



Experiences of Women regarding Accessibility of Choice on Termination of Pregnancy Services in Northwest Province, South Africa

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Abstract:

Background: Poor access to choose on termination of pregnancy services remains a disturbing health challenge to women, mostly in developing countries. In rural provinces of South Africa, this hurdle is manifested by, amongst others, fear of stigmatisation and failure to access the services due to a lack of trained staff and transport.

Objectives: This study is designed to explore and describe women's experiences regarding access to choice on termination of pregnancy services, subsequently describing recommendations to improve access to choice of termination of pregnancy in a sub-district of Northwest province of South Africa.

Methods: A qualitative, exploratory, descriptive and contextual design was used to assess the experiences of women regarding access to termination of pregnancy services. The population included women of childbearing age with a history of legal or illegal termination of pregnancy at selected public health care facilities. Purposive sampling was used to identify participants for the study, and 10 women were interviewed using unstructured in-depth face-to-face individual interviews. All ethical principles were adhered to throughout the study, and thematic analysis with six phases was utilised in evaluating the data generated.

Results: Difficulties in accessing choice of termination of pregnancy services and strategies for improvement of accessibility emerged as the two themes. Amongst others, pervasive negative attitudes of nurses, fear of stigma, and lack of psychological and social support were reported as cumbersome experiences in trying to access the service. To improve access, women recommended that more nurses should be trained and deployed to render choice of termination of pregnancy services to women. They also recommended advertising choice of termination of pregnancy services available on various platforms.

Conclusion: Based on the findings, women in the North West Province face challenges in accessing Choice of Termination of Pregnancy services.

Keywords: Access, Choice on Termination of Pregnancy, Experiences, Women, North West Province, Negative attitudes.

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1. INTRODUCTION AND BACKGROUND

Choice on termination of pregnancy (CTOP) services was introduced globally as a strategy to provide free and accessible services to women [1]. Access denotes the

ability to use available services by as many people as possible without encountering hurdles [2]. A study [3] concluded that even though free CTOP services are available, unsafe abortion remains a major problem

globally, apparently due to inaccessibility. This is corroborated by the statistics submitted by the World Health Organisation [4], which indicate that, despite the provision of free and safe CTOP services from 2010 to 2014, there were 45% of abortions reported as unsafe and self-induced. Additionally, the World Health Organisation reports that 97% of unsafe abortions occur in developing countries. The statistics bear testimony that unsafe and self-induced abortions might be attributed to CTOP services that are not accessible to women who need them [4]. It also demonstrates that when CTOP services are not accessible, these women opt for unsafe and self-induced abortions. This reason justifies the operationalisation of this study to explore and describe women's experiences regarding access to CTOP services.

Studies in London and Washington DC, corroborate the benefits of providing free CTOP services, such as a reduction of morbidity and mortality related to unsafe abortion [5]. This study further demonstrates that access to legal abortion improved women's economic and social lives [5]. Even though the benefits of freely providing CTOP services are reported, practices of unsafe abortions thrive. The reported benefits suggest that if CTOP services were readily accessible, the morbidity and mortality emanating from unsafe and self-induced abortion could be reduced, thus improving the quality of life for the concerned women.

One study conducted in Europe reported a lack of training for health professionals in offering legal termination of pregnancy services, with an increase in the rate of street abortions [6]. In Italy, it was established that structural factors such as long waiting lists contributed to poor accessibility of health care services, including CTOP [6, 7]. The studies above were based on general access to health care and not specific to CTOP [6, 7]. The same studies exposed accessibility as a health problem in almost all aspects, including CTOP. The findings on poor access to health care services, including CTOP, justify the need for the current study.

A study in India recommended improving access to health care services for rural communities because of the high burden of diseases and concern regarding women and child health [8]. Hence, the current study focuses on the accessibility of CTOP services to cater to health care for women. The study [9] confirmed that women who opted for unsafe and self-induced abortion in India suffered severe complications such as haemorrhage, uterine perforation, and septicaemia.

