of picking up the complications before they arise (Greenslade et al., 2009:875). Shortage of health care workers leads to poor supervision when patients are admitted in the ward; there is no education about signs of complications that the patient needs to report, what to do when complications arise, and that severe bleeding can lead to shock or death. Almost all the respondents agreed that there is no close 24-hour monitoring of patients in the ward; instead, patients have to look after each other.

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FGD 1 R10

Clients who come to the hospital reporting incomplete abortions need to be admitted in the ward for observation but due to a shortage of manpower and beds, they are sent straight to me in TOP clinic for MVA. After the procedure, they sit on the bench because of lack of beds and are discharged after 2 hours. The work is too much for one person to handle and that is known by the management.

FGD 4 R6

The main problem in our facility is shortage of staff (looking so angry) we can't continue working like this this is not acceptable, one person needs to do admission, do counseling, MVA and expected to monitor the patient closely, that is impossible.

Generally, adequate provision of PAC services is influenced by sufficient human resources, management support and staff prioritization. Health care workers are already scarce in most African countries including South Africa. Shortage of health care workers is either a supply and demand problem, or a systematic problem and supply problem. That is the reason why the existing health care workers shortage is being felt more intensely than those in the past. Therefore, management must ensure that the staff is retained to ensure effective and efficient patient management and quality management of the woman seeking PAC services.

4.5.2.1.2 Sub-Theme 5.2: Shortage of Skilled Health Care Workers

Professional incompetence, as characterized by inadequate knowledge and experience in providing good and quality PAC services, was identified as a challenge. One of the respondents expressed how defeated she felt and dissatisfied with her job, and her quest for more knowledge of PAC services. Health care workers also claim to be insufficiently trained to handle the high volume of women seeking PAC services. Respondents express the need to have adequate knowledge about the provision of

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PAC services and management so that they know what to do if the clients present with challenges and abortion complications.

The PAC service providers in the study facilities were observed for their skills during provision of care. Health care workers claimed not to be sufficiently trained to handle the high number of women presenting to the facilities with complications. Participants reported that they need to have adequate knowledge on management of PAC and the treatment so that they know what to do when the patients present with various challenges and clinical manifestations. Participants expressed that it is necessary and imperative to undergo training so that they can be able to differentiate between emergency and non-emergency conditions and act appropriately. Some reported that they are reluctant to render PAC because of inadequate knowledge and fear of mismanaging the patient that will lead to complications.

The above was supported by the study done by Vega et al.,(2013:321), that confirms that the majority of health care workers lack adequate PAC knowledge to manage and advise the patients about what is wrong and right, and what they should do when emergency arises to prevent complications. According to Vega et al., (2013:554) some health care professionals lack PAC knowledge to advise their clients and the public on what they should do to prevent unwanted pregnancies and what to do in case they have an unwanted pregnancy that leads to abortion. Knowledge was vital in provision of quality PAC that will reduce the occurrence of complications and death in health facilities of KZN. The above was supported by health workers' perspectives, detailed in the quotations below:

FDG 2 R1

One participant expressed that the TOP training that he had taken was insufficient, mentioning that if he were given the opportunity, he would like to be trained for comprehensive sexual and reproductive health, suggesting that it would help him in terms of better managing PAC patients in terms of skills and knowledge.

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FGD 3 R3

We see that I have a need of being trained as an SRH nurse, because it includes holistic care of the patients, but they always say, there is shortage in your unit, if you go away for three days, who would look after the patients.

Although participants have basic bachelor degrees or diplomas, these are only regarded as formal programmes of qualifications; but what is needed is post-graduation training on post abortion care, Chen et al. (2004:1984). Participants deemed it necessary and important to be provided with regular in-service training that would update them and introduce new guidelines for effective and quality post abortion care. Such in-service training should include up-to-date and current information for health care workers. Health care workers felt that it is the responsibility of the facility managers to coordinate post abortion care in-service training programme (Begum et al., 2015:776; Freedman et al., 2006:332).

Figure 4.14 show that 40% of health care workers lack the skills or knowledge to maintain aseptic techniques during the procedure. Some pointed out that:

FGD1 R4

Sometimes I don’t feel confident when providing the service. I feel that “yes” we need to be properly trained and regularly in-serviced.

FGD1 R8

“Ehee” we need training, because it is not fair to the patient when you are offering the service that you are not sure of. We need workshops so that we can be up to date with the latest information.

In support of the participant quotation, evidence from the integrated literature review indicated that training and in-service training is an investment in the health fraternity (Bluestone et al,. 2013:371). Participants verbalized that there is a need for the management to identify the competency and the skills as well as the willingness of the health care provider and send her/him to timely training, and not wait in line or queue, or for seniority. This will then yield positive results for the health institution and also

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benefit the patients. Sending young health care workers who are willing to be trained was viewed as an important way forward, because the young health care workers will have a longer service before they could retire, hence they will benefit the facility including the province Khomeiran et al., (2006:76).

FGD 5 R3

Yes training is a challenge, I have seen older people being sent for training because they are due and after few years they retire and the service suffer.

FGD 4 R2

Some people are sent for study leave because they are regarded as a problem in the unit. Managers send them for two years of study knowing that when they come back they will be going for pension.

In the context where health care providers did not undergo the prescribed training for providing PAC, fear of poor quality care is a major concern. Health care workers felt that their lack of skills restricts them from performing proper PAC. This fear has both rational and irrational components (Nwaigbo, 2010:148). In general, providing in-service workshops and facility support visits can effectively lessen irrational fears. Health care workers should be motivated to change their behaviour so that they can deal with rational fears, for example, taking preventative measures with respect to poor skills and technique of provision of PAC. This was confirmed by respondents:

FGD 3 R1

Sometimes you end up feeling defeated because you might feel that you want to do something more but end up doing much less. I felt that I need more knowledge on management of post abortion care services. Whereas working as nurse I realized that training on post abortion care services was inadequate. When women present with incomplete abortion of unknown gestational age or septic abortion, I don’t know the proper management of the woman.

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FGD 5 R6

I was expected to provide post-abortion care services in the institution without being fully experienced. By that time I felt that I still needed to work under supervision and there was no one trained for abortion care services. I then just worked by trial and error, which then led to my being stressed when providing post-abortion care services. Some of the states that the clients came in with are so scary.

4.5.2.1.3 Sub-Theme 5.3: Increased Attrition Rate due to Increased Workload

Although the health care workers are required to provide holistic quality care to the patients, staff shortage has rendered it impossible. In addition, factors such as increased workload, professional frustration, staff burnout, and attrition are all attributed to staff shortage (Kruk et al., 2010:753). The findings of the study examined the impact of shortage of nurses in the provision of abortion care on health facilities in South Africa, outlines that both public and private sector health facilities have reported an increase in the number of patients seeking clinical abortion care services, leading to increased admissions to Gynaecology and Surgical wards and increased workloads (Shisana, 2014:421). Respondents further mentioned that another cause of shortage of staff is that some members of staff are resigning from government hospitals to the private hospitals or other countries outside South Africa. This was supported by one nurse who said:

FGD 1 R6

I am experiencing professional burnout, which is manifested by emotional exhaustion, depersonalization, and reduced personal accomplishment resulting in poor quality nursing care and overall negative effect on most areas of personal, interpersonal and organizational performance.

Resignation of health care workers for better working conditions and greener pastures is not unique to this study. Health care workers are leaving hospital government

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positions for better paying jobs. The situation of shortage of staff is not unique to these institutions as Vega et al. (2013:671), confirm that in sub-Saharan Africa, where there is critical shortage of health care workers, only few health care workers remain the core of health workforce and the quality of the patient care they provide has been questioned. Mullins, (2009:874) stated that it is difficult to attain adequate nurse-patient ratio due to increased demand for provision of PAC. One respondent had this to say:

FGD 5 R10

> One nurse that has been working were I am working has resigned because of the stress and the pressure that she was getting from the community. She told me that she felt that she can't take it anymore, she has been called names and her family was also called names and felt that she can't take it anymore.

Additionally, there are issues regarding discrimination of health care workers by colleagues, which cause health care workers to move out of the unit and that affect the PAC service outcomes. Participants reported that once allocated in that unit you are called by names like "devil, witch" there is no support from other health care workers and when reporting to the management there is no action taken to prevent that. This was expressed as:

FGD 4 R4

> We lose interest of providing PAC because there is no support from the management and there is no good relationship between other colleagues which lead to stress. This poor relationship leads to communication breakdown which leads to service collapse.

FGD 2 R8

> Another problem is that once the patient arrives in the hospital, she is directly sent to you. It would be good benefit to the patients if there was a team work between the health care providers and that could reduce the waiting time of the patients.

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Figure 4.15 illustrate that there is poor continuity of care and management of patients in all study sites. The study revealed that 25% of health care workers do not do clinical observation due to shortage of staff. Several dimensions of the challenges have been documented as resulting in an adequate supply of health care workers, competitive, global and in-country demand on the health care workers leading to internal and external brain-drain, inefficiencies in the organization of health care delivery services, and poor allocation of human resources (Demtsu et al., 2014:97)

The organizational structure of all study sites exists for both the medical and nursing staff team, however the PAC unit is extremely short staffed. Due to shortage of staff, health care workers are performing clerical duties. One of the hospitals in the urban area of eThekwini District, Addington hospital, had about thirty-five patients waiting for abortion care service and only one nurse was there to provide the service. A newspaper reported that at this same hospital, patients slept on the pavement outside the hospital while waiting for abortion service. However, this move would require training in specialty care for effective and efficient service delivery. During the interview with the women from King Cetswayo district, the women reported that they travel long distances of more than 100km to access the service and due long distance to travel, they end up resorting to back street abortions. The excerpts from health care respondents were:

FDG 3 R2

> Women always complaining about travelling long distance to access PAC service, due to lack of service in their area.

4.5.2.1.4 Sub-Theme 5.4: Moral Views towards Abortion

In conscientious objectors, some staff refused to be involved in the provision of PAC services. Sadly, this has led to the death of some patients in need of PAC services. Conscientious objection, an objection in principle to a legally required/permitted practice, is allowed in case of abortion (Harries et al., 2006). In South Africa, a health professional may object to perform this legal permitted practice on the basis of

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conscience, belief, thought and opinion. However, irrespective of conscientious objection, health professionals are obliged to provide a woman seeking an emergency PAC, give accurate information, refer to necessary services, support the woman emotionally, and administer medications. Unfortunately, this is not the case in many hospitals in the KwaZulu Natal province as evidenced in this study when one worker revealed the following:

FGD 1 R9

Yes, moral views is a challenge, I have seen many patients referred to my facility because they are told that are not emergency and there is no health care worker who is willing to render the service.

FGD 4 R6

During perinatal review meetings, managers always request the health care workers to assist with PAC and they, cite “conscientious objection”.

FGD 4 R7

The other time in the hospital where I am working, a 19-year-old girl came in TOP clinic accompanied by her aunt requesting TOP. On examination she was above 18 weeks I then referred her to the doctor that I am working with. He then admitted her in the ward and prescribed her treatment to be given every 3 hours in the ward. After 7 days being in the ward, the girl then bled to death. When we did the file audit we then realized that her vital signs had not been registered and post abortion care services were not given to the girl, because the staff that was in the ward reported that they cannot take care of the person who has done abortion.”

One of the respondents cited that some providers intentionally withhold information on how a patient can access such services. Even some non-medical workers avoid any involvement with PAC services:

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FGD 5 R4

> Some of them can't even direct the patients to our unit and that makes it difficult for the clients to access our services. The co-workers are not supporting abortion care services at all and they sometimes call us names. Even some of the cleaners – it's so difficult for them to come to our clinic to clean the rooms.

The above statement was supported by the information given by women when she reported that one patient died in the ward due to bleeding, because she disclosed that she had undergone back street abortion.

FGD 4 R9

> Yes, I have seen patients that I was admitted with taking care of each other without a nurse in the ward the night I was admitted and the following day I discharge myself.

The above findings of the study provide strong evidence that South Africa health system has a long way to go in combatting discrimination and prejudice around abortion and PAC services. Similar to these findings are findings of the qualitative study in South Africa that explored health care providers' attitudes towards termination of pregnancy (Harries et al., 2009). In order to retain and attract PAC providers, stigma and abuse surrounding abortion must urgently be addressed in all the health care facilities in the country.

4.5.2.1.5 Sub-Theme 5.5: Stigma attached to the Provision of Abortion Care Services

The participants shed light on challenges of the negative attitudes and behaviours of some of their colleagues in the hospitals regarding abortion and PAC services. The health care workers who are rendering PAC services are being ostracized and called names such as "abortionist, killers". In addition, the fear of stigma and abuse that has kept some health care workers away from PAC services has consequentially

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worsened the problem of staff shortage in the hospitals. This was confirmed by the following quotes from respondents:

FGD 5 R2

Jaa, the issue of stigma is a serious problem in our facility. Other staff members are refusing to work in this unit because of fear of stigma from the community and the subordinates. I am called by names like “child of the devil”. Some even told me that when I die I will find babies waiting for me in heaven crying.

The effect of negative attitudes was supported by another participant when saying:

FGD 3 R7

I have been working in this unit alone for the past 7 years. There is a doctor that I have been working with but now he left because of his new religious beliefs.

During the interviews with women seeking PAC, they reported that when you walk around the hospital looking for the ward and if you mention TOP ward, some nurses won’t even respond to you to give you directions.

The findings of this study revealed that health care workers play a critical role in patient care, but are often ill-equipped to deal with their own fears of occupational risk and handle the clinical aspects of PAC, leading to stigma and discrimination from the community and colleagues. Fear of victimization, cultural diversity, religion, guilty, personal guilty conscious, family rejection has a negative impact on how health care workers provide post abortion care. Fear has influenced health care workers’ career choice, and has contributed to a decrease in quality of patient care due to stigma related to PAC services (Gaidhane et.al, 2009:454). Fear of HIV transmission during manual vacuum aspiration procedure also has a negative impact on the provision of care to patients diagnosed with HIV/AIDS related illness. Participants expressed fears about occupational risks.

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FGD 2 R10

I used to work with a colleague, who will always avoid performing MVA procedure to HIV positive women. When the HIV positive women come, If I am not on duty she will always refer them to other facility.

The study done by Shisana, (2014:765) revealed that health care workers were reluctant to provide PAC as a result of concerns about stigma. Stigma is reported to aggravate stress amongst the health care workers that leads to reluctant in providing care to the patients. Stigma is the term that describes negative attitude and rejection behaviour that is held by members of a group or community, against others who are perceived to be different; it is either disturbing or threatening (Ritzer, 2006:906). The health care workers were found to be faced with unjust social stigma. Some PAC services providers were forced to resign due to the threats, abuse and assaults they faced in their communities. The findings of these study revealed that health care workers are directly or indirectly emotionally affected by either subordinates or community stigma. Some patients accused the health care workers of breech of patients' confidentiality, even though they reported that they do not disclose anything about their patients.

FGD 1 R5

Yoo, the issue of stigma is a serious challenge. One day I was in town, this man came to me and starts blaming me for aborting her child. I became a victim because I was doing my job when the women come to request abortion service to me. The man was so angry telling me that he did not give consent that his girlfriend could abort the baby. He was blaming me for his childlessness.

The above reflects the seriousness of social stigma of abortion. Consistent with these findings, a paper examines the presence and intensity of social abortion stigma in five countries, namely: Mexico, Nigeria, Pakistan, Peru and the United States (USA) in 2006. The authors reported numerous social consequences following abortion and perceived similarity of social abortion stigma was found in both legally liberal and restrictive settings. Nevertheless, the problem was more

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pronounced in countries where abortion is not legalized (Shellenberg, 2010:253). It is known that safe abortions and quality PAC services provision significantly improve women's health and reduce maternal morbidity and mortality; however, the above are undermined by abortion-related stigma in many countries across the globe as confirmed by these findings.

Apparent stigma involves a person's internal sense of shame or fear of prosecution whereas enacted stigma is linked with over acts of discrimination perpetrated against those requesting abortion care services (Vance and Denham, 2008:317).

FGD 1 R5

> Christianity faith is a strong belief amongst Africans, that is why it is so problematic for other health care workers to engage in abortion care services, but because it is legalized, and I believe that it saves lives and decreases the burden of looking after unwanted pregnancy and unplanned children and helps in solving dilemmas and problems in the family – that's why I am doing it.

FGD 2 R10

> For our community, it is a norm that if a woman is admitted to a TOP unit, there is a conclusion that she has had an abortion. Women always hide when they are in the ward, because they are being asked why were they admitted in the unit and they are pointed at as abortionists because they did not want to disclose their reasons for fear of gossip, which is a form of stigmatization that can also lead to discrimination.

Health care workers agreed that there is high stigma towards PAC services even though they believe that access to PAC services is the right for all women who experienced abortion-related complications. Health care workers agreed that absence of PAC services is likely lead to more deaths. Post abortion care providers considered it necessary to offer PAC services, because not all abortion-related complications are due to induced abortion. Health care workers believe that PAC services will only be

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accepted when its importance is well known by the community at large including all health care workers.

4.5.2.1.6 Sub-Theme 5.6: Low Staff Morale and Burnout

Morale is defined as the spirit of an employee, based on the series of feeling of appreciation which can be either high or low (Sheahan, 2015:781). Most of the participants have agreed that increased workload always negatively affects their morale. Results revealed that inadequate patient care rendered to women seeking PAC is beyond their control, because it is lessened by their moral. This is how certain the respondents expressed it:

FGD 2 R8

> Yes, I am having burnout, I am not proud of the service that I am rendering to the patients because it is of low standard resulting from less number of staff allocated in this unit, but I have no choice.

More respondents had concerns that work moral is negatively affected by the workload. Some health care workers felt that they are putting more energy and effort in their work, but their managers did not appreciate their hard work. It was again reported that work morale is also affected by ineffective support from the managers, shortage of manpower, inadequate supply of equipment and medication. The health care workers felt that low work morale always resulted from the feeling that they do not have adequate time to give quality patient care due to high workload. However, the comments from the respondents from district C offered striking confirmation the expectation of adequate provision of PAC services as stipulated by the CTOP Act has not been facilitated. This lack of health care workers' legal ability to provide PAC services is due to poorly supported structure from the management. Respondents expressed that there were some challenges with regard to retaining them in the PAC unit to render the service for a long time – particularly with the lack of support and lack of adequate structure to render the service. These were expressed as follows:

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FGD 2 R10

There is lack of enough space to provide the holistic service. The hospital management does not want to give enough structure. I am given a single room for procedure and the same room I use as a tea room. That is so demoralizing thinking that I can contaminate the germs and end up sick.

The majority, especially from the rural area facilities, referred to lack of medical doctors to offer 2nd trimester services. They explained that they are unable to render 2nd trimester service as a nurse cannot initiate the treatment for patient who presents with 2nd trimester abortion complications. This was affirmed by two respondents:

FGD 4 R8

We have sent the patient to casualty for the doctor's assessment and drug prescription. The patient has to undergo and queue and sometimes patient are put back in the line because some of the health care workers don't regard them as emergencies. It is so frustrating when you are unable to help the patient.

FGD 4 R3

We nurses we are not allowed to initiate the treatment to patients who are on second trimester– all treatment is initiated by the doctor.

Reference to limited or lack of drugs tended to focus on the need for managers to facilitate by ensuring that the pharmacist order enough stock for the unit. Comments especially related to burnout were commonly lack of resources.

FGD 5 R5

The pharmacist would tell you the drugs are expensive and only provide you with few drugs that cannot even cover the quota of people that you see per day, and then you are forced to turn back the patients without treatment.

