STUDY OF WOMEN'S EXPERIENCES OF MISCARRIAGE IN SOUTH AFRICA

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Declaration

I, Nobukhosi Ncube, declare that this dissertation is my own original unaided work. It has never been submitted before for any degree or examination at any other university. I am submitting it for the degree of Master of Arts in Health Sociology at the Faculty of Humanities of the University of the Witwatersrand, Johannesburg.

Signed ……

This **26th** day of **October** in the year **2018**

Dedication

There is no greater agony than bearing an untold story inside you.

- **Maya Angelou**

This is a dedication to all women who lost their pregnancies through a miscarriage. I know your pain, I have walked the walk, talked the talk but the scars live longer. I want you to know that you are strong, you are beautiful, you're a complete woman, your experience doesn't define who you are, and neither does if determine/validate your social standing! Do one thing for me: Adjust your crown Queen and conquer the world.

Acknowledgements

I would love to extend my gratitude to all the support and courage that I received from various team players who contributed positively to the success and the completion of this Thesis. All your contributions are greatly appreciated. My gratitude goes to;

The Department of Sociology for offering me a second home, where all my academic and emotional needs were of optimum importance

My Supervisors Prof Lorena Nunez Carrasco and Dr. Silvie Cooper for bearing with me on this emotional journey.

Women who accepted me into their private spaces and their private lives to share their miscarriage experiences with me for the success of this study. I thank you from the bottom of my heart.

Medical Healthcare professionals who took some time off their busy schedules to share their expert knowledge on miscarriages with me.

My mother for always praying for me. Your prayers took me this far Mama! Long life to you.

My brother Innocent Dube and his wife for their unwavering support and unconditional love.

My siblings for their love and mostly for believing in me and in everything I do.

My friends Thenjiwe Mpithi and Alex Khumalo for being my immediate source of emotional support.

Bongani Kamanga for being part of the struggle. All the support and your good deeds speak volumes.

To all my comrades (Sociology Students), A Luta Continua!

All your support will never be forgotten, as Maya Angelo said; ***"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."***

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CHAPTER 1: INTRODUCTION

1.1 Background to the Research

Many pregnancies end in miscarriage, making this a common rather than an exceptional event in the lives of pregnant women. Miscarriage is defined by van den Berg et al. (2012) as "… the spontaneous loss of a clinically established intra-uterine pregnancy before the foetus has reached viability. It includes pregnancy losses until the maximum of 24 weeks of gestation" (1951). This definition of a miscarriage implies that any natural or uninduced loss of a pregnancy before the complete viability of the foetus is a miscarriage. Despite these clear definitions, in the literature, the terms 'abortion' and 'miscarriage' are often used interchangeably. Stirrat (1990, p. 673) states that "although the term spontaneous abortion is medically exact, many women are distressed by the term, and therefore the term miscarriage is preferred." The English word "miscarriage" has become the preferred term for pregnancy loss, rather than abortion, because the word abortion now carries the perception of the intentional ending of a pregnancy. In this research, I will utilise the term miscarriage in place of the medically precise word 'spontaneous abortion.'

Authors such as Opitz (1987), Letherby (1993), and Van der Sijp (2010), among others, have shown that miscarriage is both a medical and a social event which is often experienced as a life-changing event. A medical event is an occurrence that necessitates medical attention or intervention (Wilcox, 1996). Since most women seek medical health care after the occurrence of a miscarriage, the result of this medicalization of miscarriage transforms it into a medical event (Pincombe et al., 2015). Miscarriage as a social event is presented by the role of social interactions in shaping miscarriage experiences. Van der Sijpt (2010) articulates that miscarriage, as a social event is a phenomenon of paramount importance embodied in the 'daily social lives' of women, characterized by individual narratives. These narratives portray the interconnectedness of the miscarriage event and social issues such as the body and person-hood, pain and suffering, illness, marriage, and kinship, or death and mourning (Van der Sijpt, 2010).

Miscarriages have been categorized as 'events' characterized by pregnancy failure as stipulated by Middeldorp (2011) rather than as an illness per se. While miscarriage has not been categorized as an illness in literature, I would argue that a miscarriage becomes an illness as it is (re) defined in women's interactions with the medical health care systems during and after the occurrence of a miscarriage. I further argue that the quality of medical health care received might further transform it into a medical condition if any complications arise following a miscarriage event. Pincombe et al. (2015) confirms from the medical perspective the medical trajectory of a woman who is experiencing miscarriage as entailing a need for medical referrals, different miscarriage management options such as the surgical

evacuation, expectant treatment, and medical therapy in incomplete miscarriage. This is important as it reinforces the notion of a miscarriage as a medical event which causes the transformation of the event into a medical condition deserving of medical attention, which impacts on the lived illness experiences of women.