In Zambia, poor accessibility to CTOP services resulted in an increase in maternal mortality rates due to the high number of unsafe abortions [10]. It was also recommended that the Department of Health should improve the distribution of information about medical abortion and community engagement and mobilisation with the sole purpose of disseminating knowledge of abortion services available [10].

In South Africa, where the current study took place, the strategy for CTOP was introduced and accepted in

1996 [2]. Even though the strategy was accepted, it is documented that accessibility to CTOP services remains a problem in South Africa, which leaves women in need of these services vicariously exposed to morbidity or mortality due to unsafe abortion [11]. It is estimated that between 52% and 58% of the estimated 260,000 abortions that take place in South Africa every year are unsafe and self-induced [12]. The same phenomenon is reported in KwaZulu-Natal province [9]. It is evident from the statistics that, irrespective of free CTOP services, women in KwaZulu-Natal choose unsafe and self-induced abortion due to negative staff attitudes and the stigma attached to them by the community when they request such services [9]. Consistent with the reports in KwaZulu-Natal, a study conducted in Mpumalanga concluded that women also opt for unsafe abortion due to a lack of facilities offering CTOP services and negative staff attitudes [13]. In addition [13], recommended future research to focus on ways of preventing unsafe self-induced practices. These cumulative results prove that access to CTOP services is a chronic health problem in the provinces of South Africa [9, 13].

One study conducted in the North-West Province of South Africa did not explore the experiences of women regarding the accessibility of CTOP, pointing to a gap in literature [14]. The same study in Northwest province explored preferences of pregnancy *versus* termination of pregnancy by teenage girls [14]. The same study reported a lack of knowledge and stigma as recurrent challenges in the provision of CTOP services [14]. Additionally, the researcher in the current study observed poor access to CTOP at one selected hospital where he worked. The lack of access was demonstrated by admission records of 2019 at one hospital in the Northwest, showing an increasing number of women admitted with complications arising from unsafe and self-induced abortion. This explains why the current study focuses on the experiences of women at one selected hospital in the sub-district of the Northwest province. The findings could close a knowledge gap regarding women's experiences in accessing CTOP. The aim of the current study is to explore and describe the experiences of women regarding access to choice on termination of pregnancy services. The study also proposes recommendations to improve access to CTOP services in a sub-district of Northwest Province, South Africa.

2. MATERIALS AND METHODS

The research design, study setting, population and sampling, sample size, recruitment and process of obtaining informed consent, data collection and analysis are discussed under materials and methods.

2.1. Research Design

A qualitative, exploratory, descriptive and contextual design was used to explore and describe the experiences of women regarding access to choice on termination of pregnancy services in one selected hospital in the Northwest Province.

2.2. Study Setting

This study was undertaken at one selected hospital and two community health care centres offering CTOP services in a sub-district of the Northwest Province. The province is divided into four districts, which further consist of 19 sub-districts. The sub-districts cover vast geographic areas comprising regional and district hospitals, in addition to community health centres (CHC) and local clinics (Government Gazette Number 39070 of 2015). Due to the sensitivity of the research topic, the study avoided conducting interviews at the homes of the participants or health facilities. Hence, a central place used for conducting the interviews was the School of Nursing Science building at one of the campuses of one institution of higher learning.

2.3. Population and Sampling

The target population included women of childbearing age with a history of legal or unsafe self-induced abortion and those who received CTOP services at the selected public health care facilities in the sub-district of Northwest province. Therefore, the researcher applied purposive sampling to identify women who participated in the study.

2.4. Sample Size

The number of participants was determined by data saturation, and the total number of participants was 10. Data saturation was achieved by prolonged engagement until no new information emerged during the interviews.