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FGD 2 R7

We need more staff to be able to integrate the PAC service to other SRH services. There are other programs that we would like to do like HIV, TB but due to short staff we can't.

Participants' responses indicated that there was vital support missing from their teams, which ought to provide effective management of the patients. They emphasized this by saying they do not have support from the O&G specialty team and they do not have a doctor who covers their clinics in case of emergency; this makes it difficult for them to attend to patients who need the expertise or with complications that arise during care.

FGD 1 R3

In my facility there is no doctor allocated that I can call in case of emergency and I don't even have resuscitation equipment in the unit

FGD 2 R3

Sometimes you will call the doctor who is on call and it will take him hours to respond or respond only by telephone and order treatment by telephone.

During the interviews, the women/patients also complained about the low and incomplete care that they were receiving from the health care workers. They also support that their low standard of work of health care workers always negatively affects their health care–patient relationship. One participant said:

FGD 2 R 5

I went to the hospital three times for abortion and I was told that the nurse who does abortion is on leave for four weeks, so then I decided to go for illegal abortion.

Many of the respondents expressed emotional and physical exhaustion. The reason is that some providers were unable to take leaves because there is no one to replace

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them when on leave. Therefore, many continue to work despite burnout. One participant said:

FGD 3 R5

I sometimes feel a situation where I feel that I am physically and emotionally exhausted. I can't take leave because I know that if I take leave women who come for post abortion care that need to be managed by the doctor won't get any service since I am the only one rendering or supporting the service in that hospital.

FGD 5 R5

I am always feeling tired due to the number of clients that I offer post abortion care to.

Some health care providers have resigned, while some are contemplating leaving due to stress and lack of management intervention in addressing their problems. The respondents reported an increasing number of patients seeking PAC services on a daily basis, hence increased workload.

FGD 4 R4

There is one professional nurse a – colleague of mine who has resigned because she was under pressure and she felt that she couldn't cope with the stress resulting from the challenges associated with the provision of abortion care service.

FGD 5 R9

I feel like resigning too, because I can't take in anymore because I always feel very tired as the number of women seeking post abortion care increases on a daily basis due to few facilities that are rendering legal abortion which leads women to seek illegal abortion.

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FGD 5 R5

> The work morale is low. I have burnout and I feel hopeless. I am just working because I need to earn a leaving, but the environment is not conducive or motivating at all. I wish the government could change this situation.

Unsurprisingly, health care workers have a long history of reported unconducive work conditions which may negatively affect the provision of patient-cantered care that is safe and of high quality. However the facility management are working with the provincial office to identify proper spaces in the facilities. The provincial office has come up with the commitment form were facility manager has to sign to commit that, when they send their health care workers for training, thereafter, they will support them when providing PAC service

The literature suggests that the work environment and staffing are two major causative factors of burnout which is characterized by extreme overextension and depletion of one's emotional and physical feelings in response to chronic job stressors and job satisfaction (Ekstrand et al., 2009). These study findings revealed that ineffective management, enormous workloads, abortion stigma and discrimination, and a shortage of staff are all contributing to burnout experienced by PAC services providers in South Africa.

4.5.2.2 Theme 6 Deficits in Knowledge and unwillingness to Provide PAC

Table 4.10 presents theme 6 and its sub-themes from the data analysis.

Table 4.10 Theme 6: Deficits in knowledge to provide PAC

Theme	Sub-Themes
6. Deficits in knowledge to provide PAC	6.1 Explanation related to management of women seeking Post Abortion Care Services

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4.5.2.2.1 Sub-Theme 6.2: Explanation related to management of women seeking Post Abortion Care Services

The study findings revealed that health care workers have no PAC guidelines that they can refer to when managing women seeking post abortion care services. Some health care workers only referred to WHO Safe Abortion: Technical and Policy Guidance for Health System, Second Edition, 2012, which directs them how to manage pregnant women with complications. They also referred to their facility Standard Operational Guideline (SOP) and some referred to the Essential Drug List Guideline which does not direct them on how to manage the women, but directs them on which treatment to prescribe and give.

According to WHO (2012:89), women with abortion complications must be attended by a trained health care provider in a well-equipped facility to avoid risk associated with complications. Health care providers at all levels of care should have the competency to recognize the signs and symptoms of complications related to abortion and either treat or immediately refer to the nearest facility were the woman will get treatment.

On attending to the women with abortion complication, the health care workers manage them according to their own facility level. If the woman comes to the clinic, they refer them to the nearest facility that offers the service. Depending on the urgency of care for the women, they sometimes are asked to get their own transport and sometimes they wait for the ambulance which sometimes takes 3 to 5 hours before it arrives. At hospital level, Manual Vacuum Aspiration procedure is done. In some facilities the procedure is done in an operating theatre and in some it is done in the unit and thereafter the patient is discharged to go home, or admitted either to share a bed with other patient or sleep on the chair.

Certain respondents indicated that they did not feel competent due to lack of guidelines in some facilities. One respondent said:

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FGD 5 R8

Yes, there is a serious problem with managing the patients. We don't have guidelines that we need to refer to; sometimes you just give treatment using your own discretion.

FGD 1 R7

It was a problem to me because when the woman came in the ward due to bleeding after abortion, I would take time to manage her properly. The other day the client asks, why are you not cleaning me to stop the bleeding? That was very painful to me and I was hurt, because the client can see that I am not sure of what I was doing.

Health care workers are expected to adhere to all guideline that are mentioned on Figure 4.9 in order to provide quality PAC services. Implementation of PAC guidelines was an aid to proper management of women seeking care in different levels of care. In order to effect positive changes, it is important to create effective management post abortion care guidelines as a driving force for change in addressing issues related to post abortion care related for both miscarriage and incomplete abortion. The guidelines would help in monitoring the ongoing process of how activities of PAC are being implemented and their results in terms of output.

4.5.2.3 Theme 7 Logistics System, Material Resources and Infrastructural Barriers

The lack of proper facilities and necessary resources in the hospitals, time constraints and lack of management and administrative support could all be barriers to providing quality and efficient PAC services.

Table 4.11 presents theme 7 and its sub-themes developed from the data collected.

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Table 4.11 Theme 7: Logistics system, material resources and infrastructural barriers

Theme	Sub-Themes
7. Logistics system, material resources and infrastructural barriers	7.1 Limited proper facilities and necessary resources to provide PAC
	7.2 Time constraints
	7.3 Insufficient management and administrative support

4.5.2.3.1 Sub-Theme 7.1: Limited Proper Facilities and Necessary Resources to Provide PAC

The health care workers reported lack of proper facilities and necessary resources in the hospitals as a serious challenge that leads to poor quality care that increases maternal mortality in the health facilities of KZN Province. The ethics of maintaining patients' confidentiality and privacy which is vital in health care is been compromised due to inadequate and lack of appropriate structure and resources. Also, the lives of the women seeking PAC services were endangered as a result of exposure to unsterilized and contaminated equipment and this was aggravated by old and dilapidated buildings as well as shortage of supplies.

Health care workers, therefore, suggested that there is a need for allocating the PAC services seekers in well-established designated bedded units specifically for SRH services including abortion services. They further suggested that for them to provide quality care that will reduce the burden of maternal death, the facility managers need to budget for more equipment and more health care workers in all health facilities within the district.

The well-established infrastructure and increased equipment will boost coverage of abortions complications and reduce occurrence of death. WHO advocates planning and managing safe abortion care and ensuring increased access and high quality services for all women in need, to the full extent of the law. This should be achieved

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if managers include health system costs for infrastructure, supplies/equipment and capital costs.

FGD 1 R1

Yes, there is lack of confidentiality and privacy in this unit. There is not enough space to work in; I am allocated only one room to do the procedure. In this room there is no even a basin to wash my hand after the procedure , I need to go out to the next room to wash hands and clean the instrument and where I go out with dirty instruments is a passage of waiting area for other women to get in for the service. If the women are screaming due to pain, the other women waiting can hear her.

FGD 1 R10

In that unit we are working with patients who are bleeding on a daily basis. We are exposed to HIV infection due to our exposure to blood and body fluids from the patients diagnosed with HIV/AIDS-related illness. When we order the protective clothing it is so difficult. We need to wear the goggles, gloves, face mask, aprons and it is so difficult to get goggles and aprons and sometimes blood spills on our uniform.

FGD 4 R4

Yes, when you place your order in the stores it takes more than 2 months to receive the supply and sometimes when you do follow up at stores they will tell you that your order form is misplaced.

As seen in the above quotes, the health care workers felt unsafe at work as a result of lack of protective resources such as proper hand washing equipment, disinfectant, gloves, etc. The aforementioned escalate the frustration experienced by PAC providers, and consequently result in burnout and staff turnover. Observations of the skills of health care workers at the rural hospital facilities showed that they were not practicing infection control measures.

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Lack of adequate medical resources and proper hospital structure are not unusual in Africa (Wasis-Shattuck et al., 2008:391; Simkhada et al., 2008:214; Pittet et al., 2008:631). In line with the findings of this study, Bacon et al. (2014:621) identified inadequate medical supplies as one of the major challenges faced by Uganda midwives in providing PAC services. According to Page (2004), inefficient workspace design features undermine patient safety and privacy. According to Tabbutt-Henry and Graff (2330:431), privacy is very important during counselling in the delivery of PAC services. Having a private counselling room may help to ensure privacy and help the woman to talk freely. But during this study, this was not possible in most of the study sites; most of the health care workers were using curtains and sat beside the clients' bed and spoke softly. However, organizational change and quality improvement intervention have been suggested to address this issue (Hussein et al., 2011).

4.5.2.3.2 Sub-Theme 7.2: Time Constraints

Because of work overload, it is not uncommon for health care workers to view time constraints as a barrier (Park & Song, 2005; Anoosheh et al. 2009). For the patient to receive quality PAC, health care workers are supposed to spend 35 minutes including counselling with each patient. In this study, time limitations were a barrier to the provision of proper and quality PAC services. The excerpts for respondents were:

FGD 3 R10

Sometimes I feel that the work and the care of the patients are compromised because we have too much to do. It is difficult to give proper nursing care and prioritize my skills because I am always in a hurry when performing the procedures as almost every day I am always behind schedule.

FGD 1 R10

We are working in a very strenuous situation, standing the whole day and sometimes when you check time you are just surprised that it has passed by. Working in an abortion unit is very much different from working other units,

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because of the number of patients with different age groups you see every day and some of those women always look sad and miserable.

Due to cultural diversity of health care providers and the women, Figure 4.10 shows that 74% of the health care workers were unable to respond to the women's questions due to language barriers. Conversely, insufficient time and workload demands are viewed as hampering the health care worker-patient relationship (Park & Song, 2005; Beckstrand et al. 2006; Magnus & Turkington 2006). In 2010, Tejero observed that quality time with patients resulted in significantly higher levels of bonding and allowed for more 'information, interventions and interpersonal exchange' to take place between health care workers and their patients. Despite time constraints experienced by providers, evidence suggests that they implement a range of time management strategies, such as the routinization and prioritization of tasks and skillfully adjust interactions to suit the available time to help improve time management (Barrere, 2007:97).

4.5.2.3.3 Sub-Theme 7.3: Insufficient Management and Administrative Support

Insufficient management and administrative support was identified as a challenge. The respondents mentioned that despite the difficulties encountered – such as work overload, shortage of staff, discrimination and verbal abuse from other staff when performing their duties; the management put no measures in place to support them, hence health care works felt neglected. This was supported by the following excerpts:

FGD 1 R10

There is poor support from the management of the hospital. They do not take the time to come and visit the unit or phone to check the progress of the unit. Provincial office is giving support because they invite me for debriefing sessions at least once per year. At the hospital there is no psychological or emotional support.

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FGD 3 R10

I have been working with abortion services for the past 9 years and there has been no support given by the hospital management. Again, the hospital management always tells that they can do nothing about shortage of manpower… I felt that I had to continue to work in the challenging environment without any promising of effective support from the management. I have never been sent for psychological counselling.

According to the participants, operational managers were not always available to oversee how health care workers are coping with the challenges that they are experiencing on daily basis. Sometimes a community health care worker – who is usually a newly qualified professional nurse who is to work under the supervision of experienced professional nurse – is allocated the unit alone. The operational nurse could hardly visit to observe what the health care worker is doing.

FGD 2 R5

Ohh yes, when I join the unit, I used to work alone and I was expected to see all the patients who come for PAC service, without even getting orientation.

Hospital managers often failed to ensure that an adequate number of health care providers are employed and allocated in the hospital, despite the fact that the total number of patients admitted to the hospital seeking post abortion care management increases steadily.

FGD 3 R8

Emotional support is achieved through debriefing and team building sessions. No one is supporting us emotionally. Sometimes when I am counselling a woman who has just had a miscarriage or who reported that she has undergone a botched illegal abortion and she is crying. After that I need to continue with my work with no one taking care of my emotional stress and psychological exhaustion as there is no time for me to go for counselling. I think we need to be supported emotionally and psychologically – especially

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when it comes to deeply touching conditions of these women as a way of preventing traumatic stress.

Some of the health care workers also stated that they were demoralized by lack of well-deserved incentives in the organization for PAC services providers.

FGD 1 R9

The work we are doing is stressful and demanding and we deserve special allowance such as OSD in our salary. We should be provided with special allowance and our work that we do need advanced mentoring and support for development and patient care.

FGD 4 R7

Rendering post-abortion care services is difficult and could be nice if they can give us some form of allowance to motivate more staff to come forward and be trained and increase the services for PAC.

FGD 2 R5

In my facility, hospital management does not acknowledge that the unit is busy, and they don't see a need for giving us special allowance or take us as nurses with scarce skills… We also need training on post abortion care service but they don't consider that as important.

Despite the above statements, a few of the respondents attested that the provincial office did organize debriefing sessions once a month and sometimes met their needs.

FGD 3 R9

We do meet with DoH provincial manager once per year and if we explain our situation sometimes our problems get resolved quickly. We wish we could communicate regularly. The provincial office organized a debriefing session for us once a month and during the session the emotional support is achieved through that debriefing session and team building sessions take place. We

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play games, do some exercises. A motivational speaker and the psychologist are invited for counselling us. An open discussion is used where we are allowed to talk about issues related to abortion and managing such patients.

FGD 5 R8

Three-day debriefing sessions are conducted to relieve stress from health care workers who are responsible for providing post abortion care services on a daily basis. Talks are offered by experts such as psychologists. During the session the health care workers share their experiences and the problems that they encounter during their work. We feel that we are important, knowing that out there are people who are ready to listen to us and our challenges. During the sharing of our experience we really feel relieved from the stress that we are having.

As cited in the above statements, the respondents are not motivated to perform their duties due to lack of organization and management support. PAC services providers can be enthused to work effectively by the provision of adequate necessary supports and incentive. A study examined the relationship between organizational commitment, job satisfaction, and nurses' intentions to leave their current position. The authors found predictive relationships between financial status, organizational commitment, job and professional satisfaction, and intent to leave their post (Lynn & Redman, 2005:284). Kinfu et al. (2009:111) suggest aggressive retention policies, such as improving the remuneration and working conditions to motivate and reduce health care workers' attrition.

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4.5.4 Theme 8: Suggestion for Provision of Quality and Accessible PAC care Services

The health care worker respondents suggested a number of measures which they believe would improve the provision of PAC services in the hospitals. Two sub-themes were identified under this theme.

Table 4.12 presents theme 8 and its sub-themes developed from the data collected.

Table 4.12: Theme 8: Suggestion for provision of quality and accessible PAC care services

Theme	Sub-themes
2.4 Suggestion for provision of quality and accessible PAC care services	2.4.1 Ensuring operation management and administrative support
	2.4.2 Providing more PAC and post abortion trained nurses

4.5.2.4.1 Sub-Theme 8.1: Ensuring Operation Management and Administrative Support

The respondents suggested that effective operation management and administrative support such as organizing stress management programs and provision of debriefing would help improve and motivate PAC services providers to perform their duties. Respondents suggested interventions that could help them.

FGD 4 R1

> Working with the patients seeking abortion care services is stressful and demanding. Therefore the hospital needs to organize stress management, debriefing sessions, for us who are dealing with such patients. The hospital should provide us with opportunity to attend.

An organization's success depends on the individuals who work for it. Stress is an extreme condition that can affect an individual in different ways and to different

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degrees. It can, therefore, severely affect the performance of an organization to the detriment of its staff and hence its end product or service. The most detrimental effects of stress include high levels of absenteeism, poor job performance, low morale, and low commitment, increased incidence of accidents, difficult industrial relations and poor relationships with customers. Employee morale is vitally important to the success of any organization. Low morale and lack of recognition by the employer was often leaded to the loss of valuable trained personnel (Quirke, 2001:542). Therefore, stress management in every organization is imperative, particularly in health care facilities where staff is expected to provide holistic quality care to their clients at all times.

4.5.2.4.2 Sub-Theme 8.2: A need for more PAC and Post Abortion Trained Health Care Workers

The health care workers need quality counselling skills and MVA skills. The respondents strongly expressed the need for more staff training on PAC.

FGD 3 R5

> Furthermore, training for the health care professional nurses on post abortion care services is needed. The TOP training is organized once per year by the province but I think that it is not enough. We need to cascade the training to the district level.

FGD 5 R3

> According to the TOP Act, all registered nurses and midwives must undergo prescribed training before conducting abortion services. If all the nurses are trained on abortion services during their basic training, we may achieve SDG5 and healthy personnel.

The development of the guideline would contribute to the country’s commitment to Sustainable Development Goal (SDG5) that stated that women and girls everywhere

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must have equal rights and opportunity, and be able to live free of violence and discrimination. This study revealed that staff training is an important contributor to quality PAC services provision. This suggestion is supported by the findings from a study by Forsetlund et al. (2009). These authors claimed that educational meetings through workshops and continuing medical education result in improving professional practice and, thereby, patient outcomes. A similar recommendation was made by Sooruth et al. (2015) of regular in-service education of trained staff is needed to reinforce and update their knowledge and skills of professional nurses. During observation of availability of all guidelines related to abortion care e.g. National strategic plan guidelines on CTOP, it was found that only 32% of the facilities have guidelines regarding TOP services and another 56% have standard operational guidelines.

4.5.5 Summary of Main Perspective 2

Although the Choice on Termination of Pregnancy Act gives the woman the right to choose whether to have a safe and legal termination of pregnancy according to her individual beliefs, its implementation is hampered by its stringent legal and administrative requirements. The requirement that says that after thirteen weeks, a pregnancy may be terminated if it poses a health risk to the woman or is due to rape or incest; this also creates serious legal barriers to women's access to safe abortion which then lead to increased need of PAC services (Reproductive Right Alliance 2008:8).

Given the state of concerns in rural areas where facilities are far away, not easily accessible due to lack of transport and with no more than one health care provider allocated to the unit, this is a virtually impossible requirement to comply with. Shortage of trained human resources needed specifically to render PAC services is also found to be a serious barrier.

The law also gives health care workers the right to conscientious objection. It further restricts the kind of facilities that TOP can be rendered to approve facilities as stated on the Amendment Act no1 of 2008. With only few registered facilities in KZN and the country as a whole, these restrictions mean that only few facilities are available

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for women to access safe abortion that can prevent them from getting complications that lead to the need of PAC services. Few health care workers, including the doctors, were available to offer PAC services from the study sites because they are not obliged to perform abortion services if it impinges on their religious or moral grounds. The women must then be referred.

Health care workers have reported the societal norms and define them as the acceptability or rejection that influences their decision of participating on PAC services. They have reported that abortion service is considered a silent problem in their community. They have stated that in their communities, abortion services are viewed as a taboo and when one offers the services it must be done in secret. This means that health care workers who are seen rendering PAC services are stigmatized and this causes low morale. Stigma produces inequality, discreditation and discrimination against those rendering the PAC service.