This shows that the experience of a miscarriage can be constructed in multiple ways. It can be a negative or a liberating experience, or both. The influence and the intersection of variables such as age, relationship status, financial status, pregnancy planning, quality of medical health care received, and the social environment plays a part in how women articulate their miscarriages experiences and make sense of their feminine identities following a miscarriage event.

1.2 Research Interest

Miscarriages are a common problem affecting many women throughout the world. Everett (1997) asserts that before the 20th week of pregnancy, bleeding occurs in a fifth of documented pregnancies. More than half of these pregnancies are miscarried (Everett 1997). Although miscarriages may embody various connotations, a miscarriage event is a potentially life-changing event (Letherby, 1993), therefore deserving of sociological analysis.

This research sought to explore how women articulate their experiences and navigate their everyday life following a miscarriage event. The link will be made between the miscarriage event, medical health care and women's social lives in the aftermath of a miscarriage and how all this comes together to influence their miscarriage experiences. The perspective taken in this study is that a miscarriage is a social construct. The lens adopted by Crotty on constructionism as an understanding that, "all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context,"(1998, p. 42) resonate with this study. A miscarriage as a social construct is rooted on the notion that women's experiences of a miscarriage are not universal but reliant on contingent variables of social realities, hence the interplay between personal experiences, the interaction with the medical arena and the social environment. This report will also explain the place of culture in the experience of miscarriage and its contribution in shaping miscarriage experiences.

This study is inspired by my personal experience, which triggered an interest in other women's lived experiences of miscarriage and the stories they carry forward with them. Therefore, this kindled my curiosity to explore how women construct their miscarriage experiences, as well as how they negotiate their femininity within their social spaces following a miscarriage. Additionally, I wanted to

explore the impact of the medical health care received as well as the social interaction surrounding miscarriage experiences.

1.3 Research Question

This study sought to explore the interplay between the social environment and the quality of the medical healthcare received in shaping South African women's experiences of miscarriages. The research aimed to understand how participants' construct their experiences based on the social interactions in which their life experiences are embedded, their interactions with the medical health care institutions and the cultural structures informing their understandings of miscarriage and influencing identity formation following a miscarriage experience. Many women experience miscarriages at some point of their childbearing journeys, hence the study was conducted with women between the ages of 19 to 49, as most women partake in their childbearing journeys during this age range.

1.4 Research Justification

Freidenfelds (2016) asserts that there are strong but inadequate studies focusing on miscarriages within the humanities and social science literature. This assertion points out that miscarriage studies have not received much attention within this literature, thus this study sought to contribute to the body of knowledge in miscarriage studies through an exploration of the interlink between the social, the cultural as well as the medical health care interactions in shaping miscarriage experiences among a group of women.

Looking at the history of miscarriage studies, the following topics have been covered; the effects of miscarriage and required support systems (Letherby, 1993), the traumatic impact of miscarriages and proposed interventions (Lee & Slade, 1996), the cultural aspects of miscarriages (Layne, 1990), as well as certainties of pregnancy following a miscarriage (Freda, Devine & Semelsberger, 2003). There is little that is said about the construction of miscarriage experiences and identity formation following a miscarriage experience. Furthermore, miscarriage studies within the African context are limited, South Africa included. This might be due to the fact that African women are still finding it hard to openly and publicly talk about their miscarriage experiences. The limited possibility to openly discuss miscarriages relates to the cultural taboo surrounding it and to the societal ideologies of miscarriages as being 'women's private problem' (Van Den Boogaard et al., 2011, Kincaid, n.d, Mayor, 2015, & Mander, 1999). This study explores how a group of South African heterosexual women construct their

miscarriage experiences; focusing on the role of medical health care received, cultural ideologies influencing their understanding of miscarriages, their social environment as well individual circumstances influencing the way they live through the experiences of miscarriage.