2.5. Recruitment of Participants and the Process of Obtaining Informed Consent

The researcher consulted with the ward manager of the concerned ward where CTOP services were offered. This helped in building rapport for the recruitment of prospective participants. The unit manager approached potential participants face-to-face and explained the purpose of the study; the researcher was also introduced as a professional nurse and Master's student. She also requested them to give the researcher their contact details should they be interested in participating in this study. Informed consent was obtained by an independent person, who was a fellow Master's student.

3. RESULT

3.1. Data Collection

Data were collected by the researcher from 20 March 2022 until 30 June 2022 after obtaining ethical clearance from North-West University with ethics number NWU-00222-21-A1. A pilot study was done with two participants from the concerned healthcare facilities around the selected sub-district in the North West Province with the aim of assessing the feasibility of this study. The questions were given to study supervisors to validate them as experts in qualitative studies. This made the researcher aware of the dynamics and challenges involved, such as the sensitivity of questions. Due to the sensitivity of the research topic, the study avoided

conducting interviews at the homes of the participants or health facilities. The School of Nursing Science building on one of the campuses of the North-West University was used as a central place for interviews, and the identified room remained anonymous to avoid stigma.

The study used unstructured, in-depth, face-to-face individual interviews to explore and describe the experiences of women regarding access to CTOP services in the sub-district of the North-west Province. The interview guide consisted of two broad questions, simplified as follows: "Tell me about your experiences regarding access to choice on termination of pregnancy" and "Tell me what should be done to improve access to choice of termination of pregnancy." A voice recorder was used to document the voices, and permission to use a tape recorder was requested from the participants. Field notes were taken from observational, personal, and methodological, vantage points. The interviews lasted from 30 to 60 minutes, with a break of 5 minutes in between the sessions to avoid mental and emotional exhaustion.

3.2. Data Analysis

Data analysis applied six phases of thematic analysis [15]. The first phase was familiarising myself with the data, whereby the researcher immersed himself in the data by listening to the recorded interviews to capture the depth and breadth of the contents in the data. The first phase included verbatim transcription of the interviews. In phase two, initial codes were generated by writing down a list of ideas about experiences evident in the data. These helped the researcher to identify initial codes and potential themes. The third phase was searching for themes, which was achieved by analysing the generated codes to form initial themes, and further analysis of how these codes could be combined to make final themes. This was achieved through a mind map displaying the relationship between the codes. The fourth strategy involved reviewing coded data extracts by reading each theme and checking if they formed a coherent pattern. The fifth stage refined themes for analysis and presentation. This stage also outlined what each theme represented and which data aspects they captured. In the sixth phase, the analysis developed a full narrative of the data on the merit and validity of the themes and representation of the true story of the data. Finally, the data was given to the co-coder to do an independent analysis and thereafter, consensus was reached between the researcher and co-coder.

3.3. Measures to Ensure Trustworthiness

The study applied measures to ensure trustworthiness through adhering to principles of authenticity, credibility, transferability, dependability, and confirmability [16, 17]. For authenticity, the researcher gave the participants a consent form and a recruitment pamphlet that reflected the research aims, questions and objectives of the study. The researcher explained to the participants that they had the right to terminate the interview session if they felt uncomfortable, and no penalty would be enforced. Credi-

Table 1. Experiences of women regarding access to choice of termination of pregnancy services in North-west province, South Africa.

Major Themes	Sub-themes	Sub-subthemes
1. Experiences of difficulty in accessing CTOP services	1.1 Experiences of fear of stigmatisation	1.1.1 Experience of fear of stigmatisation by family and community members 1.1.2 Experiences of the negative attitudes of nurses 1.1.3 Experience of lack of emotional and psychological support 1.1.4 Experiences of feelings of hopelessness and stress
	1.2 Experience difficulty in accessing the services due to a lack of resources	1.2.1 Shortage of staff to perform the procedure 1.2.2 Lack of equipment to perform the procedure 1.2.3 Lack of information about CTOP 1.2.4 Long distance to travel to access the service. 1.2.5 Lack of finances due to poverty
2 Strategies for improvement of accessibility of CTOP	2.1 Use of various platforms to access CTOP 2.2 Employment & training of more nurses to render the service. 2.3 Community awareness campaigns 2.4 Offering of CTOP services at local clinics	