Study findings indicated that treatment of post abortion care complications remains inadequate due to health care workers incompetency. With a low PAC services coverage rate, most health care workers rely on the skills that they have learned during their basic training. The researcher has noticed that progress has not been made in the provision of PAC services.

There are a lot of challenges with regard to willingness to provide PAC services by the health care workers. There is inadequate staff in all study sites. Further, the researcher find that facilities in rural areas have serous staff and equipment shortages and are unable to provide PAC services. Some of the facilities in the rural areas are inadequately staffed with no health care workers with PAC knowledge and services are delivered by untrained staff without even a guideline. Resignation was reported as another challenge phased by the health care workers in all study sites.

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4.6 Presentation of Quantitative Results

4.6.1 Overview of Fieldwork Activities in the Quantitative Approach

In the quantitative research approach, data were collected through observation using competency skills assessment tool to assess 92 respondents at 23 selected facilities The objective of the observation was to assess the skills of health care workers when providing post abortion care services. The competency skill was composed of closed-ended items that you have to tick yes or no. The checklist was developed based on the TOP Act to suit the context of the study. The researcher planned what was going to be observed and have a clear purpose. During the observation, the researcher acted as a non-participant observer so that interaction in the health care setting can be observed freely without influencing the participants. The competency checklist tool includes the provider code, name of the assessor, facility code and date of assessment. The checklist was divided into 9 sections that are relevant to post abortion care services. Under each section, a series of items were included that represented criteria for assessing the section's characteristics (Annexa 6).

The questions were divided into sections namely:

1. **Section A:** Demographic Data
2. **Section B:** Infection Control Activities (Infection Prevention Control can minimize the risk of spreading infections especially in hospitals and human or animal health care facilities amongst women seeking post abortion care services).
3. **Section C:** Guidelines Availability in 23 Facilities (Guide the health care workers in the provision of post abortion care).
4. **Section D:** Client Interaction Activities (importance of interactions helps the client to understand the process of post abortion care services through counselling process)
5. **Section E:** Pre Abortion Care Activities (Ensures that the woman signed the consent form)

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6. **Section F:** Contraceptives Methods (Identify the knowledge of health care workers in terms of providing suitable different contraceptives methods after post abortion)

7. **Section G:** Surgical abortion (MVA) Services (Improves quality of care available for women seeking uterine evacuation)

8. **Section H:** Post abortion care services (promote continuum of care to treat potential life-threatening complications from incomplete and unsafe abortion and therefore reduce abortion related morbidity and mortality.

9. **Section I:** Continuation of care (Care given after post abortion management).

4.6.2 Presentation of Quantitative Results

The quantitative results were presented from section A= Demographic Data, section B= infection control activities, section C: guidelines availability in 23 facilities, section D: client interaction activities, section E: pre abortion care activities, section F: contraceptives offered, section G: surgical abortion (MVA) services, section H: post abortion care services and section I: continuation of care.

With the help from the statistician, quantitative data obtained from the 92 participants during observation were entered into the computer software, SPSS version 20 for analysis. In this study, descriptive statistic, specifically frequency distributions and percentages were used to summarize data collected. Frequency distributions were used for standard deviations, means and categorical variables.

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4.6.3 Section A: Demographic Data

Demographic data of the health care workers who were observed and assessed are presented in Table 4.13.

Table 4.13 Distribution of the health care workers (Observation) according to their characteristics (n=92)

Characteristics	**Frequency(n)**		**(%)**	
Age				
21-25 yrs.	13		14 %	
26-30 yrs.	21		23 %	
30-35- yrs.	19		21 %	
36-40 yrs.	23		25%	
40 and above	16		17%	
Total	**92**		**100 %**	
Marital status				
Single	34		37%	
Married	41		45 %	
Cohabitating	17		18 %	
Total	**92**		**100 %**	
Experience of health care workers in post abortion care services	1 year		18%	
	3 years		52%	
	5 years and above		30%	
Position of health care worker in the unit	Doctor		17%	
	Registered nurse/Midwives		83%	
District code	**Nurses gender**			
	Male		Females	
	N	%	n	%
A-eThekwini	09	29%	11	18 %
B-Harry Gwala	03	10 %	17	27%
C-uMzinyathi	04	12 %	12	20%
D-uMgungundlovu	07	23%	09	15%
E-King Cetswayo	08	26%	12	20 %
Total	**31**	**100%**	**61**	**100%**

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Religious affiliation		
Muslim	26	28 %
Christian	66	72 %
Total	**92**	**100 %**

Source: Primary analysis of the survey data.

Age

The ages of the nurses ranges from 21- over 40 years. Health care providers less than 35 years old were more likely to provide abortion care services compared to those above 35 years (58% vs 42%). This provides strong evidence that training young health care workers on PAC represents a wise investment of resources, as they are more likely to become more active in post abortion care services more than adults.

Marital status

This study found that more than (37%) of the health care workers were not married, 18% cohabitating and only 45% were married. This finding is similar to findings by Likwa and Whittaker (2014:197), the study shows that health care workers who are not married are more likely to provide abortion care services compared to married health care workers. From these findings, both married and unmarried health care workers may provide post abortion care services in case of the women presenting with abortion complications.

Experience of health care workers in post abortion care services

Health care workers were significant, for the researcher to be able to collect data to develop the guideline for the management of PAC. Table 4:13 illustrated that 52% of health care workers had more than 3 years' experience, 30% had 5 years and above and 18% had a 1 year experience. The majority of health care workers were not comfortable to participate to abortion care service; they felt that abortion is a sensitive issue that they don't feel comfortable to render. Nurses provide a sensible investment of resources as they are more likely than doctors to become more active post abortion care service providers following TOP training. In addition, they are less

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transfer away from the facilities or units where they are posted in comparison to highly mobile doctors, ensuring more sustainable provider coverage in health facilities. Nurses increase post abortion care services access by reaching more under privileged women with unwanted pregnancies in the rural area. Nurses are more allocated at the primary health care services like PHC facilities to offer PAC, therefore increasing the reach of life-saving abortion care to more women, especially in deep rural areas.

Position of health care worker in the unit

Data shows that 83% of health care workers were Nurses and 17% doctors offering post abortion care services in the study areas. It was important to include this variable to determine the extent of experience to determine if option of rendering PAC service is influenced by pre-existing experience of abortion and post abortion care. Again the importance of offering abortion services may influence a health care worker to deliver the service. This might include prior experience or exposure to narratives about abortion from familial or social networks. A study conducted by Banerjee, Andersen et al. (2014:118) in India revealed that few health care workers who had limited exposure to mass media, showed that they had no knowledge about abortion experience from family, friends or community were more likely to notice the importance of abortion no have positive attitudes toward.

Nurse's gender

The PAC patients were attended to either a male or female provider depending on the shift and the facility she attended. Female health care workers constituted the majority (67%) of the respondents very much keeping with demographics of the nursing profession which is predominantly females in South Africa. The male counterparts constituted the remaining (33%). The study shows that both females and males health care workers were involved in PAC services for upscaling sexual and reproductive health services, prevention of unwanted pregnancies, sexual health information, education and counselling as appropriate to human sexuality, reproductive health.

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Religious affiliation

Two dominant religious affiliations were found in the study area. More than half of health care workers were Christian (72%) and the rest (28%) were Muslims. Those who were Christians were not asked about their denomination. This finding suggests that nurses from various religious background offers PAC services to women who need service. As stated in various literature reviews, most of the religious teaching condemns abortion services. However, the way in which nurses from different religious affiliation would act on issues related to abortion and PAC services may differ.

4.6.4 Section B: Infection Control Activities

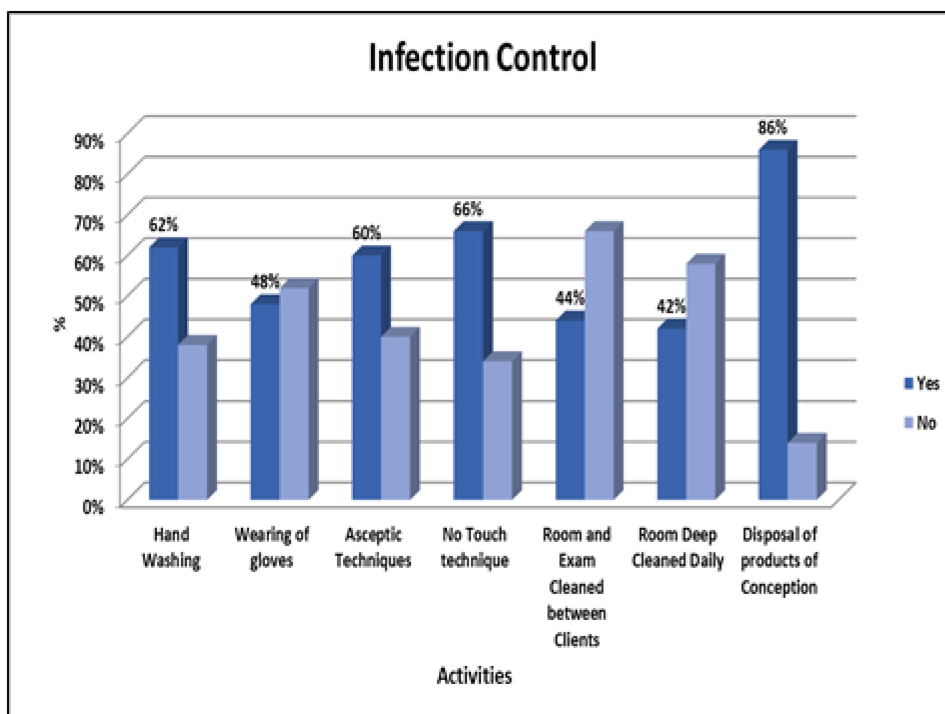

Figure 4.8 Infection control activities

Infection Prevention Control (ICP) refers to policies and procedures used to minimize the risk of spreading infections especially in hospitals and human or animal health care facilities. When practiced effectively it ensures that health care workers protect themselves and the patients from transmission of infections. The section consists of seven activities that were observed to assess the skills of health care workers during

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the provision of PAC as illustrated in the above graph. The activities were Hand Washing, Wearing of barriers, Aseptic technique, and no touch technique, room and exam table cleaned between clients, Room deep cleaned daily and disposal of products of conception

The activities were observed by researcher and make a cross on yes if the activity was done and on if was not done. Out of 7 activities, only 66.2% of health care workers were observed maintaining infection control. Of the 66.2%, 54% were from uban hospitals. Hand Washing activity, out of 92 total observed health care workers, 62% washed hands before the procedure while 38% did not washed their hands before procedure because their facility did not have a basin and running tap.Fourty eight (48%) were observed wearing cloves as compared to 52% who did not wear cloves during the procedure. Asceptic Techniques were observed on 60% while 40% did not maintain asceptic technique. Total of 66% adhered to no touch technique while 34% did not adhere to no touch technique. Room and exam cleaned between clients, there were 44% cleaned rooms between clients whereas 56% rooms were not cleaned between clients. Room Deep Cleaned was observed done daily by only 42% and 58% room deep cleaning was not done daily. Many health Care Workers disposed products of conception, there was 86% of health Care Workers disposed products of conception properly and only 14% did not dispose products of conception properly after procedure.

Overall, the infection control has shown upward trend but still below recommendend expectations.With no time, after the implimentation of PAC guideline it is hoped that provision of wider range of infection control mesesures during PAC services such as aseptic technique, cleaning room between clients and room deep-cleaning daily will will increase the prevention of infections. Post abortion care services that are rendered in an unhygienic conditions and without following proper technique are more likely to results in complications , which can cause death of most women seeking PAC services. Omen most frequently suffer from complications like severe haemmorhage and septicemia.

The ongoing poor management of infection control need to be adressed and monotored effectively as infection control is one of the most important public health

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interventions needed. Monitoring infection control can determine how best the policy makers can influence infection control policies. Overall, there has been marked excellence in managing the disposal of products of conceptus.

4.6.5 Section C: Guidelines Availability in 23 Facilities

As illustrated in the above graph, sexual and reproductive health guidelines and protocols, including CTOP Act No 92 of 1996, were not available in five sites (22%). All of the five sites were in the rural area. Furthermore, twenty three sites (100%) of the study sites were not having CTOP guideline. Only 78.2% of the study sites were having provincial TOP policy and the remaining 21.8 percent were in the rural areas. Only three facilities were found to have Conscientious Objection document, one facility from rural and two from urban area. National strategic plan for the CTOP Act No 92 0f 1996 was not available in nineteen sites (82.7%), out of that 18 sites were in the rural and one site was in urban area.

There were no TOP local protocols on management of PAC emergency cases in twenty of the sites (87%). Moreover, none of the study sites conduct any in service training for management protocols of patients seeking PAC service. One of the health care provider acknowledge that they are not managing the properly by saying, we have not been well trained in managing the patients in the correct way. The 50 health care workers who participated on focus group discussion reported that they strongly agreed that facilities must have their own guidelines or protocols because, different health care workers may face different stages of the management of induced abortion. The use of clinical protocols should be individualized to each facility with the emphasis of individuals to each woman clinical needs.

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4.6.6 Section D: Client Interaction Activities

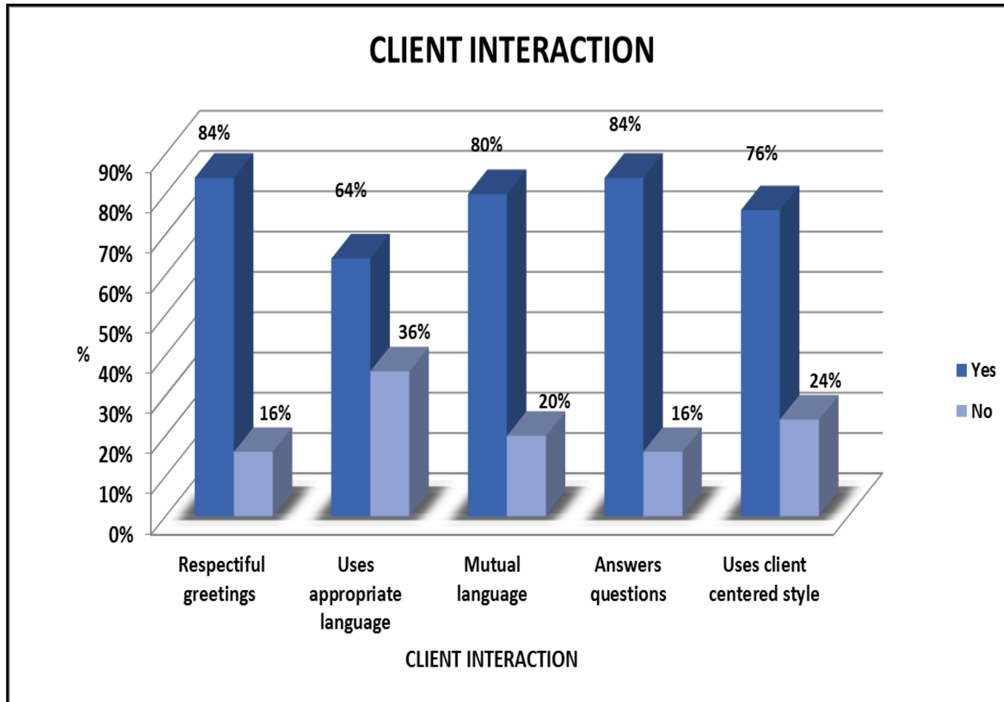

Figure 4.9 Client interaction activities

As illustrated in figure 4.9, none of the facilities from the study sites achieved 100% on client interaction activities. Results show that 20% of the health care workers were having barrier language during interacting with the patents. Hence it was discovered that 16% of the health care workers does not have respect to the patents. Only 80% of health care workers use mutual language and 64% use appropriate language. Only 74% of health care workers are able to answer the questions that they are asked by the women and 20% don't answer full and this tells us lack of knowledge from the health care workers.

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4.6.7 Section E: Pre Abortion Care Activities

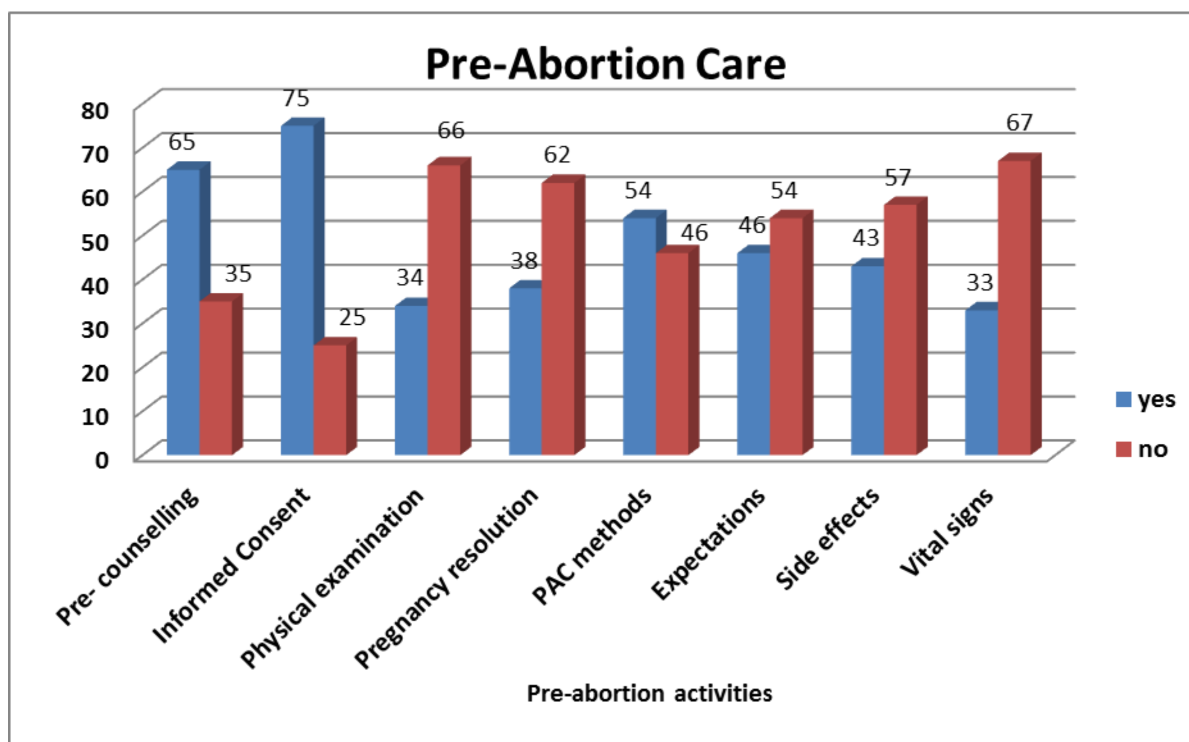

Figure 4.10 Pre abortion care activities

Post abortion care service should meet the criteria of high standard and quality care as compared to other health services in terms of privacy, confidentiality, accessibility, promptness and flexibility. There are number of steps that need to be followed and adhered to by the health care worker before offering the procedure. The health care worker should be able to determine gestational age, provide accurate and correct information to the woman and use of medication including antibiotics and pain medication correctly. Those are some of the recommendations from the 2nd edition of WHO Safe Abortion Guide (2012:134)

It is critical for the health care providers to be able to determine the gestational age. Determination of gestational age can be accomplished by proper history taking including taking information on last menstrual period and conducting bimanual pelvic examination and abdominal examination. During clinical observation of the health care workers it was observed that 24% of health care workers did not do the bimanual examination to determine the gestational age of the women but they were

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relying on the last menstrual period date offered by the patients. The majority of the health care workers reported that they don't know how to perform bimanual examination. Gain it was observed that 32% of health care workers do not do abdominal examination of the woman. About 18% of the health care workers allocated in the urban area reported they rely on the ultrasound results, since their facilities has ultrasound equipment. According to the WHO recommendations use of ultrasound to determine the gestational age for abortion services is not necessary.