This research sought to explore the construction of miscarriage experiences from the social interactionist, feminist, embodiment, as well as the medical healthcare perspectives. These perspectives are important for us to understand the construction of miscarriage experiences as they touch on the impact of the social, the cultural as well as the medical health care on identity formation and meaning-making in relation to miscarriages, loss, and childlessness. From the social interactionist perspective, this research explores how social interactions affect the formation of identities following a miscarriage experience. This includes how women are affected by miscarriages, the role of family and social support in the way miscarriage is lived, the role of social class on miscarriage experiences as well as the place of culture informing the interpretation of miscarriages and the experiences thereafter (recovering, whether a sense of loss is experienced, coping with loss or whether a liberation experienced, etc.). A feminist perspective helped to deconstruct how a group of women from different racial and cultural backgrounds construct their feminine identities following a miscarriage experience. The embodiment framework was useful in how women derive meanings and make sense of their world from their bodily experiences. From the medical healthcare perspective, this research will explore the impact of the quality of health care received on miscarriage experiences.

In general literature, miscarriage is an experience that is poorly studied, given the sensitivity of the subject and people's unwillingness to speak about it, including South Africa. Therefore, the purpose of this study is to fill the literature gaps and add to the existing studies by exploring the construction of miscarriage experiences amongst a specific group of women with the first-hand experience. This research will enrich miscarriage studies in South Africa as miscarriages are a widespread social phenomenon not only affecting women who have had a first-hand experience but as a social and medical phenomenon, which, when managed properly, can improve women's experiences for the better.

1.5 Objectives

Many women experience miscarriages at some point in their childbearing journeys. As a social scientist, I was compelled to a study of how women navigate through their lived experiences and articulate their feminine identities following a miscarriage experience by offering them an opportunity to tell their stories. The objectives of this study were:

• To understand women's miscarriage experiences.

• To explore the role played by the social environment (immediate interactions such as family, friends and partner, cultural and religious beliefs) in shaping up women's miscarriage experiences.

• To understand the influence of the medical healthcare received in miscarriage experiences.

• To understand how women articulate their feminine identities following a miscarriage event.

• To understand what these stories/narratives from women can teach us about how to support women who have experienced miscarriages so as to help advocate for a woman-centered healthcare and provide women with the best maternal health care possible, as well as help with the development of social support systems in the best interest of women.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This study seeks to explore women's miscarriage experiences and the role of the social environment and the medical health care received in the construction of their experiences. The core themes of the study are women's experiences following a miscarriage, their experience during the interactions with the medical healthcare institutions, the social support networks available to them, belief systems or cultural values informing their interpretation of miscarriage and the effects of a miscarriage on the relationships they had with their partners prior to the miscarriage event. These themes were useful for this study as they uncover women's emotional responses to a miscarriage event and the role of the social and the medical interactions in shaping their miscarriage experiences. Conceptual frameworks that are utilized for this study are the feminist, the symbolic interactionist and the embodiment. The feminist frameworks will be instrumental in theorizing the women's femininity embodiment following a miscarriage experience. The social construction of illness experiences and medical knowledge framework will be useful in the theorizing women's interactions with their social environment and the medical health care institutions following a miscarriage. Embodiment as defined by Shilling (2001) refers to a way in which people live through the experience of their bodies, the meanings they attach to their bodily experiences and their interactions with the socially constructed notions prescribing how their bodies should appear and function. This will help explore how women make sense of their bodies and their experiences following a miscarriage and how they articulate their experiences based on the bodily experiences of a miscarriage.

2.2 South African maternity services

An understanding of the changes in the South African maternity services in the last 20 years is crucial for this study. Chopra et al., (2009) point out to the harsh effects of apartheid on women in South Africa, especially in the marginalized rural homelands. Prior to democracy, health care services were under-resourced (Mkhwanazi, 2014, Chopra et al., 2009a). To a larger extent, this compromised the lives of women due to higher mortality rates emanating from pregnancy-related complications and childbirth (Chopra et al., 2009b). A thin line between induced abortion and miscarriage, coupled with the discourses which depict women as solely liable for induced abortions, impacts negatively on the quality of care that women receive when presenting an incomplete miscarriage at the hospital (Erviti et al., 2004). The commitment by the government in democratic South Africa to improve health care services for all has been crucial for improving the quality of health care, including maternal health care services for the previously segregated communities (Chopra et al., 2009a). However, the work of

feminist scholars such as Davis-Floyd (1990), Oakley (1980), and Rothman (1993) on the medicalisation of pregnancy, applauds their critique of biomedicine as having facilitated a shift of control over women's bodies by isolating women's active involvement in their bodily experiences, hence women's subjection to passive medical care recipients (as cited by Neiterman, 2013). Therefore, despite the changes in the accessibility of the maternal health care services in South Africa and the positive contribution in decreasing mortality rates related to pregnancy and childbirth, there is a shift of power and control, women are still subjected to the passive reception of medical health care.