bility was maintained through prolonged engagement during data collection and analysis, as well as peer reviewing of the findings. Credibility was also ensured by returning transcripts of individual participants for comments and correction. All participants confirmed that the data was representative of what they said. Confirmability was achieved by ensuring that the findings reflected the participants' voices and by transcribing the audio-taped interviews verbatim. In addition, copies of transcripts and field notes from the study were given to an independent coder for verification. Dependability was ensured by submitting the final report of the study for external examination, whereby the application of the whole research process was critically examined for quality. Transferability was achieved through the purposeful selection of the sample, as well as through a dense description of the research methodology and results.

3.4. Ethical considerations

To get ethical approval, the proposal was presented to the SONS (School of Nursing Sciences) Scientific Committee, Quality in Nursing and Midwifery (NuMIQ), and Faculty of Health Research Ethics Committee (HREC). Permission to conduct the study was requested and received from the North-west Department of Health, hospital and sub-district managers of the selected facilities in South Africa. The study adhered to the principles of beneficence and anonymity. Participants were assured about the confidentiality and privacy of the study and that their identity, audio, field notes and transcripts were privy to the research team. Participants signed consent forms after satisfying themselves with the contract and its implications.

4. FINDINGS

A total of 10 participants were interviewed by the researcher of the main study who held an Honours degree. All participants were between the ages of 15 and 50 years, each with a minimum of 12 months post utilising the CTOP

services. Out of the women, 7 were able to access legal termination of pregnancy, while 3 of them performed unsafe-self-induced abortion.

Two main themes, sub-themes and sub-subthemes, were derived from data. In the first main theme, participants reported difficulty in accessing CTOP services with two sub-subthemes, namely (1) experiences of fear of stigmatisation (2) difficulty in accessing the services due to lack of resources. The sub-subthemes that emerged from the first sub-theme are (1) experience of fear of stigmatisation by family and community members (2) experiences of the negative attitudes of nurses (3) experience of lack of emotional and psychological support (4) experience of feelings of hopelessness and stress. The sub-subthemes that also came out from the second sub-theme of the first theme are (1) shortage of staff to perform the procedure (2) lack of equipment to perform the procedure (3) lack of information about CTOP services (4) long-distance to access the service (5) lack of finances due to poverty. The participants recommended strategies for improvement of accessibility of CTOP in the second theme, and only three sub-themes were reported, which are: (1) Use of various platforms to access CTOP (2) Employment & Training of more nurses to render CTOP service (3) Offering of CTOP at the local clinics. Table 1 below summarises the themes that emerged from the current study.

The following section discusses the main themes, sub-themes and sub-subthemes.

4.1. Theme 1: Experiences of Difficulty in Accessing CTOP Services

The two sub-themes and the sub-subthemes that emerged from these experiences are discussed in the subsequent sections.

4.1.1. Sub-theme 1.1 Experiences of Fear of Stigmatisation

During the discussion with the participants, it was

patently clear that women were afraid of the stigma related to unsafe and self-induced abortion. The sub-themes on their experiences of fear of stigmatisation are reported as follows:

4.1.1.1. Sub-subtheme 1.1.1: Fear of Stigmatisation by Family and Community Members

The participants reported that they feared stigmatisation from family and community members. This experience emerged differently from the vignettes each submitted in the open interviews. One of the participants said:

I got pregnant at an early age, and I was afraid of what people would say about my pregnancy since I was still young and would also seem like I disrespected my family.” (Participant 4)

“Another pandemic, before I forget, is the stigma surrounding abortions, which leads to discrimination in our communities.” (Participant 6)

“I did not even want my family to know about my situation. I wanted no one to know about it because when a person decides to terminate a pregnancy, that person is deemed immoral or has committed a sin or an illegal act. This issue can go as far as the person not being accepted in the community for taking such a decision.” (Participant 10)