Health care workers who are abortion service providers should be trained to take proper medical history and conduct bimanual examinations and abdominal examinations in order to determine correct gestational age. If the staff allocated for abortion service is not appropriately equipped with the knowledge, the woman should be promptly referred to the colleague for proper examination. The missed opportunities for lack of skills of bimanual and abdominal examination can miss the diagnoses of ectopic pregnancies that can be life threatening to the woman.

Irrespective of age and background, every woman seeking PAC services should be given appropriate information that is clear and easily understood about the process that she is undergoing. Every woman should be given information that will allow her to give full, informed consent for the procedure. The counselling given to the women should not be non-mandatory.

The above graph illustrated that, during observation of the health care workers skills it was then observed that 46% of health care workers provide directive cancelling. Women should be provided the information that allows her to give full, informed consent for the procedure. Women should also be offered counselling to assist in considering her options, if she so desires. However, options counselling should not be mandatory.

It was again observed that the importance information like what the woman should expect before and during the procedure was not given to some of the woman for example what the woman is likely to experience e.g. cramps or pain, the duration of the procedure, side effects after care and follow up needed.

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Informed choice and voluntary decision making is the cornerstone of providing quality contraceptive information and services. The acceptance of the contraceptive method by the woman depend on the understanding of the information on available options provide by the health care worker. Emphasis was made that health care workers should not coerce the woman to opt for one choice of contraceptive (WHO, 2012:38). During the observation of information given about the contraceptive method, it was observed that 4% 0f health care workers do not provide accurate contraception methods to the women. Women should also be given information about emergency contraceptive method to prevent further unwanted pregnancies.

According to the WHO, it is recommended that prior to surgical PAC; cervical preparation must be done for women with the pregnancy of any gestational age in particular those who came requesting PAC because they are at high risk for cervical injury or uterine perforation. However, during the skills observation it was observed that 18% of health care workers don't perform cervical preparation.

During PAC, medication for pain must be offered and provided to women without delay upon the request e.g. (Non-steroidal and anti-inflammatory drugs) but not paracetamol. It was then observed that 9% of the health care workers do not offer pain medication because of non-availability of stock. Out of 9%, 7% were in the rural facilities. It is evident that there is shortage of drugs in the rural facilities compared to the urban facilities.

With the global increase of infectious urgent such as HIV, Hepatitis B infectious microorganism that can be transmitted in the clinical area, therefore health care workers must be vigilant about protecting women and themselves. Microorganism can leave in the instrument and some are difficult to destroy, therefore proper processing for instruments must be followed. The clinical observation of the competency of the health care workers is shown in the above table. Of those health care workers observed 34% don't know how to process the cannula properly and 4% of the health care workers rely on their assistance for processing and disposing of the cannulas. It is important to identify and address these punitive so that women receive prompt, safe and respectful and care and are not made to suffer unnecessarily.

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Table 4.14 Competencies and knowledge of health care workers in the provision of PAC (n=92)

Question	Yes		No		Not sure	
	n	%	n	%	n	%
1. **Determine the gestational age** Bimanual examination	32	35	60	65	0	0
2. **Provide information for decision-making** None directive cancelling	47	51	45	49	0	0
3. **Can do MVA procedure**	79	86	11	12	2	2

Table 4.14 shows that 65% of the total respondents don't know how to do bimanual examination to determine the gestational age of the women, where in only 35% know how to do abdominal examination. According to the observation findings, health care workers rely mostly on ultrasound results and last menstrual period verbalized by the respondents. Total of 47% uses non directive cancelling when providing information to women and 45% uses directive which leaves some of the respondents with no choice on contraceptive method or choice on method to be during post abortion care services. Data also revealed that 79% of participants can do MVA procedure and 12% don't know how to do the procedure and rely on medical post abortion care.

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4.6.8 Section F: Contraceptives Offered after PAC Services

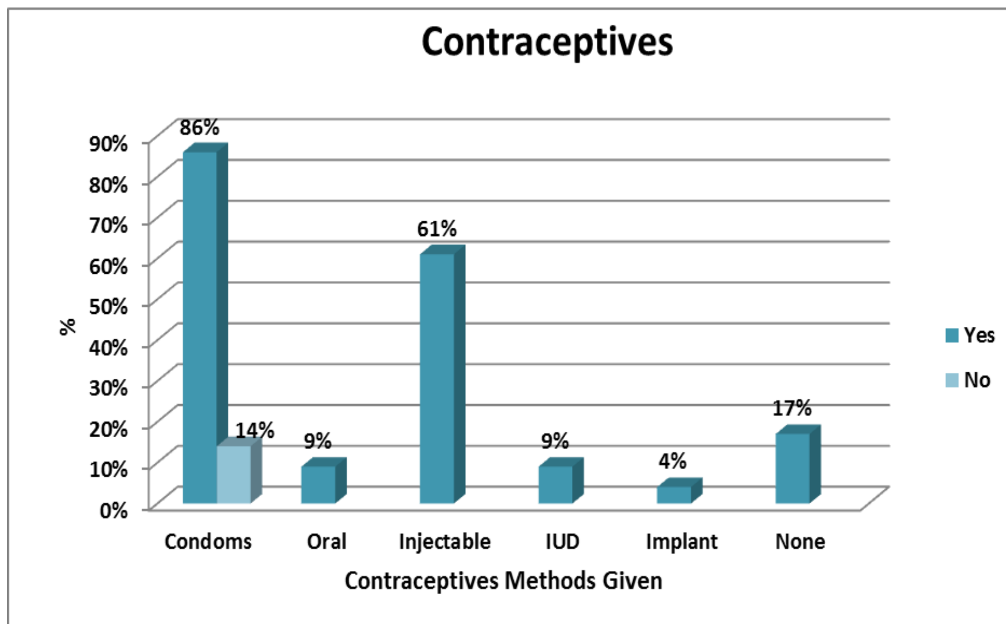

Figure 4.11 Contraceptives methods offered

Figure 4.11 illustrated that, 0nly 86% of women were given condoms and 14% were not given. It is important that dual protection is practiced to prevent pregnancy, HIV and STI. Many women are reported to be having unwanted pregnancies and also HIV positive because they are not getting any information about proper and sustainable use of contraceptives including condom. According to data obtained during observation the following women were given the following contraceptives; 61% injectable, 9% IUD, 9% oral and 4% implant. Total of 17% women were not given any form contraceptives and some were referred to the nearest facilities to obtain the contraceptives, hence some of these women are living in communities which is way from health facilities and this was of great concern. Total of 86 % were given condoms. Providing healthcare services, and promoting long term contraceptive, are an entry point to ensure that they begin to look after their health and prevent the unwanted pregnancies. Issuing of contraceptives after post abortion services is aiming to first change behaviours, then introduces and provides access to the solutions of induced abortion.

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Health care workers need to target women including young women of child bearing age, for example those not planning to have any child soon and promote the uptake of long term (intra-uterine devices and implants) and short-term (the pill, condoms, and injectable) contraception solutions. Approaching them at their community will allow the department to allay fear such as: fear of side effects, health concerns, belief that methods interfere with the body's normal processes.

Even though data indicates that some women were not given contraceptives, majority of health care workers proven to have high knowledge of contraceptives counselling skills. Health education about different contraceptive methods was offered to women during PAC. Although information about all contraceptives methods was offered, half of the methods were discussed 100%. The largest portion of respondents report that their main reason for not discussing oral contraceptives with all women is because women tend to forget to take the oral contraceptive daily and end with unwanted pregnancies. Respondents also indicate that other clients were not interested in discussing IUD because they believe that it has a lots of myths related to it. For every woman seeking post abortion care services, whether from unsafe induced or spontaneous abortion, her reproductive choices must be respected at the time of treatment. To prevent future unwanted and unplanned pregnancies, the women at child bearing age must be offered contraceptives information and services as an essential post abortion care services. Health care workers must show responsibility of integrating comprehensive SRH services into treatment of women with abortion complications.

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4.6.9 Section G: Surgical Abortion Services Rendered

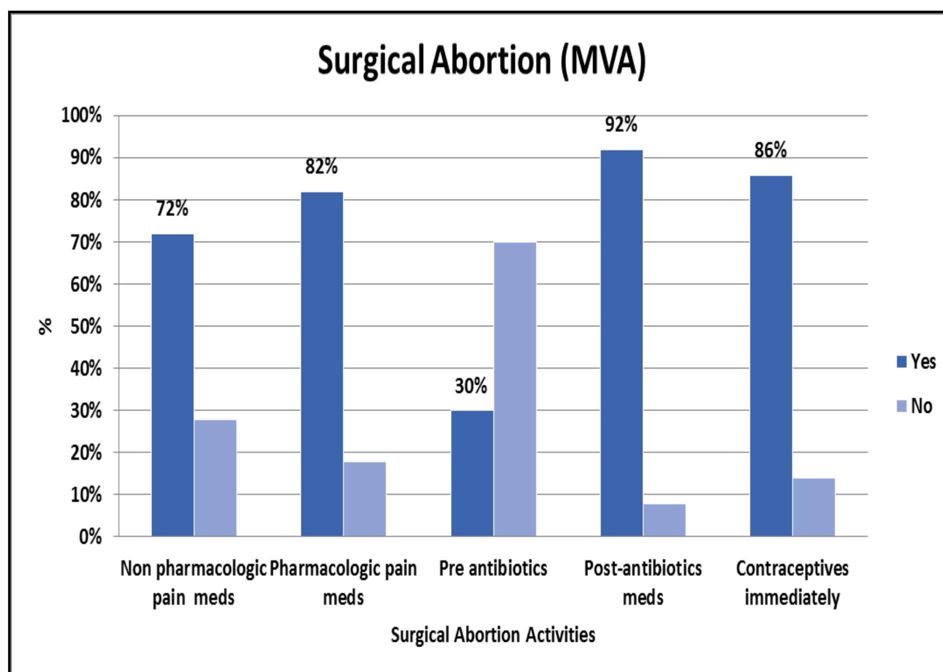

Figure 4.12 Surgical abortion (MVA) services

As illustrated in the above graph, it is noted that 72% of health care workers provide non-pharmacological pain reassurance to women seeking post abortion care and 28% reported that they don't see any necessity of giving reassurance because they have given the women pain medication. Every woman who undergoes abortion care suffers from anxiety and the anxiety is affected by the level of perception of pain. However, non-pharmacological pain management may address the level of anxiety. Non-pharmacological methods include physical and verbal reassurance to the women. The technique is important because it makes a woman feel comfortable and relax during the procedure. Therefore, it is important for the health care provider to make sure that she asks the woman the method of preference in terms of support during PAC care. The results revealed that 82% of health care workers offer pharmacological medicine to women before offering post abortion care services. The remaining 18% reported having stock out of either antibiotics or pain medication in their facilities. During observation it was identified that women are more likely to be offered Voltaren 25mg intramuscularly thirty minutes before manual vacuum aspiration and Ibuprofen 400mg orally post procedure. Premedication with none-

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steroidal analgesics such as above has shown that they decrease pain pre and post procedure.

Data indicates that 76% of health care workers offer contraceptives immediately after the procedure. The remaining 24% are sent to the other providers for provision of contraceptives, because the provider is busy and working alone. Most of the women, who have experienced complications of abortion, whether or not they have been fortunate enough to reach a health facility for treatment, often receive no contraceptives information or services. These cases represented one group of women at high risk of unwanted pregnancy and repeat of unsafe abortion. When health care providers fails to offer contraceptives it must be counted as missed opportunity to assist women in the safe regulation of their fertility.

4.6.10 Section H: Post Abortion Care Services Rendered

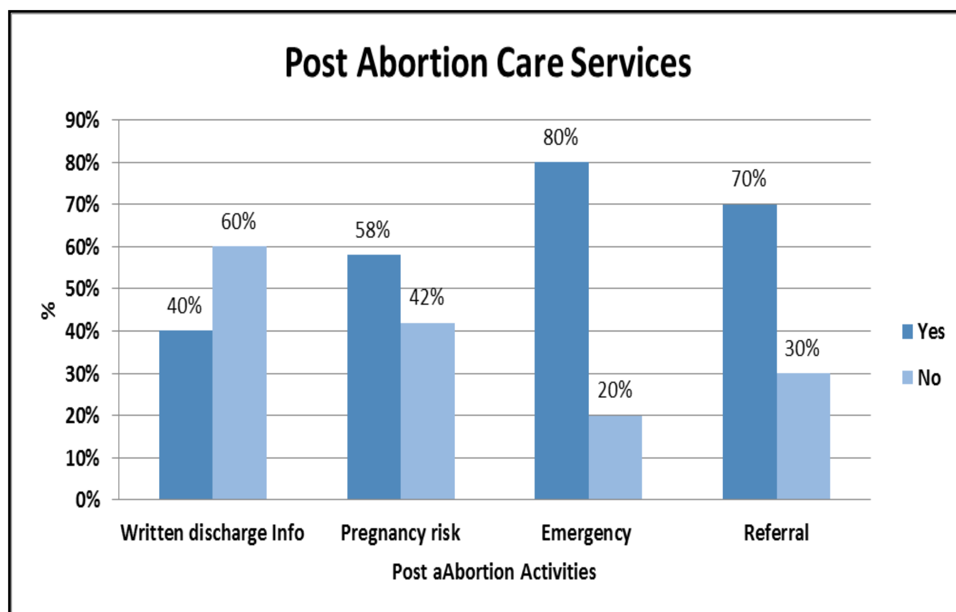

Figure 4.13 Post abortion care services

In the above graph it is noted that, 40% of health care workers give women oral/written discharge information, hence 60% of health cares don't have written discharge leaflet in their facilities. The majority of women went out of the health facilities without any information which poses the risk to women. At discharge

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women should understand what to expect during the post abortion recovery period and where care is available in case of need. It is important that this information is given verbally or in writing. Again data shows that 78% of health care workers advise the women about pregnancy risk after post abortion care. In order to reduce the mortality and morbidity from unwanted pregnancy, it is important that provider determine whether women want to become pregnant again and address the contraceptive needs of those women who are at risk of unwanted pregnancy. Ovulation frequently occurs by the third week after abortion; therefore, the women who wish to delay or avoid pregnancy should begin using contraceptives without delay.

4.6.11 Section I: Continuation of Care after Rendering PAC Services

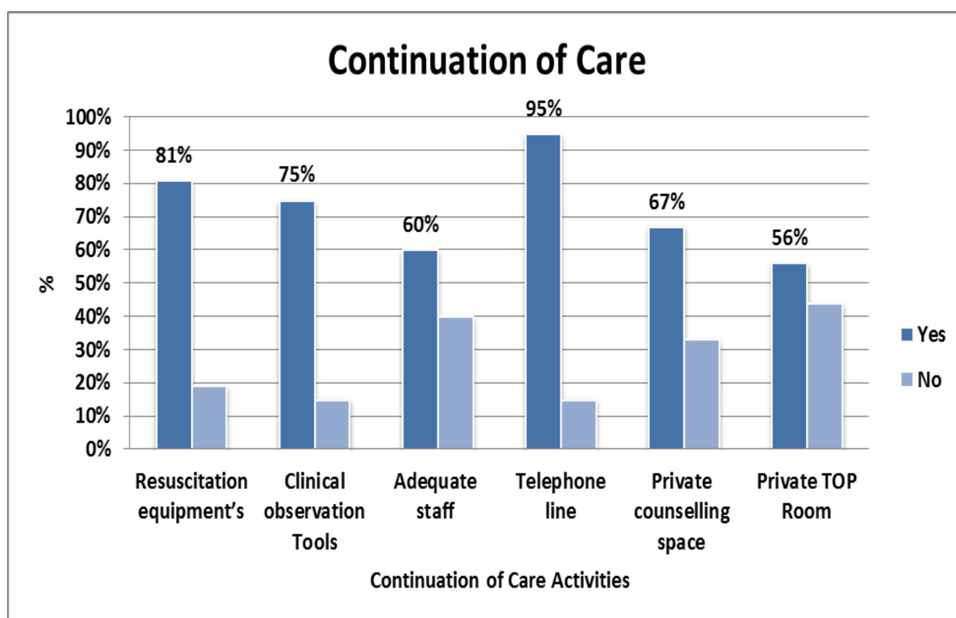

Figure 4:14 Continuation of care

The above graph showed that there is variation on how patient were being managed when accessing PAC services in the different sites. None of the study sites were offering the service for full seven days. In some sites, service was only rendered twice per week, whilst other, services were only offered five days per week. In fourteen study sites all located in the rural area (60%), there was only one health care worker allocated to see the patients, therefore some of the patients has to be

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booked to come on the next day depending on their urgency. Findings also revealed that only twenty one sites have access to telephone communication (60%) and the remaining 40% are situated in the rural areas. Out of twenty three study sites, only twenty sites (75%) has access to clinical observation room separated to procedure room. There is, therefore, no continuity of care post procedure, patients had to be done vital signs and discharged after 2hours sitting on a chair. During the emergency for resuscitation patients had to be sent to the other wards for management. A study done by Green et al. (2008:231) revealed that continuity of care was associated with good recovery and better quality of life.