Despite the improvement of health care services for all, miscarriages are still a problem and amongst the causes of maternal deaths. Cooper et al. (2016) cite the findings from the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) report (2012-2013) that maternal deaths have decreased as compared to previous years and miscarriages were pointed out as contributing to a 13% of maternal deaths.

2.3 Conceptualisations of pregnancy and miscarriage

Pregnancy loss is a prevalent experience among women and affects a vast number of people all over the world (Corbet-Owen, 2003). In non-Western societies, a pregnancy loss within thirty weeks (seven months) is termed a miscarriage (Freidenfelds, 2016). In developed countries, the loss of a pregnancy is considered to be equivalent to the loss of a baby (Freidenfelds, 2016). This distinction emanates from a wide range of medical, technological and social changes, as well as the escalation of prenatal care in early pregnancy (Freidenfelds, 2016). Freidenfelds (2016) asserts that medical and technological advancements have resulted in new technologies such as the home pregnancy tests, ultrasound and in vitro fertilization, etc. Moreover, the increase of contraceptive expertise has precipitated the birth rate drop in the 19th and 20th centuries; the infant and child mortality decline in the 19th and 20th centuries; the constant increase in responsibilities and expectations of parenting as of the late 18th century; growing marketplace consumption for expected babies; as well as an increase in mothers' ages at first birth also contributed to social variations in meanings attached to the loss of pregnancies (Freidenfelds, 2016). Therefore, the medicalization of childbirth made it possible for the early confirmation of pregnancy, which, in turn, made documentation of miscarriage cases possible (Barker, 1998).

While documentation has occurred, accounts of women's experiences of miscarriage are thin, especially before the 1960s. This means that while historical inferences are well argued, they still remain largely speculative (Freidenfelds, 2016). Historically, early pregnancies were regularly treated to detect possible miscarriage threats (Pollock, Ellisman, and Benzer, 1990). Maternal health care has

been medically managed in order to specifically prevent miscarriage from occurring. As well as medical caution surrounding pregnancy, there is also social caution practiced in relation to the high possibilities of a miscarriage happening during the first trimester of pregnancy. Pregnant women may, therefore, avoid feeling or expressing more excitement about their pregnancies during the first trimester and may seek emotional detachment from the experience until they are more certain of the successful continuation of their pregnancies (Lupton, 2013).

2.4 Causes and effects of miscarriage for individuals and families – grieving, social visibility, acceptance, and support

A wide range of factors contribute to the likelihood of a miscarriage. The medical literature points out to STIs, HIV infection and other chronic diseases and medical conditions to increase the likelihood of miscarriages and genetic disorders in foetal development (Collier et al., 2013; Manavi, 2006; Dudgeon & Inhorn, 2004). According to Hannebaum (2014), when a miscarriage happens, it affects the entire family, and coping becomes a crucial part of healing. Miscarriages put women at a greater risk of developing mental health issues such as depression and anxiety, and men's feelings are usually ignored as miscarriages are hardly perceived as a concern for men (Martinez 2002). Therefore, it is essential for health practitioners caring for the family and people experiencing a miscarriage, and the broader society they all belong to, to be as supportive as possible, so they can manage, cope and move past the occurrence (Hannebaum, 2014).

Miscarriages are often difficult for people to acknowledge and discuss. This can lead to social invisibility being a frequent component of the experience, though there are cultures that use cleansing ceremonies and bereavement rituals to commemorate the short foetal life that was lost, and this is crucial to those who have experienced a miscarriage (Lupton, 2013). Sometimes, it becomes a challenge for individuals to mourn pregnancy loss especially in early miscarriage cases, as there is no physical body or person to remember, which can make it hard to define what it is they are grieving for (Kevin, 2011 as cited in Lupton, 2013). This brings about an assertion that, "miscarriage involves multiple losses: the loss of identity as a pregnant woman or couple; the lost potential for becoming parents; the loss of a future child; and the loss of future hopes, plans, and expectations" (Brier, 2008 as cited in Bute & Brann 2015, p. 24). Shilling (2001) argues that people live through the experience of their bodies, the meanings they attach to their bodily experiences and their interactions with the socially constructed notions. Therefore, an interplay between visible/invisible and physical/personhood solely depends on an individualistic interpretation of the loss.