4.1.1.2. Sub-subtheme 1.1.2 Experiences of the Negative Attitude of Nurses

The participants mentioned that they experienced negative attitudes from nurses when they went seeking CTOP at the health care facilities. There is no doubt that the women in question had significant challenges in accessing the service. The participants said:

Eish, the problem is the attitude. You know, somebody told me, I also witnessed it, you know how nurses are. I am pregnant, and again, I want to terminate the pregnancy, they shouted at me. (Participant 2)

They took me to the nurse at the termination room, and then she was very rude to me, asking me questions like why I did whatever I had done. (Participant 6)

The nurse started to act surprised when I mentioned the issue of termination, which also made me feel bad. (Participant 4)

In this study, women divulged the difficulties experienced in accessing CTOP services because of the negative attitudes they received from nurses.

4.1.1.3. Sub-subtheme 1.1.3: Experiences Regarding Lack of Emotional and Psychological Support

The participants stated that they lacked critical and perhaps essential emotional and psychological support during their journey in accessing CTOP services. These emerged from data as the participants put it this way:

“I did not want to involve him because he was a married man, so he did not know anything by then... When I told him this news, instead of helping me, he denied that

he was the father and that he did not want to be part of all this. For me, this was very stressful.” (Participant 8)

“Emotionally and mentally, I was not [in the right state] to deal with the situation if my information was to be known to people, especially at home.” (Participant 5)

I had to make means that my parents did not know what I was up to. I had to lie, saying I was going to school (Participant 4).

4.1.1.4. Sub-subtheme 1.1.4 Experiences of Feelings of Hopelessness and Stress

During the discussion, participants said they felt disappointed, hopeless and stressed in their efforts to access CTOP services. The finding is supported by the following quotes:

“I felt hopeless because I went to the clinic with the aim that I was going to terminate my pregnancy. I had already made that decision.” (Participant 5)

“I felt hopeless because I did not want my parents to know what was happening and I also had to plan to come to the clinic on that day without them knowing. I felt hopeless when I got to the clinic. I found that they did not offer the services.” (Participant 4)

4.1.2. Sub-theme 1.2 Experience of Difficulty in Accessing the Services due to Lack of Resources

This study established that women experienced difficulty in accessing CTOP services due to a lack of resources. This experience is discussed in the following sub-subthemes:

4.1.2.1. Sub-subtheme 1.2.1 Shortage of Staff to Perform the Procedure

Women were concerned about the shortage of staff who could effectively render CTOP services at the healthcare facilities. This is reverberated in the voices of participants as follows:

“All clinics lacked professional doctors or any other qualified practitioner [dealing] with pregnancy termination procedures.” (Participant 3)

“The nurse that I was talking to told me that the nurse who dealt with termination of pregnancy services was not available.” (Participant 2).

“When I got to the termination of pregnancy department, they then told me that the person who was supposed to help us was on leave and that she was going to come back after 3 weeks.” (Participant 7)

4.1.2.2. Sub-subtheme 1.2.2 Lack of Equipment to Perform the Procedure

During the interviews, the study established that the lack of equipment to perform termination of pregnancy at the health facilities was a recurrent challenge. The above sub-subtheme is supported by the voices of the participants as follows:

“The only option I was left with was to go to the hospital because hospitals are more equipped therefore, I

knew that I would find help.” (Participant 3)

“When I got to the hospital, the queue was very long, and they also told us that the machines were not working, so I had to return home and come the following week.” (Participant 8)

4.1.2.3. Sub-subtheme 1.2.3 Lack of Information about CTOP

Lack of information regarding termination of pregnancy services was a perspicuous idea raised during data collection. The following are the vignettes supporting the above sub-subtheme:

“The only thing you will see about termination of pregnancy is when these doctors advertise themselves on the public electric poles on the streets that they offer one-day abortion, safe abortion what, but from the public health facilities there is nothing, not even a pamphlet.” (Participant 10)

“The thing is, there is no other information that says you can go to the clinic to terminate pregnancy. I got it from social media. They said there were pills, and there was a doctor who sold abortion pills.” (Participant 1)

4.1.2.4. Sub-subtheme 1.2.4 Long Distance to Access the Service

The participants reported long distances that they had to travel to access the services as follows:

No, I did not manage; the baby I was pregnant with was here. I did not manage because the hospital is far (Participant 2).