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4.7 Summary of results from Quantitative and Qualitative Approaches

Both the quantitative and qualitative results shows that there is inadequate management and substandard post abortion care in most hospitals of KZN province leading to increased occurrence of post abortion complications and maternal deaths (figure 4:15)

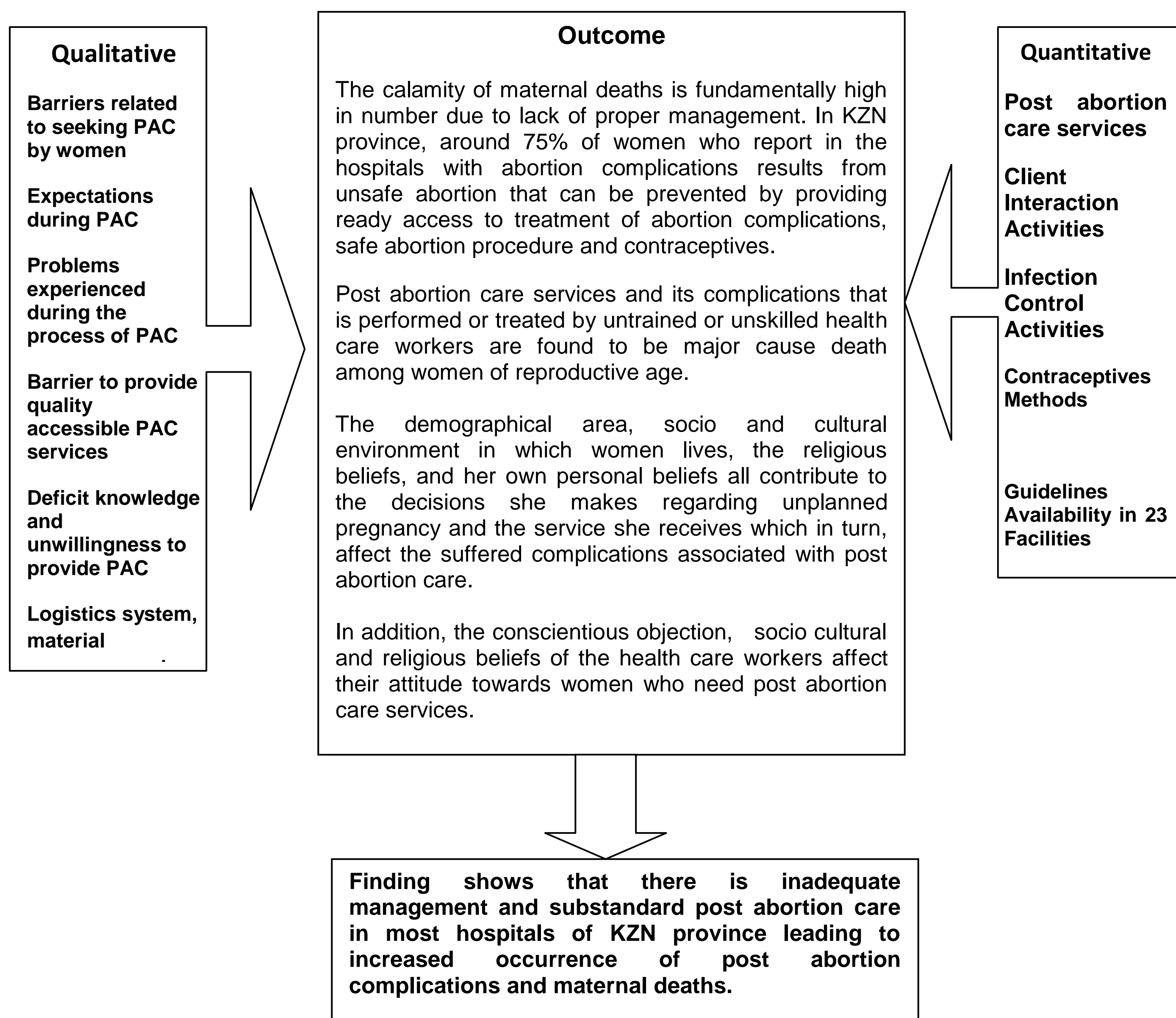

Figure 4.15: Summary of results from quantitative and qualitative approaches

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Women had a problem in sustaining contraceptives as a way to prevent unwanted pregnancies, where's health care workers is were found to have challenges to provide post abortion care contraceptives to all women due to either lack of skills or shortage (Keogh, Kimaro, Muganyizi, Philbin, Kahwa, Ngadaya, & Bankole, 2015:361). Women experienced knowledge deficit of early post abortion care seeking behavior and which put them at risk of abortion complications and maternal death in KZN Province (WHO, 2012:19).

Women education may enable women to seek post abortion care in time and enhance their socio-economic status. The study findings shows that health care workers were failing to participate in community based outreach program to prevention unwanted pregnancies and unsafe abortion. Health education may facilitate contraceptives use by increasing a woman's economic power and ability to use contraceptives (Chakraborty, Islam, Chowdhury, Bari and Akhter, 2003:337).

Women reported that early post abortion care seeking behavior is hampered by its stringent legal and administrative requirements, stigma and discrimination around the community and legal and administrative requirements. The law gives health care workers the right to conscientious objection, which give them right to choose to offer abortion services or not to offer the service and that lead women to seek unsafe abortion (Rasch, Yambesi and Massawe, 2008:32).

The women also raised concerns giving a state of in rural areas where facilities are far away, not easily accessible due to lack of transport and have one health care provider allocated in the unit, this is makes it a virtually impossible requirement to comply with early treatment. Majority of these women are living in the communities where there is no nearby proper and continuous provision of health services (Vlassoff, Altaf, Maddow-Zimet, Sinhg & Bhuiyan, and 2012:214). This leaves out a significant group of women and young women in the reproductive age group at high risk of complications.

KwaZulu-Natal Province is currently faced with deficit and deficient uptake of contraceptives, high maternal mortality ratio, and high unsafe abortion due to unplanned and unwanted pregnancies. Few health care workers including the

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doctors were available to offer PAC service from the study sites because they are not obliged to perform abortion services if it impinges on their religious or moral grounds (Kruk, Rockers, Mbaruka, Paczkowski, and Galea, 2010:97).

Women also complain about long waiting que that results in longer waiting times and lack of health education to clients while at the facility waiting for the service. Shortage of trained health care workers lead to inadequate PAC service and predispose women to poor post abortion care that leads to morbidity in KZN (Likwa, Biddlecom and Ball, 2009:4).

Health care workers have reported the societal norms and define it as the acceptability or rejection that influences their decision of participating on PAC services. They have reported that abortion service is considered as a silence problem in their community. They have stated that in their community abortion services is viewed as a taboo and when one offers the services it must be done in secret. This means that health care workers who are seen rendering PAC services will be stigmatized and this cause low self-moral (Azmat, Shaik, Mustafa, Hameed, & Bilgrami, 2012:13). On the other hand women reported that they don't want to be seen entering the abortion clinic because in their community if they are seen, community members always conclude that they have done abortion and they are regarded as killers, which brings shame to them and their families.

Stigma produces inequality, discreditation and discrimination against those accessing and rendering the PAC service (Henshaw, et al., 200848). Women and health care workers who are affiliated to Christianity are subjected to heavy moral and psychological pressure if they admit to having associated with PAC services. Women and health care workers who opt to render or access PAC services are hence forced to do it in secret for fear of stigmatization should the church find out about it and that lead to majority of women dying to complications (Shah and Ahman, 2009:1149).

Study findings indicated that treatment of post abortion care complications remains inadequate due to health care workers incompetency. With a low PAC services coverage rate, most health care workers rely on the skills that they have learned during their basic training. The researcher has noticed that progress has not been

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made in the provision of PAC service (Jones and Dreweke, 2011:61). There are a lot of challenges with regard to willingness to provide PAC services by the health care workers. There was inadequate staff in all study sites. Further, the researcher find that facilities in rural areas have serous staff and equipment shortages and unable to provide PAC service (Gebreselassie, Fetters, Singh, Abdella, Gebrehiwot, Tesfaye, Geressu & Kumbi, 2010:9). Some of the facilities in the rural area are inadequately staffed with no PAC trained health care worker and without PAC guideline. Resignation was reported as another challenge amongst the health care workers in all study sites. Currently, it was not clear how many sites are offering PAC services in the province. Shortage and unwillingness of health care workers negative attitude towards PAC service has implications on women safe and adequate access to safe post abortion service.

Unfortunately, most of the health care workers interviewed verbalized that there is insufficient management support in their facilities. Women also report poor management and inadequate post abortion care services in the facilities. There is a strong need for the facility managers to show support to the health care workers who provides PAC services and on the other hand there is a need of support to women who came to access the service Sathar et al., 2013). Without support from the managers the PAC service will be offline in most of the facilities. Management should ensure that they support the unit by providing management post abortion protocol or guideline to improve the service and ensure that there is adequate equipment's supply. Management should also support the health care workers by providing debriefing sessions in the hospitals (Graff & Amoyaw, 2009:79). Management must ensure that there is continuous psychological support and counselling for women. Women reported that in other facilities they turn to be admitted in the unconducive ward because of shortage of beds and some reported that they are taken to theater due to lack of equipments in the unit. Health care workers and women were also facing challenges with regards to shortage of infrastructure. Majority of facilities have no privacy to women due to shortage of space. Women report back at the facilities with complications that are precipitated by lack of adequate skills and knowledge to render quality PAC services by the health care workers (Sathar, Singh, Rashida, Kamran and Eshal, 2013:53).

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4.8 Summary

Chapter 4 focused on the presentation and discussion of the results. There were 2 main themes, 8 themes and 26 sub-themes. These themes were discussed in detail in terms of data collected from the respondents and placed in proper perspective with the literature, i.e., the response of the respondents were contextualized in terms of previous research and assertions in the field. Quantitative and qualitative results findings Shows that there is inadequate management and substandard post abortion care in most hospitals of KZN province leading to increased occurrence of post abortion complications and maternal deaths. Such correlations have been outlined in the respective summaries of challenges.

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CHAPTER 5

DEVELOPMENT AND VALIDATION OF THE GUIDELINES

5.1 Introduction

The findings of the study of PAC in KZN Province that were reported in Chapter 4 revealed the need for the development of guidelines for management of PAC in KZN Province. This need became apparent from the findings that emerged from both the qualitative and quantitative data collected through interviews and focus group discussions at eThekwini, Harry Gwala, uMgungundlovu, uMzinyathi and King Cetswayo districts. Participants were women who had accessed PAC services, and health care workers (doctors and nurses). The results revealed two main aspects related to the above. The first aspect was challenges faced by women when accessing post abortion care services. The second aspect was challenges experienced by the health care workers when rendering PAC services. These two main aspects comprised 8 themes and 26 sub-themes that emerged from the analysis of the raw data. An important finding was the poor level of PAC management in most of the facilities in KZN Province which leads to complications that may result in maternal deaths. Thus, the objective of the work described in this chapter was to develop guidelines for the management of PAC in KZN Province.

The researcher decided to develop guidelines based on the two main aspects identified, that led to negative outcomes, as evidenced by high maternal mortality rates in the facilities. The development of the guidelines was in accordance with the principles set out in the "WHO guideline development" (2012:4). The approach used 10 steps outlined in the WHO guidelines to develop guidelines for management of post abortion complications in order to reduce maternal morbidity and mortality associated with poor abortion care. It also used WHO's PICO model (Population, Intervention, Comparator and Outcomes) A systematic literature search was conducted and a review of the evidence undertaken. The certainty of the evidence on safety, effectiveness and satisfaction was assessed using the Grading of

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Recommendations, Assessment, Development and Evaluation (GRADE) approach (WHO, 2014).

This chapter has two main parts. The focus of the first part is to describe the process of the development of the guidelines, as well present the results. The focus of the second part is on the study that was carried out to validate the guidelines.

5.2 The WHO Guideline Development Model

5.2.1 Selecting the Topic

The researcher selected the study topic under the supervision of the two National Research Foundation (NRF) rated researchers. The topic was **Development of Guidelines for Management of Post Abortion Care at Selected Hospitals in KwaZulu-Natal Province, South Africa.** It is anticipated that this provincial guideline will be used as a basis for the development of local protocols and guidelines which will take into account local post abortion provision and the need to improve quality of care to women accessing post abortion care services.

5.2.2 Forming a Guideline Development Group (GDG)

The Guideline Development Group (GDG) is a small group of multidisciplinary experts from Maternal Child and Women's Health (MCWH) that have sufficient knowledge and experience to explore the topic. The group comprised 12 experts to facilitate interaction: two MCWH provincial managers, one Sexual and Reproductive Health (SRH) provincial manager, six MCWH district coordinators and 3 District Clinical Specialist Team Advanced Midwives (DCSTADM). The eThekwini district was selected because of the highest number of women admitted for PAC services. The experts were purposively selected from 4 district and 2 regional hospitals viz., Addington, King Edward the VIII, Prince Mshiyeni Memorial, Wentworth, RK Khan, and Mahatma Gandhi Memorial hospital. Necessary meeting costs, which included travelling and food, was funded by the University of Venda. Emails and teleconference communications were also used in order to avoid unnecessary

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meetings and travelling, and to minimize the cost and increase efficiency. In this study, the outstanding team of health care workers participated in the working group that produced the final version and validation of the guidelines. The process of integrating values and preference guideline development is shown in figure 5.1). The guideline recommendations were formulated based on the evidence from literature, values and preferences, e.g. evidence on the balance between benefits, harms and cost (Zhang et al., 2017:138).

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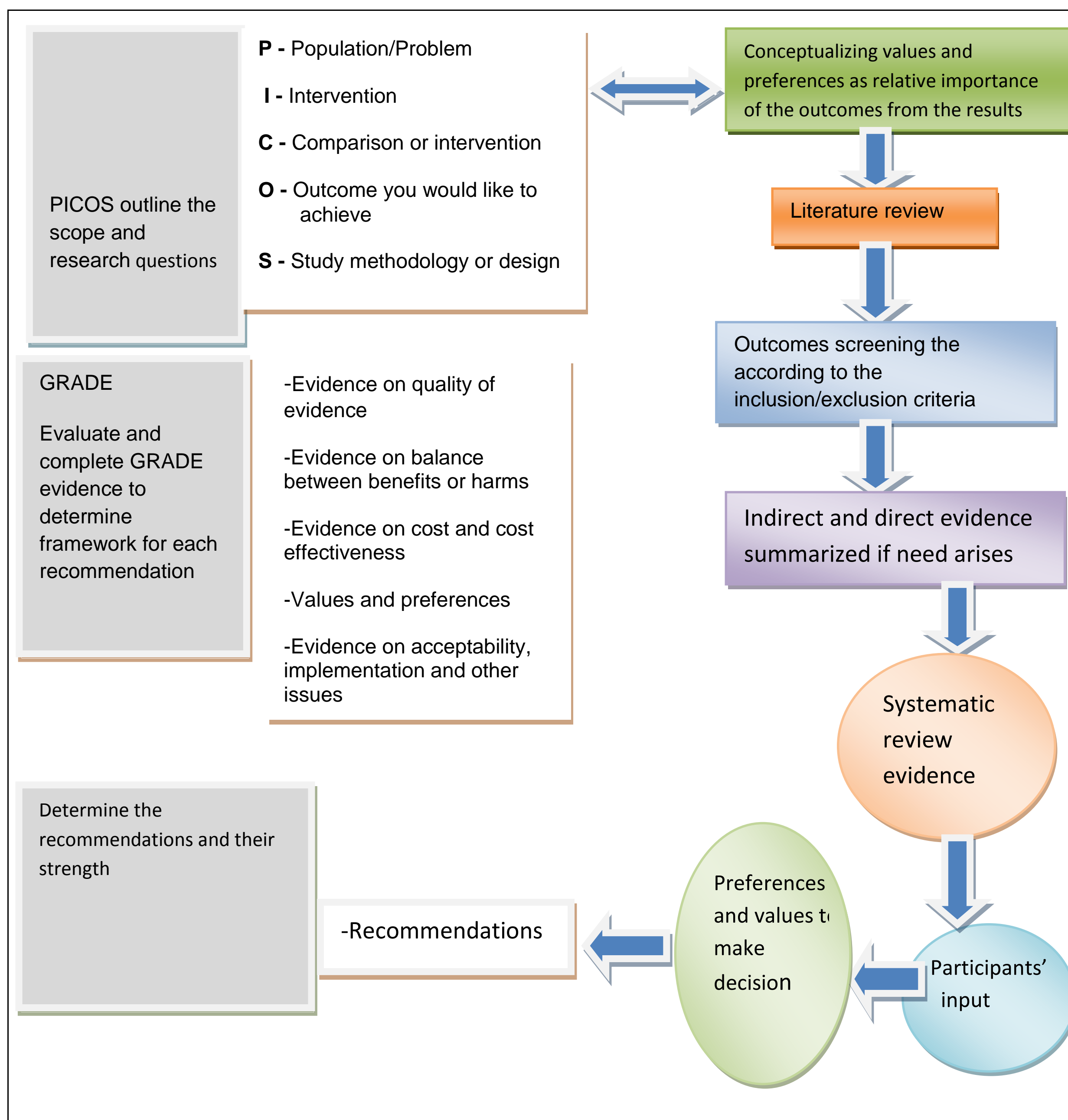

Figure 5.1: WHO (PICO and GRADE) Extracted from: Model Guyatt et al (2011)

5.2.3 Scoping of the Guidelines

The GDG group was formed during MCWH quarterly meeting. The group looked at the data and realized that the province has a high maternal death related to abortion complications. This high rate was due to the high numbers of women who are admitted due to Incomplete and septic abortion. There was no current guideline for management of post abortion care in the province and nationally. The group then

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came up with recommendations and for management of post abortion care, recognizing the need to meet the objective of preventing maternal death due to complications of post abortion. The group hoped that implementation of the guidelines across health facilities will promote future sustainable standard quality standard care, regardless of the sectors in which the woman is managed.

The guidelines recommend prevention of subsequent unwanted pregnancies and unsafe abortion and ensure that the health services reflect and meet community expectations and needs. The importance of the health care worker to discuss counselling to assist women to deal with emotional needs, physical health needs, treatment and other reproductive health services is included in the guidelines.

5.2.4 Developing the Clinical Questions (PICOS)

Table 5.1: The PICOS Model

P = Problem	High levels of PAC complications and deaths
I = Intervention	Develop post abortion care management guidelines to promote quality post abortion care
C = Comparison	Basic working standards as stated in CTOP Amendment Act no 1 of 2008. Andersen Healthcare Utilization Model, 1995 Five Essential elements of PAC
O = Outcomes	Reducing PAC complications and deaths
S = Study design	Quarterly meetings combined with quantitative approach, explorative and phenomenological design

- **P = Identifying the problem**

During problem identification, the group identified the current problems and any other problems that can emerge in the future. The responsibility of the group was also to come up with the actions and the recommendations that will ensure that the goals and the objectives are met. When identifying the problem, the researcher collected data to shed light on and determine the evidence-based problems, their scale and

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extent, their causes and effects, and their associated economic, social and environmental costs. The letter P also represents the population that the recommendations are meant to apply to. After data analysis in Phase 1, the researcher requested approval from the eThekwini district manager to conduct the workshop with the health care workers (Annexure 9) and permission was granted. The letter P represents the population which comprises the District Clinical Specialist (DCST) Advanced Midwife to recruit the participants. The researcher purposively selected one MCWH provincial manager; one SRH provincial manager and six MCWH district Coordinators and three DCSTADM.

- **I = Intervention**

Intervention includes the action to be considered, treatment, procedure or the intended intervention. In this study there was no treatment given, nevertheless, the intervention includes recommendations for post abortion care activities that must be adhered to when rendering the post abortion care services. The intention of the intervention is to improve and reduce complications that will lead to maternal deaths in KZN Province.

- **C = Comparison**

Available alternative choices of action such as frameworks, guidelines, interventions or standards were compared. In this study, comparators were the CTOP Amendment Act no 1 of 2008 and five essential elements of post abortion care. Table 5.4 summarizes the basic standards as laid down on the CTOP principle and amendment Act and compares them with the current situation as revealed in the findings of this study.

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Table 5.2 Summary of available frameworks (columns 1 and 2) and the challenges found in the study (columns 3 and 4).

CTOP Amendment Act no 1 of 2008	Five essential elements of post abortion care	Challenges faced by women when accessing PAC services	Challenges faced by health care workers when providing PAC services
Recognition of the values of human dignity	Identify and respond to women's emotional and physical health needs and other concerns.	Lack of respect and privacy from the health care workers	Discrimination by community members and colleagues
Offer safe TOP and PAC services by trained health care providers	Treat incomplete and unsafe abortion and complications that are potentially life-threatening.	Poor sub-standard care	Shortage of trained health care workers
Give access to safe transport if need for referral arises	Preferably provide on-site or via referrals to other accessible facilities in providers' networks mobilization of resources to help women receive appropriate and timely care for complications from abortion.	Lack of transport to and between the facilities	Transport problems from one facility to the other
Reduce delays in accessing PAC services	Ensure that health services reflect and meet community expectations and needs.	Facilities are offline	Limited availability of trained health care workers where the service is available

The above findings indicated that there is a lack of PAC management guidelines. From the literature review, no guidelines could be found on PAC services available in South Africa or KZN Province. There was a guideline on abortion management that includes a portion on post abortion care. The gap identified from the literature review, together with the research findings, were used to develop the guidelines for the management of PAC services in all facilities in KZN Province. After the guideline is

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developed, it will be validated in a postdoctoral study and will then be implemented in KZN Province.

- **O = Outcome**

The outcome means the health outcome and includes what will be achieved and what harm the outcome could lead to. The outcome of this study will be the results of implementing the developed guidelines. The outcome will be compared to see the benefits, potential harm, and financial cost incurred during the process of guideline implementation.