Martyn (2007) asserts that the father of the child is often the most forgotten person in the miscarriage mourning processes. Although pregnancy loss may leave both partners feeling emotional, bewildered, failing to cope and to make sense of the loss, it can be challenging for a bereaved father to have his needs met and recognized as the attention is mostly paid to the mother following a miscarriage and the feelings of the father can be side-lined. "You [the father] may be taken aside and asked how your partner is, while few people ever think to ask after you. Some people may feel uncomfortable asking a man about his feelings, but others may simply assume that you are less affected by what has happened. You may find that you are expected to hide your feelings in order to be strong for your partner" (Martyn, 2007, p. 3). Although miscarriage affects men and women, its effects may vary according to the type and the intensity of loss, and the extent of visible symptoms (Corbet-Owen, 2003). Corbet-Owen (2003) argues that male and female socialisation affects the support received by women following a miscarriage. Noting the feelings of fathers following a miscarriage is pivotal for this study as it also affects the care and support that women receive following a miscarriage, hence playing a crucial part in the construction of women's miscarriage experiences.

McGreal et al., (1997), Bute and Brann (2015, p. 24) state that for parents, the process of grieving following a pregnancy loss can be a source of strong emotional distress and could impact the quality of relationships among partners. McGreal et al., (1997) further articulate that grieving and coping mechanisms are not only influenced by gender but also by which stage in the pregnancy the miscarriage occurred within (early/late, first/third trimester). This is brought about by the assumptions that miscarriages at a later stage of pregnancy may have a greater impact on the person and their family compared to early miscarriages and women will more likely seek spiritual support, use wishful thinking and tension reduction methods and look for support from people with similar experiences of loss if a miscarriage occurs in later stages of their pregnancy (McGreal et al., 1997).

The American Pregnancy Association (2013), shows that women are often more open in speaking about their miscarriages and may seek support from others but men seldom share their feelings (cited in Hannebaum, 2014). Men often try to dodge their feelings by keeping themselves busy and this stems from beliefs by some men that strong emotional displays contradict their father and husband roles (Rinehart & Kiselica, 2010 cited in Hannebaum, 2014). Therefore, Hannebaum (2014) asserts that it is a societal obligation to offer men ways of coping with miscarriages, ways that are socially acceptable to deter incidences of irrational behaviours and possibilities of more grief. There is research focused on the impact of miscarriages on women while the impact of miscarriages on men has gone unnoticed (McCreight, 2004). The limitations of this study meant that the focus was on capturing women's experiences of miscarriage, though men's experiences are considered for future research projects.

Women do not experience miscarriages in isolation but within social networks which have the potential to either reduce or increase their stress levels (Corbet-Owen, 2003). Social support is essential in the reduction of psychological distress during times of stress as it quickens recovery and stimulates healthy behaviours and habits in the event of illness (House et al., 1988 cited in Corbet-Owen, 2003). Although social interactions will probably care and nurture, they can also be a source of conflict, criticism, and rejection (Richards, 1997). Social support has positive and negative aspects. As Richards (1997) highlights, negative social support can appear in various forms such as efforts of kindness that may be perceived as unwanted, ineffective or inappropriate, or outright sarcasm, disapproval, character degradation and reproach, which are more likely to result in conflict or eruptions of anger between the people giving and receiving support. This implies that social interactions do not always impact positively on women's miscarriage experiences but can have some damaging impacts too.

Women need positive social interactions during a miscarriage experience, and this could be emotional support concluding with expressions of reassurance of worth, comfort, love, care, and empathy. It could also be tangible support in the form of provision of services, goods or financial support, or informational support through providing appropriate advice, information and guidance (Taylor et al., 1994 cited in Corbet-Owen, 2003). Hartman (1997) defines empathy as one's projection onto another, to comprehend the other's experience better by making one's suffering your own. Hartman (1997) also questions the cold-heartedness and uncertain nature of empathy, the oppressive effects of empathy as well as the 'obliteration of otherness' and asserts that for suffering to be perceptible and comprehensible, one must put themselves in the shoes of the other. In order to give support to someone who has experienced miscarriage, the person needs to empathise which could be a challenge as those expected to offer gestures of empathy might have never been through the experience themselves.