Honestly speaking, I am very disappointed, Sir, because these services are the things we are unable to have access to, especially people like us from [remote] rural areas. (Participant 3)

4.1.2.5. Sub-subtheme 1.2.5 Poverty as an Inhibitor

The participants stated that their lack of finances had a negative influence on the accessibility of CTOP services. The participants submitted the following personal encounters:

That time I was thinking to myself that I should come to the hospital many times and I don't have enough money for these ups and downs, I am not working. (Participant 2)

I stay in rural areas; I need to utilise the money for transportation to go to the hospital. Why don't they just avail those services at the local clinics? (Participant 4)

“Because the clinic is very far from the hospital, this made it very difficult for me, as I needed money for transport and someone to accompany me.” (Participant 5)

4.2. Theme 2: Strategies for Improvement of Accessibility of CTOP

In this study women suggested strategies that could be adopted for improvement of access to the CTOP services. The sub-themes that emerged from the above theme are discussed in the following segment.

4.2.1. Sub-theme 2.1: Use of Various Platforms to Access CTOP

It was discovered that accessibility might be improved if various platforms are used to advertise CTOP services. The following captures what the participants reported:

“If they can start giving information on Radio and Facebook because us... youth... love Facebook, we love social media, so if information can be made available there, things will be better for most of us.” (Participant 1)

I have never seen any pamphlet at the hospital or clinic giving us information about where to terminate pregnancy, whether it's legal or not. (Participant 10)

Those billboards can have phone numbers or guide us on where to go. They can make pamphlets similar to the ones they have at the clinics for other health programmes (Participant 8)

4.2.2. Sub-theme 2.2: Employment and training of more nurses to render the service

The participants indicated that more nurses should be hired and those already in practice should be trained on how to conduct termination of pregnancy. The following vignettes capture what the participants hoped for:

I think if they can train the ones they have or hire more nurses so that they can offer such services.

The same participant continued and said: They should train nurses for termination of pregnancy the same as they trained them for other procedures such as taking blood. (Participant 2)

Yes, and I also think there should be nurses who can render the termination of pregnancy services at the clinics. (Participant 7)

And if they could also increase the staff for termination of pregnancy services, I also noticed that there is a shortage of staff. (Participant 6)

4.2.3. Sub-theme 2.3 Community Awareness Campaigns

A need to have community awareness campaigns emerged during discussions with the participants, as reported below:

“I think parents should be educated at the clinics that there is nothing wrong about terminating pregnancy. It should be known by the society that termination of pregnancy is a choice.” (Participant 4)

I feel like there should be campaigns where young people [are] educated about things like contraceptives for sexually active people because there are some instances whereby young people throw away babies because they were not ready for them, so I think that could be very helpful. (Participant 6)

4.2.4. Sub-theme 2.4 Offering CTOP services at local clinics

The participants of this study said that having CTOP services at the clinics would give them much access and improve the provision of health care. Such sentiments

were articulated by participants as follows:

I think there should be more clinics in our communities that work 24 hours because I was turned back at the first clinic as they told me that they were closing already, although it was not even 4 o'clock and if maybe nurses would stop making decisions for us. (Participant 7)

If they offered such services at the local clinics, at least I would have had more options to choose from. For instance, if I stay in Unit 9, I would be going to seek services at Clinic B, but they don't offer those services, it's only at the hospital. (Participant 10)