- **S = Study Methodology**

To develop the guidelines, the WHO model methodology was used wherein group of 12 members was formed during MCWH quarterly meeting with the purpose of developing post abortion management guidelines to reduce the complications that lead to maternal deaths in KZN Province.

5.2.5 Evaluating and Completing the Evidence for a Decision Framework for Each Recommendation (GRADE)

Table 5.3: The GRADE model

GRADE **Evaluate and complete GRADE evidence to decision framework for each recommendation**	-Evidence on balance between benefits or harms -Evidence on cost and cost on effectiveness -Values and preferences -Evidence on acceptability, implementation and other issues

For both the original and updated literature searches, a primary examination of titles and abstracts was undertaken. From this search, full papers that are relevant to the topic were obtained. Data were collected from relevant experts from the field. The study selection and data extraction that was not related to the topic in question were rejected, with the assistance of the supervisors. Coding of collected data was done by the independent coder who was employed.

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Appraisal tools and data extraction forms were used to ensure the literature is appraised systematically and consistently using the same standards. Evidence tables were used to help collate and summarise the data to identify similarities and differences between studies. Then recommendations that meet criteria were used to develop guidelines. The researcher was guided by the PICOS and GRADE models to ensure that the information that was used to develop the guidelines was from the studies with low risk of bias (Table 5.3). Triangulation was used to reduce the risk of bias. This was also ensured through the convergent mixed method in the empirical phase of the study, the use of the multiple data sources (doctors and nurses), as well as various data collection instrument methods (face-to-face interviews and a Likert scale).To build up the strength of evidence, synthesis and the reporting of results was ensured by merging of the results (WHO, 2012).

5.2.6 Determining the Recommendations and their Strengths

Once the evidence was retrieved, synthesized and assessed, this evidence was used to develop recommendations. According to WHO, the strength of a recommendation reflects the extent to which the end user of the guideline can then individually or collectively willingly decide to act within the specific situation to achieve the maximum positive outcomes and reduce the negative health effect (WHO, 2012:114). A recommendation is not only subject to the extent of an intervention outcome but should comprise other deliberations and standards that govern the direction and strength of recommendations, such as the importance or weight of the health outcomes. Recommendations are the invention of inclusively considered impacts by a group of respondents in a research study through an organized process.

The experts in the committee that was developing guidelines included the researchers and stakeholders who might select different treatment choices when the same evidence is presented. According to Zhang et al., (2017), different choices of recommendations are based on the on the different choices of evidence-based values and preferences when full understanding of the information is ensured. In the development of the guidelines, triangulation, different data sources (doctors and

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nurses), as well as different data collection instruments (one-on-one interview and Likert scale), WHO (PICO and GRADE) models were used to produce high quality results. The results were merged and built up the strength of evidence. The suggestions and recommendations were valued and were designated to be used in the development of the guidelines.

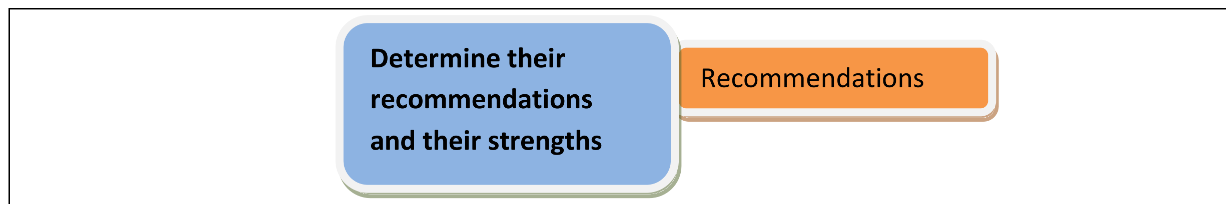

Figure: 5.2 determining their recommendations and their strengths

Both quantitative and qualitative results showed that there was poor management of post abortion care in KZN Province, leading to increased complications and deaths in the province. The respondents indicated that poor management of PAC is due various challenges experienced by the health care workers and women who provide and access PAC services.

The recommendations were assessed and graded using the guide as summarized in Table 5.3. High quality results with limited bias and few limitations were revealed after using the WHO (PICOS and GRADE) model.

5.2.7 Writing up of Guidelines

The researcher developed the guidelines based on the findings, participants' recommendations, literature review and input from the focus group discussion. Table 5.6 presents the scope, purpose and stakeholders for the guidelines. Each of the tables 5.7 through 5.15 presents each of the 9 main recommendations for Guidelines based on the empirical evidence of the researcher's findings. Each of these recommendations is supported by detailed guidelines for fulfilling the goals of the recommendations.

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Table 5.4: Scope, Purpose and Stakeholders.

Title of the guideline:	**Management of Post Abortion Care (PAC) guideline for selected hospitals in KwaZulu-Natal Province, South Africa**
Principal authors	PhD Candidate Promoter Co-Promoter
Guideline Development Group (DGD)	**Managers** 1. X2 MCWH provincial manager 2. X1 SRH provincial manager 3. X3 DCST Advanced Midwife 4. X6 MCWH Coordinators
Duration	2017/18 FY(X4 Quarterly basis) April 2017 to March 2018
Purpose of the guidelines	The main purpose of the guidelines is to provide the Clinical Practice Guidelines (CPG) that are consistent with post abortion care, philosophy and model of care, and encourage quality management that will enhance benefits and reduce women's death at different hospitals of KZN Province. This CPG is independent and is not intended to replace frameworks of Gynae units in KZN Province
Clinical problem	Poor post abortion management that leads to complications and deaths
Care providers	Doctors and Nurses in different hospitals of KZN Province
Consumers	Women accessing post abortion care service
Review date	Three years or when new WHO or National recommendations are made available.
Setting for the guideline implementation	All hospitals that admit women seeking PAC services in KZN Province

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Table 5.5: Guidance on how to assess guidelines recommendations

Guidance to assess study limitation (risk of bias) and corresponding GRADE assessment of quality of evidence				
Risk of bias	**Across studies**	**Interpretation**	**Consideration**	**GRADE assessment of study limitations**
High	High risk information from the studies is sufficient to effect the interpretation of results	Bias that seriously weakens confidence in the results	Some limitations for multiple criteria or crucial limitation for one criterion, sufficient to lower confidence in the estimate of effect	Downgrade one level, serious limitation
Low	Study Information was from low risk of bias	Acceptable bias is unlikely to effect the results	No actual limitation	Quality of evidence remains the same with no limitation
Very low	Study information is from very low risk bias	Very little acceptable bias that raises doubt about the results	Very little confidence in the affect estimate	No limitations

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Table 5.6: Recommended guidelines to promote quality management of post abortion care services in the selected hospitals of the KZN Province

Ways for facility management and health care providers to support quality PAC services and reduce complications and deaths	
1.	Managers to provide an enabling, safe environment and infrastructure to ensure availability, equitable access and appropriate delivery of quality PAC services.
2.	Managers to provide adequate resources to meet the demand for PAC services such as budget, human and equipments.
3.	Managers to develop PAC standards and guidelines in line with CTOP Act and implementation plan for operational references purposes.
4.	Mainstream PAC training in such a way that all health care workers in all existing clinical training programmes receive training on PAC
5.	Health care workers must create demand for CTOP and PAC through conducting community awareness programmes.
6.	Health care workers must ensure provision of client friendly quality PAC services and adhere to standards of ethical practice and code of conduct.
7.	Health care workers to provide quality PAC clinical care and ensure that they meet minimum standards by giving routine pain management and antibiotics prophylaxis during post abortion care.
8.	Health care workers to set up referral system from one facility to the next for further management
9.	Health care workers to provide follow up care after post abortion care as outlined in the standards operational guidelines.

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Table 5.7: Guideline 1

Managers to provide an enabling, safe environment and infrastructure to ensure availability, equitable access and appropriate delivery of quality PAC services.	
Competent management was highlighted as central to meeting the PAC service objective of optimal service delivery. Creating enabling demand, supportive environment is only possible when resources and technology are successfully managed. Empowering women to take control of their sexual and reproductive rights require accessible, appropriate contraceptives services. If contraceptives services are optimal the need for PAC services will be reduced.	
To optimise PAC service delivery the following has to take place:	
1.1	the number of trained motivated PAC providers rendering quality services must be increased by recruiting and training more health care workers
1.2	the number of appropriately designated , functional facilities, in compliance with Section 3 of the Act, with quality services
1.3	the number of twenty-four hour maternity providing PAC services should be increased;
1.4	improve information management systems and the mechanism of decision making;
1.5	barriers to the realisation of widespread access to quality PAC services have to be overcome – efficient referral services and adequate back up at all levels need to be put in place;
1.6	trained health care workers have to be supported and used optimally;
1.7	managers need ongoing capacity building; and
1.8	Good PAC practice, in accordance with policy and protocols, should be promoted.

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Table 5.8: Guideline 2

Managers to provide adequate resources to meet the demand for PAC services such as budget, human and equipments	
Reproductive health services are generally affected by macro-economic policy cutting back on social service spending. Adequate resource provision is critical to making access to safe PAC, an accessible option for all women in South Africa.	
The following should take place to ensure adequate resources:	
2.1	provide additional budget to meet additional requirements;
2.2	use the existing resource base optimally; and
2.3	form a strengthened partnership to optimise resource use

Table 5.9: Guideline 3

Managers to develop PAC standards and guidelines in line with CTOP Act and implementation plan for operational references purposes.	
To have a progressive PAC services in place, gains made for women's sexual and reproductive health rights have to be vigilantly guarded.	
The following has to take place to the defend the PAC guidelines	
3.1	develop effective legal guidelines to defend PAC and implementation on an ongoing basis;
3.2	manage according to the Act and Guidelines stipulations;
3.3	promote pro-choice health care workers initiatives; and
3.4	Promote reproductive choice as a fundamental human right.

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Table 5.10: Guideline 4

Mainstream PAC training in such a way that all health care workers in all existing clinical training programmes receive training on PAC	
More numbers of health care workers need to be trained to meet demand for PAC. The process of mainstreaming will remove stigma attached to PAC service provision and contribute to alleviate pressure on the present relatively small number of PAC service providers.	
To mainstream PAC training, the following has to take place:	
4.1	Encourage facility management buy-in and support for the importance of improving the access to post abortion care services
4.2	Involve senior management in hospitals to ensure sustainability, functionality and achievement in post abortion care services.
4.3	Prioritize staff for all Gynae units to render post abortion care service
4.5	Maintain infrastructural upgrade to facilitate more efficient flow and increase privacy and user satisfaction

Table 5.11: Guideline 5

Health care workers must create demand for CTOP and PAC through conducting community awareness programmes.	
Despite a hostile, patriarchal context, the CTOP and PAC prioritise the well-being of women and young girls by enabling them to take a great control of their sexual and reproductive lives by making responsible choices for the future.	
The following need to take place to create demand:	
5.1	Increase women's awareness of their rights and sexuality;
5.2	Increase contraceptives prevalence amongst women;
5.3	Provide client-friendly PAC services treating women with respect and dignity; and
5.4	Increase community member understands of support for women and young girl's sexual and reproductive rights.

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Table 5.12: Guideline 6

Health care workers must ensure provision of client friendly quality PAC services and adhere to standards of ethical practice and code of conduct.	
Women's experience of the health system significantly determines their use of facilities and services. When a woman seeks PAC service, the system has already failed her. At this stage she is already in a vulnerable and anxious state. How she experiences her PAC complications will now help or hinder her in taking control of her sexual and reproductive life in future. If the need for TOP is ever to be decreased, it is absolutely essential to make women's PAC service experience enabling encounters.	
The following need to take place to provide client-friendly , quality services:	
6.1	Promote positive behaviour towards PAC services provision;
6.2	Always provide few wider choice on PAC technique;
6.3	Provide services which will treat women with respect and dignity; and
6.4	Support providers in delivering client-friendly services.

Table 5.13: Guideline 7

Health care workers to provide quality PAC clinical care and ensure that they meet minimum standards by giving routine pain management and antibiotics prophylaxis and contraceptives during post abortion care.	
All women going through PAC should routinely be offered pain medication without delay upon request. All women, regardless of their risk of pelvic inflammatory infection, should receive appropriate prophylactic antibiotics. Contraceptive information and services are an essential part of PAC services as they help the woman to avoid unwanted pregnancies in the future and reduce the need for unsafe abortion.	
The following must take place to ensure that clinical care take place:	
7.1	Enhance SRH health education and outreach programs in the community
7.2	Enhance health education at waiting areas/queue and consultation rooms using health promoters
7.3	Use out-reach teams, war rooms, Operation Sukuma Sakhe, school health teams and traditional healers to give health education about SRH

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Table 5.14: Guideline 8

Health care workers to set up referral system from one facility to the next for further management	
A carefully constructed and smoothly operating hierarchy of levels of care is the key to reducing morbidity and mortality in PAC. While the majority of PAC activities can be provided at lower levels in any health system, the most severe complications require ready access to prearranged referral sites. Prompt communication, decision-making, and transfer of patient information between the units involved are important elements of any referral system.	
To ensure that referral system is in place, the following should take place:	
8.1	Indications for referral should be clearly stated in written service protocols and should be reviewed regularly to ensure that they remain relevant;
8.2	Referral arrangements for each level of care should be communicated to all relevant staff and implemented as required; and
8.3	Managers should review the capabilities and quality of care in all facilities in the referral network on a regular basis.

Table 5.15: Guideline 9

Health care workers to provide follow up care after post abortion care as outlined in the standards operational guidelines.	
The following need to take place to ensure that follow up care takes place:	
9.1	Women must be informed about the signs of complications and advised to come back
9.2	Women should be advised that if they have a need or desire to visit a health facility, the service is available

5.3 Updating and Reviewing the Guidelines

The researcher recommends reviewing the guidelines on a three-year basis from the date of implementation or when new recommendations for the guidelines are brought up. The specific date of updating the guideline is set to be three years from implementation.

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5.4 Validation of the Developed Guidelines

5.4.1 Aims and Objectives of Validating the Guidelines

The aim of validation was to collect, evaluate data and explore authenticity, importance and usefulness of the guidelines.

- To assess the applicability of the developed guideline
- To demonstrate understanding of the constructed guidelines through interpretation of the phases in relation to the sub-themes
- To check if the developed guideline can be used to address the identified gaps in management of post abortion care
- To determine reliability of the guidelines, substantiate the accuracy of the concepts and used in the guidelines, and examine if the guideline can be incorporated to other department policies.

5.4.2 Guideline validation methodology

Non-experimental, intervention design was used by the researcher. Validation was done after four MCWH quarterly meetings that took place during the period of 12 months where the researcher and the GDG conducted a literature review and came up with the recommendations for guideline development. The researcher invited 13 respondents who developed the guidelines from the districts to meet at Addington hospital Paddington hall. The researcher met with the GDG for two days during which the meetings lasted 2 hours each day. On the first day of the meeting, the researcher presented the draft to the GDG (Annexa 10). The respondents were divided into 4 groups and each group was allocated a group leader who presented the outcome of the discussion from the group. The researcher called the group together to discuss the findings as one group. Assessment of the draft guidelines was done using a checklist at the end of the second day. Assessment was part of validation to determine if the draft guidelines were in line with practice. See detailed analysis below.

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5.4.2.1 Data Collection Method

A checklist with 6 questions (Table 5.16) was used as outlined by Chin and Kramer (2008:279) see annexure 8. To assess the quality and applicability of the guidelines, the appraisal of guidelines research and evaluation (AGREE) reporting checklist (Annexure 9) was used (Brouwers et al., 2016:189).

5.4.2.2 Data Analysis

Data were summarized using the frequency distribution, and simple descriptive statistics were used.

Table 5.16 Validation of the developed post abortion care management guidelines by Provincial Managers, District Clinical Specialist Advanced Midwives, and District MCWH Coordinators

Validation	**Provincial managers (n=3)**		**Advanced midwives (n=3)**		**MCWH Coordinators (n=6)**	
	Yes	No	Yes	No	Yes	No
1. Are the guidelines goals and practice goals congruent?	3	0	2	1*	5	1
2. Is the intended context of the theory congruent with the practice?	3	0	3	0	6	0
3. Are there, or might there be, similarities between the guidelines and practice variables?	3	0	2	1	3	3
4. Are the explanations of the guidelines sufficient to be used as a basis for post abortion care management action?	3	0	3	1	6	0
5. Is there research evidence/literature supporting the theory?	3	0	3	0	4	2
6. Will the use of these guidelines influence the practical management of post abortion care?	2	1	2	1	5	1

The above table 5.16 illustrates that 100% of managers agreed that goals and practice goals of guidelines were congruent and it can expand the access of post abortion care services. The findings also show that all managers agreed that the context of the guidelines were congruent with practice and there were similarities

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between the guidelines and the practice that can help to address challenges and attitude of health care workers towards post abortion care services. Findings also support that the guidelines can be used as the basis of post abortion care. Literature review was done to support the guidelines.

All the midwives agree theory were congruent with the practice and there is similarity between the guidelines and the practice variables; the literature was used to support the guidelines, and the guidelines could influence the practical management of post abortion care. All MCWH Coordinators believe that the context of the guideline is congruent with the practice and the explanation of the guideline is sufficient enough to be the basis of the post abortion management in the units. Only 83% of nurses agree that the goals of the guidelines were congruent with the practice whilst 17% disagree to the statement.

The mean of the managers' responses was 94.5%, and the mode was 100%. The mean of the doctors was 72%, mode 66%. The mean of the MCWH Coordinators were 80.5% and the mode was 67%. The findings indicated that majority of the health care workers and managers agreed that the developed guidelines will improve the management of post abortion care services in the selected hospitals of KwaZulu-Natal Province.

5.5 Consultation of Peer Review of the Guidelines

The health care providers at eThekwini district were asked to provide an extensive review and comment on the content, validity, clarity and applicability of the draft of the guidelines prior to widespread dissemination and implementation of the guidelines. After the health care workers appraised the content, validity, clarity and applicability of the guidelines, the guideline development group deliberated on the comments from these experts and essential changes were made to the document before final publication. The external reviewers were included, i.e., methodological experts in the topic area. These included Prof MS Maputle, Prof DU Ramathuba and Prof N Eik-Nes.

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5.6 Summary

This chapter has covered the development of management of post abortion care guideline that will provide quality post abortion care services in the selected hospitals of the KZN Province. Guidelines were developed using the WHO steps of guidelines development. The guidelines were then validated and adjusted according to the findings of the validation.

Chapter 6 summarizes the study and provide the conclusion, limitations and recommendations of the study.

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CHAPTER 6

Validation, Limitations, Summary, Recommendations and Conclusion of the study

6.1 Introduction

The previous chapter showed how study findings from the qualitative and quantitative studies were used to develop the guidelines to help the health care workers to manage women who require post abortion care services. The qualitative study explored perceptions of women who accessed post abortion care services. It also explored the challenges experienced by health care professionals when managing abortion complications. The quantitative study was carried out to assess the hospitals and the skills of health care workers providing post abortion care. The descriptions and knowledge gleaned from these studies made it possible to develop evidence-based guidelines that can improve and scale up quality post abortion care management of abortion complications at selected hospitals in KwaZulu-Natal Province, South Africa.