2.5 Child bearing, femininity and womanhood.

The study of women's miscarriage experiences and the factors that impact on the construction of these experiences necessitate exploration of the notion of childbearing and its impact on women's feminine identity following a miscarriage experience. These issues are crucial for this study and they guided both the interview question(s) and the data gathered.

Perhaps the value of a woman, which is tied to her ability to produce an offspring, is problematic as it subjugates and coerces women into patriarchal expectations of childbearing from which they cannot escape but passively promote through their docility and comfortable subjection as portrayed in Davaseeli (2011) and Hartman (1997). The ability to bear children is often viewed as an innate quality

or talent of women, and so the inability to have children, either entirely or in the case of miscarriage, is often framed as a failure to embody a feminine identity. Watson (2006) states how women's desirability is closely tied to notions of motherhood, and so the active decision to not have children, difficulty having children, or loss experienced following a miscarriage, are all used as derisive mechanisms of casting women as undesirable. Watson (2006) argues that this is why motherhood is celebrated as a sign of success or achievement where a woman who bears a child gains the status of an adult and is addressed with respect, therefore, being called a 'mother' a fundamental display of social standing and strength in South Africa. As stressed by Lewis (1999), the 'mother' label for women, does not show the experiences of specific women, but instead an authenticating title symbolizing their social standing.

This brings about a strong pressure to conform to the status quo to produce offspring, which ties a woman's value to her ability to bear children and care for a family (Watson, 2006). Mupotsa (2015) asserts that female spectators of their staged scripts tend to adopt a male point of view and lack a necessary detachment from the masquerade as they are representations of the desired and "the femininity is constructed as an overwhelming presence-to-itself of the female body" (Doane, 1991, p. 222 cited in Mupotsa, 2015), and "this leads to… the desire to become an object of one's own desire" (Mupotsa, 2015, p. 190). Therefore, for women, experiencing a miscarriage strips them of their chance to motherhood (the desired), which becomes a sign of failure and deviation from the script in being unable to embody femininity in losing a child. Mupotsa (2015) points out that "… through the performance of certain rites of passage, femininity can at least be momentarily achieved" (p. 190). "The future promise of happiness intangible temporality … is one that requires or depends on malaise of disappointments, failures, mistakes and incompleteness" (Mupotsa, 2015, p. 196). In relation to this study, I can infer that motherhood is and can be temporally achieved through the experience of pregnancy but also stripped away by a miscarriage experience.

Children are perceived to be an assurance of family continuity. Hence, couples consider their children to be sources of pride and power. Tabong and Adongo (2013) state that the anthropological and sociological studies bear witness to the considerable suffering related to involuntary childlessness, which leads to detrimental psychosocial issues such as stigmatization, abuse, and marital instability. As asserted by bell hooks (n.d), our cultural values are shaped by patriarchal thinking. This connotes that we are socialised into the patriarchal system by learning patriarchal attitudes in our families where they were usually taught to us by our mothers, and reinforced in religious institutions and schools (bell hooks, n.d).

According to Berlant (2006), the 'object of desire' refers to a 'cluster of promises' that we expect to be made possible to us by someone or something, and these could be embedded in a variety of things ranging from individuals, places, ideas, sounds, smells, or things. Therefore, perhaps having children is an object of desire for most couples, embedded in the woman's ability to successfully carry the pregnancy. Berlant (2006) further argues that the representation of the desired object as inseparably connected to the promise or hope allows us to question our 'endurance in the object' as well as understand that though our attachments to these objects may not always 'feel optimistic', they are inherently 'optimistic'. This is 'cruel optimism', a concept that is defined as "a relation of attachment to compromised conditions of possibility" (Berlant, 2006, p. 21). This means that despite how harmful, self-destructive or cruel the nature of one's relation to a specific object of desire may be, the attachment is closely linked to the way this individual perceives and negotiates the world, such that its loss may destroy any reason for life. Therefore, it is pivotal to note that it is not the object that is problematic, but how we are taught to relate to it (Berlant, 2006).