5. DISCUSSION

In this study, women were unable to disclose their CTOP service issues because they feared stigmatisation from their own families and community members. The study [18] states explicitly that community members in Kisumu and Nairobi cities viewed the termination of pregnancy as a deviation from the social norms and perspectives embedded in the religious and cultural beliefs of the community. Similarly, a study [19] highlights that in Kenya and India, women reported that termination of pregnancy was disapproved because people viewed it as an abomination. The findings of a study [18 & 19] suggest that African communities viewed CTOP as a social stigma, and South Africa is not an exception. All this is evident as the current study also verified that it was difficult to access CTOP services because women lived in fear of stigmatisation after a legal and illegal abortion.

It is further observed in the current study that women experienced negative attitudes from nurses, and this compromised the accessibility of CTOP services. This is evidenced in the women reporting that they were sworn at and nurses were rude when the women went seeking CTOP. Furthermore, women reported that nurses made them feel as if they were committing a sin. In support, a study [20] reported that negative attitudes toward abortion persist both inside and outside of healthcare systems. The findings by a study [20] and of the current study suggest that the attitudes of healthcare personnel as well as the community at large may have an influence on accessing termination of pregnancy.

The current study discovered that women could not share their experiences with their family, friends or community members and opted to go through the journey all by themselves. The inability of women to share experiences with other women points to a lack of emotional and psychological support for women seeking access to CTOP services. The same phenomenon was reported by a study [21] as women were uncomfortable, lonely and felt sick when they travelled far from home. In this study women were not able to get CTOP services on the first visit to the health facilities. In this regard, they were turned back home or referred to other facilities, causing such women to develop feelings of hopelessness and stress regarding accessing CTOP services. The findings of the current study, also proven by another study [21], demonstrate that women seeking CTOP need emotional support by both friends, family and community members.

It came to light that lack of resources had a negative influence on the access to CTOP services. This was evident in the shortage of staff to perform CTOP, lack of equipment and lack of information. The participants were also concerned about traveling long distances to get the services and lack of finances due to poverty exacerbating the challenge of accessing CTOP services. Despite the establishment of the Midwifery Abortion Care Training programme after the implementation of the CTOP Act in South Africa, limited opportunities for providers to attend abortion training persists [22]. In the current study, two participants could not access CTOP services because there was no healthcare provider who could help them. The findings [22] in the current study suggest that little has been done by the Department of Health (South Africa) regarding improvement in the provision of CTOP. Hence, there is a manifestation of some women who were unable to access legal termination of pregnancy because of a shortage of staff trained on termination of pregnancy.

The study [23] concludes that the third delay in receiving appropriate care was attributed to the hospitals' non-prioritisation of medication and equipment, resulting in long hospital waiting times before treatment. In this study, traveling long distances and lack of services close to the clients could be attributed to non-prioritisation of CTOP in the health facilities.

According to a study [24], poor women had difficulties in accessing healthcare facilities which were far removed from them, such that only those with high income were able to obtain abortion services at a health facility. In this study, some of the participants expressed their disappointment because the facilities, which were near to them, did not offer CTOP services, complicating accessibility for them because they had to travel long distances. The findings of the current study suggest that poor women could not afford to travel long distances, as established by a study [24].

Women in this study clarified that CTOP services should be advertised on various social media platforms so they know where, when and how to access the services. Similarly, a study [25] recommended that patients and the whole population should be better informed about national abortion laws, the recommended legal procedures and the location of abortion services. This finding demonstrates information sharing amongst women is one of the fundamental factors contributing to the improvement of accessibility to CTOP services.

Women in this study mentioned that more nurses should be employed to render CTOP services at health facilities. They further explained that nurses who are currently employed should be enrolled for training on how to offer CTOP services. The finding of the current study is confirmed by an author [26] who explains that there is a need to train more nurses and midwives to enable them to effectively engage in abortion care and provision.