The study was explorative and descriptive, conducted in 5 districts and 23 selected hospitals between March 2016 and March 2019. The study was based on a convergent parallel mixed method, qualitative and descriptive quantitative approaches were run concurrently. In the qualitative approach, convenience sampling was used to select the total of twenty-three women who had sought PAC services, and fifty health care professionals who worked with PAC services. For the quantitative approach, convenience sampling was used to select 93 health care workers to observe their skills competency during the provision of post abortion care. In addition, a total of 5 FDG were carried amongst the health care workers. The qualitative study used in-depth interview to collect data from the twenty-three women, and FGD's to collect data from the health care workers. The quantitative study used direct observation to collect data. Data was analysed utilizing Tech's eight steps of open-coding method for qualitative approach. Inductive and deductive approaches were used to generate themes from the qualitative information. For the

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quantitative study, data were analysed using the IBM Statistical Package for Social Sciences (SPSS) version 20. The findings, qualitative findings were supported by quantitative results.

6.2 Limitations

The researcher took cognizance of the limitations in interpreting of the findings of the study. Therefore, the findings discussed thus far should be considered against the following limitations:

- Data collection in this study was limited to only five districts, therefore findings are not necessary transferable and generalized to other provinces.
- Some women were unable to participate in the study due to sensitivity of the topic.
- Unavailability of some health care workers due to resignation, shortage and transfer to the other units in the facilities was another limitation.
- Some of the health care workers refused to participate in the study due to fear of discrimination and stigma.

6.3 Summary of the Results

The study found that about 17% of post abortion care users were less than 25 years of age. About 48% of women were not on any contraceptives when they fell pregnant. Only 9% of the women had not had any children and this was their first pregnancy. More than half (52%) were not married. About 48% of the women were employed while 52% were unemployed. Almost all women (100%) had a formal education, 78% had attended high school while 22% had a tertiary education. The majority of women who participated in the study were from the rural area (61%) and 39% from the urban area. Having a higher proportion of educated women (100%) seeking post abortion care services may be associated with barrier of information

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dissemination to the community level. Results may indicate low awareness of the availability of post abortion care services to the uneducated people.

The study found that 52% of the health care workers who provide PAC services were females. More than half of the providers (74%) were nurses whereas 26% were doctors. More than half (78%) of the providers were Africans, 14% Coloured and 8% Indians. Total of 59% of the nurses had more experience than the doctors. This finding is an indication that nurses are a sensible investment of resources as the nurses are more likely than the doctors to become more active in providing post abortion care services.

The study also found that the factors that are associated with delay in access to post abortion care services in the districts were: few facilities offering PAC service, un availability of transport, distance from the community to the hospital that provides PAC service, lack of transport, shortage of staff, unskilled staff, shortage of equipment, long waiting queues, stigma and discrimination. The study found that in some of the districts a woman has to travel 165 km to access PAC services and again wait for more than 2hours for the ambulance. In addition, the study found that in most of the study sites there is one provider to provide PAC services, and if he or she is not there, the service is not provided. This finding is an indication of poor access to PAC services.

The study found that the factors that demotivate the woman from using PAC services were: fear of negative attitude on the part of the health care workers, fear of being seen by the community members at the unit that renders PAC services, fear of discrimination and stigma, fear of mismanagement by the health care workers and fear of suffering pain during the procedure. The study found that 85% of the women complain about mismanagement and negative attitudes from the health care workers. This finding is an indication of low utilization of PAC services.

The study found that the majority of women were complaining about the quality of PAC and they rated the quality as poor and unsatisfactory. Health care providers also raised concerns about offering PAC services. The main concerns raised by the women were lack of respect, lack of privacy due to limited space where they have to

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share a bed and insufficient time with the health care provider. The main concerns raised by the health care providers were lack of support from the management, shortage of staff, lack of training, unavailability of the guidelines or protocols and shortage of equipment. It was found that the short of equipment was because their orders were put last on the list of priorities at the pharmacy department. They also complained about staff turnover that leads to shortage and burn out.

The study found that 39% of the study sites use medical abortion as a treatment followed by MVA if it fails. The majority of facilities, 61%, use the MVA method as a uterine evacuation. MVA is the recommended method of management of incomplete abortion because it is easy to use, less painful and does not need electricity. A total of 15% of the study sites were managing their patients in theater.

Another important finding was that the patients were booked to be treated the following day if they were not bleeding or having severe complications; in some of the hospitals, some were sent back home and some were admitted based on the availability of beds. This is considered a one of the challenges in accessing post abortion care service.

The study found that some of the facilities do not offer family planning counselling and family planning service immediately. However, some women left the hospital with contraceptives, but without having been given counselling or options to choose a method for contraceptive. In some facilities, patients were referred to the next unit or PHC facility to receive their contraceptive method. Health care providers also reported that some of the women left the hospital without family planning because they did not want to wait for contraceptive counselling and method. Some women were reported to leave the hospital quickly to avoid being seen by other community members. On the other hand, some of the women reported that they left without contraceptives because the health care worker had no skills to give them the method they wanted e.g. IUCD, and some said they left without being informed about the post abortion care contraceptives.

The study found that the perception women had concerning PAC were negative. Women reported that accessing post abortion care services is a challenge. Women understand that post abortion care services are important and are needed by the

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people to save their lives. Health care workers were considered important in the provision of post abortion care because their absence may lead to increased maternal mortality in the province. The study further noted that as much as PAC is considered rights for all women who need it, regardless of the cause of the complications, health care workers also have the right to get support from the management and the coworkers. Women indicated that the majority of community members are unable to access post abortion care and contraceptives services. They further noted that there must be increased access to PAC services to save life and increase the life expectancy of the women.

6.4 Conclusion

This study concludes that women, irrespective of their age, race, marital status and religious beliefs need post abortion management care to prevent complications that can lead to death. The service that is available depends on the availability of skilled health care providers, well equipped facilities and reliable transport from one place to the other in case need for referral arises. Stigma and discrimination against PAC providers and women who seek the service is a major challenge that can prevent access and provision of PAC. Women with abortion complications may delay seeking of health care service for fear of discrimination. Failure to seek post abortion care, on the other hand, can lead to severe complications that can increase chances of maternal death.

Quality post abortion care must be provided for women to access it at all times of need. Quality post abortion care can be provided only when there are trained health care providers, adequate equipment and supplies. Long waiting time can be reduced when there is enough allocated staff to render the service in the hospital. Well-equipped units with staff to provide PAC ensure that the service is rendered continuously without delaying access. Adequate staff also ensures that comprehensive post abortion care service is offered to the women include counselling and provision of contraceptives.

This study was guided by Andersen's model of health care utilization. The model was suitable to be used for framework analysis and could be used in both

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quantitative and qualitative studies. Andersen believes that there are predisposing factors that are associated with utilization of the health care services such as social cultural characteristics, health beliefs and demographics. The Andersen model includes community, family or persons as enabling factors that convince an individual to seek utilization and access health care, including post abortion care (Andersen and Davidson, 2001:98).

The study found that all the women who had access to post abortion care were educated and that was regarded as a predisposing factor for accessing post abortion care services. The study's findings also showed that the majority of women in the study area who access post abortion care services were unmarried and above 35 years of age. In accordance with Andersen's model, age and marital status were predisposing factors for women to access PAC and for health care workers to render service. Knowledge about the use of contraceptives and early access of PAC was also a predisposing factor to access the PAC service. Long waiting periods, negative attitudes and long and difficult distances to the facility was the factor that caused women not to access the PAC service on time. The need factor was also identified during the study, where women delay seeking post abortion care services on time because they did not know the consequences of delaying post abortion care.

6.5 Recommendations

The results of the study have identified several implications for policymakers and for further research.

6.5.1 Recommendations for Action

The study found that there was lack of knowledge about the availability of PAC services amongst the women. This study recommends that efforts must be made to create community awareness about the availability of PAC services. Community awareness will help in creating demand of the service and reduce discrimination, stigma and negative attitude and promote early seeking behaviour of PAC before complications arises.

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The study found that there is shortage of PAC providers in the study sites. The shortage of health care workers affects the quality of PAC offered in the facilities. The study recommends that adequate staff should be allocated in the facilities. Adequate staff will reduce the waiting time and patient bookings. It will also help the patient to receive the service without being admitted and sharing beds in the unit. The study also recommends that the facility be equipped with enough equipment for smooth running of the service.

The study found that there is lack of skills regarding provision of PAC services amongst the health care workers. Lack of skills is likely to affect the delivery of quality PAC services. The study recommends that PAC service at the health care facilities should be revived through training and continuous re-orientation of PAC providers on management of PAC. Monitoring and supervision of PAC providers should be carried out to ensure that they provide quality PAC services. In terms of improving the psychological support to the providers, it is recommended that debriefing sessions and psychological counselling sessions be implemented because they reduce stigma and enhance support.

The study also found that some women leave the facilities without counselling and method of contraceptives. The study recommends that family planning and counselling services should be offered at the same time at the same place to avoid referring the patient from one place to the other. The study also recommends that PAC must be offered on request the same day.

The study findings show that there is lack of guidelines and protocols on PAC at the study sites. The researcher recommends that post abortion care services should be scaled up by offering services that are based on scientific evidence and by adhering to the developed PAC guidelines and protocols. PAC services at the health facilities should be strengthened to ensure that PAC patients are managed holistically.

6.5.2 Recommendations for Further Research

The study found that some women delay in seeking post abortion care service. Women reported that they delay in seeking post abortion care because they were

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afraid of stigma and of negative attitudes from the health care workers. This study recommends additional clinical, institutional and community research which will give broader details and understanding on the challenges that cause delay for seeking immediate post abortion care services.

The study found that there is poor quality management of post abortion care due to lack of trained health care providers, shortage of staff, lack of post abortion care guidelines, shortage of facilities providing post abortion care services. This study recommends further research on strategies to improve quality management of post abortion care services.

6.6 Summary

Participants viewed that the development of post abortion care guidelines will assist in providing quality PAC services at all times. However, health care workers need to be capacitated to attain more knowledge and skills to render post abortion care. Participants recommended that post abortion care services should be accessible with increased number of facilities and functional equipment and guidelines to prevent complications and death.

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ANNEXURE 1

ETHICAL CLEARANCE FROM THE UNIVERSITY OF VENDA

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms M Netshinombelo

Student No:
11576212

PROJECT TITLE: **Development of guidelines of post abortion management at selected hospitals in Kwa-Zulu Natal Province, South Africa.**

PROJECT NO: **SHS/17/PDC/15/1808**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof MS Maputle	University of Venda	Promoter
Prof RT Lebese	University of Venda	Co-Promoter
Prof DU Ramathuba	University of Venda	Co-Promoter
Ms M Netshinombelo	University of Venda	Investigator – Student

ISSUED BY:
UNIVERSITY OF VENDA. RESEARCH ETHICS COMMITTEE

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ANNEXURE 2

REQUEST FOR PERMISSION TO CONDUCT THE STUDY: LETTER TO KWAZULU-NATAL PROVINCE DEPARTMENT OF HEALTH

P. O. Box 1331
Thohoyandou
0950
To the Head of Health

Department of Health
KwaZulu-Natal Province

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am a doctor of philosophy (PHD) student at the University of Venda in the School of Health Sciences. The topic of research is **"Development of Guidelines for Post Abortion Care Management at Selected Hospitals of KwaZulu-Natal Province, South Africa".** The research therefore requests ethical clearance to conduct research at selected hospitals from the five selected districts. I hereby request permission to conduct a study in your department. The study will be conducted among health care workers and women who have accessed abortion. The developed guidelines will guide the health care workers on post abortion care management.

The researcher will use qualitative data collection method. The participants will be interviewed and the health care workers will be engaged in focus group discussion. Confidentiality was maintained whereas written informed consent will be required from the participants.

Thank you

……………………………………..

Mrs. Netshinombelo, M

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ANNEXURE 3

PERMISSION FROM THE KWAZULU-NATAL PROVINCE DEPARTMENT OF HEALTH TO CONDUCT THE STUDY

Dear Ms M. Netshinombelo
KZN DoH & University of Venda

Approval of research

1. The research proposal titled **'Development of guidelines of post abortion management at selected hospitals in KwaZulu Natal province, South Africa'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at Addington, King Edward VIII, Prince Mshiyeni Memorial, Wentworth, Christ the King, Rietvlei, St Margaret's, Appelsbosch, Edendale, Northdale, Charles Johnson Memorial, Church of Scotland, Dundee, KwaMagwaza, Lower Umfolozi War Memorial, Nkandla, Mbongolwane and Nseleni Hopspital.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 14/09/17

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ANNEXURE 4

PERMISSIONTO CONDUCT WORKSHOPS WITH THE HEALTH CARE WORKERS IN FIVE DISTRICTS

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

330 Langalibalele Street, Pietermaritzburg, 3201
Private Bag X9051, Pietermaritzburg, 3200
Tel: 033 3952116 Fax: 033 3423574 Email: pinky.phungula@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
MATERNAL,CHILD&WOMEN'S HEALTH

INTERNAL MEMO

Date: 28 August 2017
Enquiries: P Phungula

Principal Investigator: Mrs. M Netshinombelo
Name and address: Pietermaritzburg

RE:_Support for Research Study on "*Development of Guidelines for Post Abortion Care Management at Selected Hospitals of Kwa-Zulu Natal Province, South Africa*"

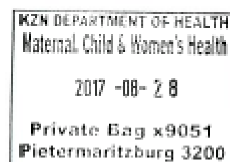
I have pleasure in informing you that I support your conduct of the research study entitled Development of Guidelines for Post Abortion Care Management at Selected Hospitals of Kwa-Zulu Natal Province, South Africa.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office/Facility will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office/Facility.

Thanking you.

MS PPM PHUNGULA
ACTING DIRECTOR: MCWH



uMnyango Wezempilo . Departement van Gesondheid

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ANNEXURE 5A

INFORMATION SHEET

Dear Respondent

My name is Muthuphei Netshinombelo and I am a doctor of philosophy (health student at the University of Venda in the school of Health Sciences. The topic of the research is **"Development of Guidelines for Post Abortion Care Management at Selected Hospitals of KwaZulu-Natal Province, South Africa".** We are inviting all women who are treated for incomplete abortion to join a study that involves interview today.

Interview includes questions about your age, marital status, education, and economic activities; about your reproductive history; about your future reproductive intentions; about abortion; about the services you received today; how well you are meeting your reproductive health goals, including questions about contraception and how well your partner is supporting you in meeting your goals. It is very important that you understand that everything you say will be completely confidential, and your name will not appear on any publicly seen document. Also, you may stop the interview at any time if you do not wish to continue. And you may discontinue your participation in the study altogether if you do not wish to continue. The tapes used for recording will be destroyed after the data analysis.

Your participation in this study will help many women in this community receive better services in the future when they come to hospital with problems related to post abortion care.

Do you have any questions?
Will you participate in our study? Yes or No

Respondent Signature: ________________

Mrs. M Netshinombelo: __________________________

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ANNEXURE 5B

CONSENT FORM

I ____ hereby consent to participate in the study entitled is **"Development of Guidelines for Post Abortion Care Management at Selected Hospitals of KwaZulu-Natal Province, South Africa".** I understand that I can stop this interview at any time should I want to discontinue. My anonymity is granted by the researcher and data will under no circumstances be reported in such a way that they would reveal my identity. It was explained to me that the interview will be recorded and that the answers that I will provide will not be linked with my name or used against me and that the information provided by me will remain confidential; only supervisors of this researh will have access to the information. Once the information has been analysed it will be destroyed. The condition of the study has been fully explained to me and I fully understand the circumstances of my participation.

--- Date-------------------------------

Signature of respondent

--- Date -------------------------------

Signature of researcher

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ANNEXURE 6A

INTERVIEW GUIDE FOR WOMEN WHO ACESS PAC

1. Personnel information

Project name;	
Interview number:	
Respondent number:	
District:	
Name of the hospital;	
Interviewer name:	
Date of interview: Date/Month/Year:	
Time of the interview:	

Section 2. : Socio-demographic/Economic issues/Reproductive issues
What is your current age?
Explain your highest standard of your formal education
To which ethnic group to you belong to?
Explain your religion
Do you currently earn any income?
Explain your current marital status
How many times have you been pregnant including this one?

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SECTION 3: Discussion

- How was it for you when attending/ accessing the post abortion care services at this hospital?
- Kindly share with me the challenges you have experienced and the support that you have received when accessing post abortion care service.
- How long did you take to arrive at this facility?

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ANNEXURE 6B

INTERVIEW GUIDE FOR THE HEALTH CARE WORKERS

- Can you explain what are you doing as a health care worker to reduce maternal death due to post abortion complications?
- Can you share the challenges you are facing that affect your role of saving women who have accessed abortion?
- Can you explain in your own opinion any form of support that can assist health care workers to save the lives of women?
- Can you outline the resources available in the unit that assists you in the management of post abortion care, for emergency resuscitation equipment/ medicine available, access to an emergency referral centre or facility and a private counselling space, private space to conduct TOP procedures and enough staff/beds to meet client demand?
- Can you explain the availability of acts and guidelines that are guiding and helping you to increase life expectancy of women in management of post abortion care?
- Explain what contraceptive methods that are offered during post abortion care?
- Do you have any other information related to the subject?

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ANNEXURE 7

SKILLS OBSERVATION TOOL

SECTION A Facility details				
Mark your answers with x				
District code:				
Hospital name:				
Date of assessment:				
SECTION B Demographic data:				
Age:	20-35	36-45	46-55	56-65
Position in the unit:	Doctor	Manager	Midwife	RN
Years of experience in the position:	6 months	1 year`3 Years	5 Years	>6 years
Using the skills observation tool, state if the activity is done on a Yes, No or Not done or self-explained. Tick the answer.				
SECTION C **Infection control**				
1. Hand washing with soap and water	Yes	No	Not done	self-explained
2. Provider applies wearing barriers	Yes	No	Not done	self-explained
3. Provider applies appropriate aseptic technique	Yes	No	Not done	self-explained
4. Disposable gloves and no touch-technique applied	Yes	No	Not done	self-explained
5. Room and exam table cleaned and autoclave is available	Yes	No	Not done	self-explained

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SECTION D **Guideline availability**				
1. CTOP Act No. 92 of 1996	Yes	No	Not done	self-explained
2. National Strategic Plan for the Implementation of the CTOP Act No. 92 of 1996	Yes	No	Not done	self-explained
3. CTOP Amendment Act No. 1 of 2008	Yes	No	Not done	self-explained
4. Conscientious Objection and Termination of Pregnancy in South Africa	Yes	No	Not done	self-explained
5. National Contraception Clinical Guidelines Department of Health 2012	Yes	No	Not done	self-explained
6. Facility PAC Guidelines	Yes	No	Not done	self-explained
7. Provincial TOP Policy	Yes	No	Not done	self-explained
SECTION E **Client interaction**				
1. Greets client in a friendly and respectful manner and introduces himself/herself	Yes	No	Not done	self-explained
2. Uses age-appropriate, non-clinical, and familiar language	Yes	No	Not done	self-explained
3. Communicates in a mutually-understood language with client	Yes	No	Not done	self-explained
4. Offers client an opportunity to talk, and answers questions fully and understandably	Yes	No	Not done	self-explained
5. Employs a client-cantered style of communication when speaking to client about PAC	Yes	No	Not done	self-explained
SECTION F **Pre-abortion care**				
1. Ensure women's dignity and privacy, confidentiality and comfort	Yes	No	Not done	self-explained

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2. Health care worker takes medical history and rules out contraindications	Yes	No	Not done	self-explained
3. Health care worker conducts physical examination	Yes	No	Not done	self-explained
4. Confirmation of clients pregnancy and estimated gestational age by bi-manual exam ,+LMP/history	Yes	No	Not done	self-explained
5. Provides accurate and comprehensive information on: post abortion care method, risk, benefits, expectations, side effects	Yes	No	Not done	self-explained
6. Obtained written informed consent before procedure	Yes	No	Not done	self-explained
7. Complete vital signs before procedure	Yes	No	Not done	self-explained

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ANNEXURE 8

TEMPLATE OF A CHECKLIST QUESTIONNAIRE FOR VALIDATION OF DEVELOPED GUIDELINES

VALIDATION OF THE DEVELOPED MANAGEMENT OF POST ABORTION CARE GUIDELINES BY THE MANAGERS, DOCTORS AND NURSES

Validation questions	Yes	No
1. Are the guidelines goals and practice goals congruent?		
2. Is the intended context of the theory congruent with the practice?		
3. Is there, or might there be similarity between the guidelines and practice variable?		
4. Are the explanations of the guidelines sufficient to be used as basis for PAC management?		
5. Is there research evidence/literature supporting the theory?		
6. How will the use of these guidelines influence the practical functioning of the management of post abortion care?		

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ANNEXURE 9

MINI-CHECKLIST AGREE REPORTING 2017

1. **The guideline had been written in a generally comprehensive manner and its recommendations are easy to follow**

Yes		To some extent		No

2. **The guideline target audience and scope of application were specified**

Yes		To some extent		No

3. **The background, objectives and patients for whom the guideline is relevant were clearly describes**

Yes		To some extent		No

4. **The person that has developed the guidelines were names, and financial independent and any conflict of interest were clearly documented**

Yes		To some extent		No

5. **The search of evidence was systematic and the criterion used to select the evidence were described**

Yes		To some extent		No

6. **The guidelines recommendations are unambiguous and the evidence were describes**

Yes		To some extent		No

7. **Different treatment options are presented that take account of potential benefits, side effects and risk**

Yes		To some extent		No

8. **Clear information is provided on how to update the guidelines and for how long this is expected to be**

Yes		To some extent		No

9. **Overall quality of the guidelines based on the above score**

Poor	1	2	3	4	5	6	7	8	9	Very Good

10. **Would you recommend the guidelines to be used in the clinical practice?**

Yes		To some extent		No

Adapted from: Brouwers MC, Kerkvliet K, Spithoff K, on behalf of the AGREE Next Steps Consortium.

The AGREE Reporting Checklist: a tool to improve reporting of clinical practice guidelines. BMJ 2016; 352: i1152.doi: 10.1136/bm.i1152.

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ANNEXURE 10

FOCUS GROUP DISCUSSIONS ATTENDANCE REGISTER

KWAZULU-NATAL PARTICIPANTS DAILY ATTENDANCE REGISTER

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Training name:	Focus Group Discussion Workshop			Training facilitator	
Training Venue:				Training facilitator	
Training type	Module ☐		Workshop ☐	Other (Specify)	
Start Date			Duration	Training service provider	
End Date					

Name and surname	ID Number	Contact number	Sub-district	Facility name	Day 1	Day 2	Day N
L. Praemchand	7506190231084	0837643325	Ethekwini	Ethekwini	[signature]		
Z. Peters	6804050234083	0846277464	"	Addington	[signature]		
N. Mgoni	6712020271084	0728135638	"	[illegible]	[signature]		
N. Dodo	6201120685081	0737148667	Harry Gwala	Service	[signature]		
S. Mapho[illegible]	8103041000085	0835754624	Harry Gwala	Richmond	[signature]		
T. P Memela	5505050885089	0616337091	UGU	Murchison	[signature]		
S.S. [illegible]	5705150842089	0833081473	Ethekwini	PMMH	[signature]		
V.G Mbanjwa	8310050569089	0764425059	Ethekwini	PMMH	[signature]		
W. Adam	6704270172089 / 0781676777	0781676777	uThukela	Estcourt	[signature]		
J.S Duma	9003306317087	0802125975	UGU	St Andrews	[signature]		
S. Sibisi	7801095518089	0835593947	Mgungundlovu	Edendale	[signature]		
R Rodriguez Vazquez	6603215378081	0834193974	UGU	GJC	[signature]		
Lodwa Nfi	7204260594086	0832602786	Amajuba	Amajuba	[signature]		
N.R. Mbata	5309160882080	0834808180	uThukela	Ladysmith	[signature]		
N.F. Ntuli	5503280782080	0734770816	uThukela	Ladysmith	[signature]		
S.G. Sithole	6209230665082	0839771985	uThukela	Ladysmith	[signature]		

KWAZULU-NATAL PARTICIPANTS DAILY ATTENDANCE REGISTER

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Training name:	Focus Group Discussion Workshop			Training facilitator	
Training Venue:				Training facilitator	
Training type	Update ☐		Workshop ☐	Other (Specify)	
Start Date			Duration	Training service provider	
End Date					

Name and surname	ID Number	Contact number	Sub-district	Facility name	Day 1	Day 2	Day N
M. Phalandwa	7502010883088	0333952183	H/O	H/O	[signature]		
P. Dlamini	8212150618083	0737597564	WCG	WCG	[signature]		
B.C. Mthethwa	7805245580083	0637289254	Ehlanzeni	Ngwelezane	[signature]		
Nqobile F. Ngubane	8807290662080	073 204 5098	Amajuba	Newcastle Regional	[signature]		
Phumeza Ntontela	7903270025081	0738608927	Uthukela Ntshebe	Estcourt	[signature]		
Thobekile Mkhize	7402281266087	0722816117	[illegible]	eKhubeka	[signature]		
Priscilla J. Toro	6811005789084	0839174402	UGU D/O	UGU	[signature]		
Thabisile Hlatshwayo	6210070400083	0735391713	Uthukela District	Uthukela	[signature]		
N. Mahova	7603031408086	0732091166	Umzinyathi	Greytown Hospital	[signature]		
NP. Buthelezi	8910230340086	0710000415	Uthukela	LRH	[signature]		
M.A. Oladoja	6509090538085	0723426361	Uthukela	Uthukela	[signature]		
P.C. Mbatha	5712310202082	0727370025	Umzinyathi D/O	Umzinyathi D/O	[signature]		
M.N. Nthlalane	7605010539086	0781076856	Umzinyathi D/O	Umzinyathi D/O	[signature]		
C.N. Nomvula	5808150414083	0826803811	Ugu	Murchison	[signature]		
J. Hlabisa	8405250561084	0715631729	Ilembe	Umphumulo	[signature]		
N.L. Shezi	8003180342081	0764651193	Umzinyathi	Greytown	[signature]		

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KWAZULU-NATAL PARTICIPANTS DAILY ATTENDANCE REGISTER

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Training name:	Focus Group Discussion Workshop			Training facilitator		
Training Venue:				Training facilitator		
Training type	Update ☐	Workshop ☐		Other (Specify)		
Start date:		Duration		Training service provider		
End Date		Please sign in and out on each day				

Names and surname	ID number	Contact number	Sub-district	Facility name	Day 1	Day 1	Day 2	Day 2	Day 3	Day 3
S Nqubuko	8703[illegible]	07[illegible]6665	Ethekwini	Cato Manor	[illegible]					
G.N. Moy	68110[illegible]653084	0724192686	Amajuba Newcastle	Newcastle	[illegible]					
N.G Mthembu	5601270723083	0826055896	.	St Andrews	[illegible]					
Vuyo Phalo	8407025537080	0734030992	Uthukela	Emmaus	[illegible]					
Sthandwa Mngayi	7312180367080	0838239182	—	King Cetshwayo	[illegible]					
Dr M. Maqwentshu	7009260722085	079-841-8759	WCG	WG	[illegible]					
DR NBC NKOSI	7403035527083	0827478866	UThukela	Ladysmith	[illegible]					
Dr de Leeuw	NHK9456B2	0782566226	Harry Gwala	Rietvlei	[illegible]					
Gugu P. Zwane	7207110730086	0733763159	ILembe	Stanger	[illegible]					
Osborne K Mathenjwa	7409155737089	0822944407	Mayville	PHC office	[illegible]	[illegible] PHC				
Ruth mavelo	6306120842088	0835827148	District office	Umzinyathi	[illegible]	[illegible]				
Lindiwe P.Buthelezi	7903[illegible]4[illegible]	073092[illegible]	Hlabisa	Gateway	[illegible]	[illegible]				
Osborne K Mathenjwa	7409155757089	0822944407	Mayville	PHC office	[illegible]	[illegible] PHC				
Ruth mavelo	6306120842088	0835827148	District office	Umzinyathi	[illegible]	[illegible]				
Lindiwe P.Buthelezi	7903[illegible]4[illegible]	073092[illegible]	Hlabisa	Gateway	[illegible]	[illegible]				
M. Phalanndwa	750201 0883[illegible]	076 868[illegible]	H/O	H/O	[illegible]					

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ANNEXURE 11

WOMAN'S TRANSCRIPT – one example

Researcher: **Explain the challenges that you came across when you went to the hospital for post abortion care.**

Respondent: I was admitted in the ward with the patient who began to bleed profusely. After some hesitation, I called the nurse to come and help. The health worker who was taking care of us there was shocked when Lorraine openly told her that she had wanted to get rid of her pregnancy, because she wanted to finish her studies. She left her, and never returned to her bedside. Lorraine continued screaming of pain and saying "God help me", a health care provider heard about her fear of "death" and said: "you killed and then said but you are afraid of death...". The following day I was then discharged. I came back to the hospital after three days to check on Lorraine, when I went to her bed she was not there, I then asked the sister in charge and she informed me that she died in two days back, while waiting to be done manual vacuum aspiration. At the hospital she faced negligence because of health care workers that are anti-abortionist.

Respondent: I started feeling sick and I was bleeding and I went to a private doctor and he gave me medication to stop the bleeding; I continued to lose blood for an entire week and had to go to the hospital. When I told the hospital that I went to the private doctor they showed discrimination and provided inappropriate care they were thinking that abortion was induced, inferring pre-judgment. Ah, it was the worst for me because it was not abortion, but it wasn't a miscarriage, you know? So they did not treat me well thinking that I had illegal abortion.

Respondent: The attitude with the health care worker was very bad she was shouting.

Researcher: **Explain the treatment that you have received at the facility**

.

Respondent: They give me three pills…and then immediately after I swallowed, I started having cramping and heavy bleeding and everything. So

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seeing as though I was commuting, it was about like an hour and 45 minutes from my house, they told me that I needed to go back home because I was having cramping and bleeding and just be very uncomfortable. And they said that abortion will take place home. They did not say anything about me coming back to the hospital for post abortion care.

Respondent: Ah, I got really sick, I thought I'd die. I went to the hospital and the nurse put plastic on my bed and I stayed there the entire night, she used a speculum and put on a rubber, and a probe and tied it, I slept with that, only that in the morning I lost too much blood and couldn't stand up, so I stayed there yelling for someone to help me go to the bathroom (...) some blood clots came out, some plaque together with the rubber. I lost blood for a week.

Respondent: They left you there in the ward alone to suffering?

Researcher: **Did the health care workers give you time during post abortion process.**

Respondent: I feel that our PAC's supply is limited to the management of emergencies. I came with bleeding and I was done manual vacuum aspiration then after the procedure I was sent home by the health care worker she did not have time to see me again.

Respondent: Health care provider who was helping me managed to give me the injection contraceptive, though I have requested to be given the IUCD. She told me that she is busy and alone and she doesn't have time for IUCD. She told me to go to the nearest clinic for IUCD.

Researcher: **How long did it take you to arrive at this facility?**

Respondent: I had to travel 259 km to come to this hospital and when I was here I was given another date to come back again.

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Respondent: Getting to the hospital took a toll on me and it was awful. It was raining that day, of all the days it's raining […] I went to a place I don't know, all these busses I don't know. I had to take two buses just to get to that appointment. It was the longest day that I can remember having for a long time.

Respondent: I started bleeding while at home early in the morning. I stay very far from the clinic. My mother-in-law called an ambulance. The ambulance took 3 hours to arrive and I felt like I am almost dead because I lost too much of blood.

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ANNEXURE 12

HEALTH CARE WORKER'S TRANSCRIPT – one example

Researcher: **Good morning and how are you today?**

Respondent: I am well and you?

Researcher **Tell me about the challenges you have as a health Care provider when providing post abortion care services**

Respondent: I have been working in this unit alone for the past 7 years. There is a doctor that I have been working with but now he has left because of the attitude from the other doctors. There is no one who is offering post abortion care service except for me. All patients who are requesting TOP services during the second trimester – they don't get help in this hospital because there is no doctor who is willing to offer TOP services

Respondent: I am suffering from stigma but I am used to it. Other staff members are refusing to work in this unit because of fear of stigma from the community and the subordinates. I am called by names like an abortionist. Some even told me that when I die I will find these children waiting for me in heaven crying.

Respondent: Health care workers refuse to perform and participate in TOP and post abortion care procedure, citing "conscientious objection.

Respondent: The other time in the hospital where I am working, a 19 year old girl came in TOP clinic accompanied by her aunt requesting TOP. On examination she was above 18 weeks. I then referred her to the doctor that I am working with. He then admitted her in the ward and

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prescribes her treatment to be given 3-hourly in the ward. After 7 days being in the ward, the girl then bled to death. When we did the file audit we then realized that her vital signs were not done and post abortion care services were not given to the girl, because the staff that was in the ward reported that they cannot take of the person who has done abortion

Respondent: There are so many challenges that we encounter from our co-workers. Our colleagues can't even direct the patients to our unit and that makes it difficult for the clients to access our services. The co-workers are not supporting at all to abortion care services and they sometimes call us names. Even some of the cleaners – it's so difficult for them to come to our clinic to clean the rooms.

Researcher **What is your challenge concerning shortage in your unit?**

Respondent: I am not happy about the post abortion care service that is being rendered in our facility. There is no quality nursing care there. The quality that we are rendering is just poor. I am very much concern about shortage of personnel in our hospital.

Respondent: I am experiencing professional burnout, which is manifested by emotional exhaustion, depersonalization, and reduce personal accomplishment resulting in poor quality nursing care and overall negative effect on most areas of personal, interpersonal and organizational performance.

Researcher: **ok……Mmmm…**

Respondent: I have been working with abortion services for the past 9 years and there was no support given by the hospital management. Again the hospital management always say that they have nothing to do to about shortage of manpower, I felt emotionally depressed and I felt that I need just top continue because this is mu calling. I felt that I had to continue to work in the challenging environment without any

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promising of effective support from the management. I have never been sent to psychological counselling.

Respondent: If I am on leave the service gets closed down, because there is no one trained. Patients who then came bleeding they are taken to theatre for evacuation by the doctors and those who seek abortion care are turned away without given the service.

Researcher: **ok……Mmmm…**

Respondent: The shortage has led to increase in illegal abortion and delays in women accessing post abortion acre services, often resulting in serious complications and death of thousands of women. Sometimes I find myself in a situation where we nurses working in a very busy day offering MVA to more than 20 patients per day alone and we then leave some patients behind and book them for the following day. Shortage leads to illegal.

Researcher: **ok……Mmmm…**

Respondent: I am working in a hospital which is in CBD. I am the only registered nurse who is offering TOP services in that hospital including legal TOP services. I see more than 90 patients who come for TOP services and more than 200 patients who come for post abortion care due to incomplete abortion. If I am on leave the unit gets closed down and re-opens when I come back from leave.

Researcher: **ok……Mmmm…**

Respondent: Clients who come to the hospital reporting incomplete abortions they need to be admitted in the ward for observation but due to shortage

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of manpower and beds, they are sent straight to me in TOP clinic for MVA. After the procedure they the sit on a bench because of lack of beds and are discharged after 2 hours. The work is too much for one person to handle.

Researcher **Can you explain in your own opinion any form of support that can assist health care workers to save the lives of women?**

Respondent: Working with the patients seeking abortion care services is stressful and demanding. Therefore the hospital needs to organize the stress management, counselling, for us who are dealing with such patients. The hospital should provide us with opportunity to attend

Researcher: **ok……Mmmm…**

Respondent: There is poor support from the management of the hospital. They took time to come and visit the unit or phone to check the progress of the unit. Provincial office is giving support because they invited me for debriefing sessions at least once per year. At the hospital there is no psychological or emotional support and we need that to get going.

Researcher: **ok……Mmmm…**

Respondent: When I complain to the management they always report that there is nothing that they can do… the nurse manager needs to show support to the TOP services.

Researcher: **ok……Mmmm…**

Respondent I have been working with abortion services for the past 9 years and there was no support given by the hospital management. Again the

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hospital management always tell that they have nothing to do to about shortage of manpower…, I felt emotionally depressed and I felt that I need just stop continue because this is my calling. I felt that I had to continue to work in the challenging environment without any promising of effective support from the management. I have never been sent to psychological cancelling.

Researcher **Can you outline the resources available in the unit that assist you in the management of post abortion care for emergency resuscitation equipment/ medicine available?**

Respondent: Most of the time we experience shortage of cannulas and aspirators in the unit.

Researcher **Tell me about training that you have undergone in terms of post abortion care**

Respondent: Furthermore training for the health care professional nurses on post abortion care services is needed. The TOP training is organized once per year by the province, but I think that it is not enough. We need to cascade the training to the district level.

Respondent Shortage of trained health care workers compromises the quality of care rendered to the women as we are unable to render comprehensive management of post abortion care.

Researcher **Explain what contraceptive methods that are offered during post abortion care?**

Respondent During post abortion care services all types of contraceptives can be offered to the women according to her opted choice after counselling, because the pregnancy is already expelled unlike if its medical abortion were we cannot give IUCD because the pregnancy is not yet expelled.

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Researcher	Do you have any other information related to the subject?
Respondent	**I** think managers must ensure that values clarification is conducted to each and every individual who work in the hospital so that people can understand and respect women who come in seeking post abortion care. It is also important that the service be extended in all health facilities including the primary health care, because that is the nearest entry point for the women and if you look at the situation some women came in complicated in such a way that they need a long stay and there is shortage of beds in the hospitals including shortage of staff.
Researcher	Tell me how lack of incentives affects you while doing your work.
Respondent:	The work we are doing is stressful and demanding and we deserve special allowance such as OSD in our salary. We should be provided with special allowance and our work that we do need advanced mentoring and support for development and patient care.
Respondent:	Rendering post abortion care services is difficult and was going to be nice if they can give us some form of allowance to motivate more staff to come forward and be trained and increase the services for PAC.
Researcher	**Thank you!**
Respondent	Okay welcomed

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Creating Future Leaders

ANNEXURE 13

QUALITATIVE DATA CODING CERTIFICATE

Qualitative data analysis

Doctor of Philosophy in Public Health

For

Muthuphei Netshinombelo Phalanndwa

Study Title: Development of Guidelines for Post Abortion Care Management at Selected Hospitals of Kwa-Zulu Natal Province, South Africa

THIS IS TO CERTIFY THAT:

Professor Tebogo Maria Mothiba has co-coded qualitative data which was collected through:

Unstructured interview

I declare that the candidate and I have reached consensus on the major theme reflected by the data during a consensus discussion meeting.

Prof TM Mothiba

Signature:

Date: 2017/05/18

Prof TM Mothiba (PhD)

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ANNEXURE 14

CONFIRMATION BY LANGUAGE EDITOR AND TYPESETTER

Norwegian University of Science and Technology
Faculty of Humanities
Department of Language and Literature

Date
May 4, 2019

Department of Advanced Nursing Science
School of Health Sciences
University of Venda
Thohoyandou, Limpopo

RE: Proofreading of doctoral thesis

This is to confirm that I have proofread the thesis written by Muthuphei Netshinombelo, to be submitted as a requirement for the degree, Doctor of Philosophy in Public Health.

The title of the thesis is:

Development of Guidelines for Post Abortion Care Management at Selected Hospitals of Kwa-Zulu Natal Province, South Africa.

Nancy Lea Eik-Nes
Associate Professor Emerita

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