The findings of this study consolidate the fact that the provision of CTOP services at local clinics could be efficient and less frustrating if the whole engagement

were made economically accessible. This is similar to what is suggested by a study [27], which mentions that local and nearer services reduce travelling and cost.

6. STRENGTHS AND LIMITATIONS OF THE STUDY

The focus of this study was on women's experiences regarding access to Choice on termination of pregnancy in a sub-district of North West Province. Therefore, the findings cannot be generalised but could be replicated in other settings. The recruitment process was difficult because of the sensitive nature of the topic of the study. Three participants declined to take part; some of them took the consent forms but did not participate.

7. IMPLICATION OF THE FINDINGS

Women in the North Province of South Africa need to access CTOP services at the health facilities, such as hospitals and clinics, and to safely terminate unwanted pregnancies. In this study, women had difficulty accessing CTOP services due to a lack of resources, including limited number of staff responsible for the termination of pregnancy. Additionally, women had little information about CTOP; all they saw on the internet and street poles was unsafe self-induced abortions being advertised, making them vulnerable to opting for the illegal one [28].

CONCLUSION

Since the current Bachelor of Nursing programme addresses theoretical aspects of CTOP, it sorely misses out the practical skill. Hence, the CTOP practical skill may be included in the Bachelor of Nursing programme curriculum in the North-west Province of South Africa. This could help to build positive attitudes and interest of professional nurses towards the implementation of CTOP services. In addition, nurses and doctors who deal with CTOP might be actively screened based on their personal interests regarding the service. Active screening of nurses and doctors may ensure that they do not bring their biases to work if needed. In addition, these could remedy the problem of nurses aligning their personal values and religious interests interfering with access to CTOP services in the health facilities of the North-west Province of South Africa. Professional nurses should be trained regarding the language to be used when attending to women seeking CTOP. This could reduce negative attitudes towards women requesting termination of pregnancy. For improvement of accessibility, a policy regarding the type of facilities that should provide CTOP should be reviewed, so that more clinics could be accredited for providing the service. This is because participants of the current study reported that the health facilities that were providing CTOP were few and far from them. The local clinics and hospitals providing CTOP services may be advertised on local radio, television, and institutions of higher learning in the North West Province of South Africa. Facebook and WhatsApp pages should be used to educate women about CTOP services. Research focusing on the support of women seeking CTOP service should be conducted in the North West Province of South Africa.

AUTHORS' CONTRIBUTION

KPM is a male researcher and main author who initiated the drafting of the manuscript and implemented the corrections from the co-authors of the main study. The main researcher and author holds a Master's degree and has some experience in conducting qualitative research. In this regard, KPM is trained in the research process, including methodologies and ethics training. MGS and MEM were the supervisors and internal reviewers of the manuscript. All three researchers agreed on the terms of the publication of the manuscript.

LIST OF ABBREVIATIONS

CHC	=	Community Health centres
CTOP	=	Choice of Termination of Pregnancy
NuMIQ	=	Nursing and Midwifery
HREC	=	Faculty of Health Research Ethics Committee

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

The study focus was on human subjects, and ethical approval was obtained from the North-west University Research Ethics committee, number NWU-00222-21-A1. Permission to collect data was obtained from the North-west Department of Health of South Africa and the managers of the hospital where the study took place.

HUMAN AND ANIMAL RIGHTS

No animals were used in this research. All procedures performed in studies involving human participants were in accordance with the ethical standards of institutional and/or research committee and with the 1975 Declaration of Helsinki, as revised in 2013.

CONSENT FOR PUBLICATION

The participants consented, and it was explained that data would be published, considering that participation was voluntary. The study adhered to ethical issues of confidentiality, privacy, and anonymity.

STANDARDS OF REPORTING

COREQ guidelines were followed.

AVAILABILITY OF DATA AND MATERIALS

Data and materials used to support the results of the research are obtainable upon special request from the main researcher and author [KPM]. The researchers confirm that the data supporting the results of this study are available within the article and its supplementary materials.

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None.

CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

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