2.6 Parent Disciplines / Fields and classification models

The following theoretical frameworks were used in this research;

2.6.1 Feminist Theory

Miscarriage can trigger various personal issues concerning a woman's fertility, her relationship with her partner or her identity as a parent as well as her own attitudes to life and death (Patton and Wood, 1999). Regan (2001) asserts that self-blame and guilt are stated as common reactions following a miscarriage and the desire to know or understand why can be an obsession. Other than talking about their miscarriage experiences, most women bottle up their experiences due to the stigma that has been attached to women who have suffered miscarriages on the assumption that they may have terminated their pregnancies or may have done something to attract the unfortunate event (Adolfsson, 2004). Due to this attitude, feminist approaches try to highlight and condemn certain structures that have long been utilised in various societies such as the ability to produce an offspring as a measure of womanhood (Fledderjohann, 2012). It is pivotal for societies to break all the barriers set to define the identity of women, give necessary support to women following a miscarriage event and for the medical health care settings to be conducive, not only for healing the body following a miscarriage event but also for coping and emotional support systems crucial for the recovery and dealing with the loss.

Feminist ideologies guided this study in exploring how women from different backgrounds construct their miscarriage experiences. The feminist body of knowledge helped to unpack the position of women in societies in relation to motherhood and childbearing. Various feminists have reflected on several issues affecting women's positionality and identity formation, and these include reproduction as a measure of womanhood. Wikler (1985, p. 1043) asserts that "the social role of women has been and continues to be primarily defined by the biological fact that only the female of our species can become pregnant. Although both men and women participate in human reproduction, the tasks of bearing and raising children are commonly considered women's jobs".

Brook (2014) asserts that concerns of the body have been fundamental to all feminist perspectives and theorists have always been immersed in ways female bodies are perceived, categorized, altered, invaded, disciplined, destroyed, pleasured and decorated. Feminists, are not only interested in what occurs to the 'female bodies' but also in how female bodies hypothesise and write themselves (Brook, 2014). Brook (2014) notes that looking back at the history ladder, although not all female bodies can bear children or conceive, the social situation of women has been prearranged by the identifications of the female bodies with 'childbearing', hence female bodies have been 'objects of exchange' amongst men. Therefore, the feminist perspective on the policing of feminine bodies and reproduction has helped in drafting the interview question for this study as to explore women's understanding and interpretation of their feminine bodies and how they embody the desire for motherhood through the lived experience of a miscarriage. Women's embodiment of feminine identities is essential in the construction of illness experiences following a miscarriage event.

2.6.2 Social construction of illness experiences and medical knowledge

The purpose of this project was to uncover how identities are formed and to study meaning-making through interactions. This study drew on interactionist perspectives in pointing out the role of women's interactions with the social environment, cultural elements informing the interpretation of miscarriages, the medical health care facilities and health care professionals following a miscarriage in shaping miscarriage experiences. Swanson (1965) asserts that to understand social interactions it is pivotal to adopt Talcott Parson's general systems theory. The general systems theory enables an understanding of the interconnectedness of various systems (Gray, Duhl, & Rizzo, 1969). Swanson stipulates that "general systems theorists also hope that the revelation of formal similarities between different subject matters will foster a suggestive and fruitful interexchange of experiences and discoveries" (1965, p. 109). Therefore, this theory was useful for my study and has enabled me to draw understandings on the interconnectedness of the social, the cultural and the medical health care

systems in shaping up women's experiences following a miscarriage. This was achieved by exploring various factors at play in the construction of women's miscarriage experiences as women narrated their experience of miscarriage, hence a clear interlink of these systems in shaping women's miscarriage experiences.

Bellack et al., assert that the general systems theory must include three essential elements "the alternative course of action; the feedback mechanisms that enable the system to make adjustments, and system goals" (2013, p. 80). Therefore, this approach was pivotal for this study as it is aimed at bringing about transformation in the social, the cultural and the healthcare systems in favour of women who have experienced miscarriages. However, this is limited for this study, since this research project is for academic purposes. This research serves as a feedback mechanism drawing on the untold realities of women's experiences following a miscarriage event. Given consideration, this research advocates for change in either systematic policies, norms, values or practices, hence paving a way for an alternative course of action for the best interest of women who experience a miscarriage.

Symbolic interactionism theorists (Cockerham, 2004; Vannini, 2016; Hewitt, 1976) argue that health and illness are socially constructed. Symbolic interactionism emphasizes negotiation in the occurrence and social response to illness negotiated elements in the detection and naming of symptoms. Thus, doctor/nurse-patient relationships are seen as a part of the negotiated order (Cockerham, 2004). Therefore, this theoretical framework is instrumental for my study as it shaped the interview guidelines. These interview guidelines were crucial in exploring women's interactions with their social environment, the medical healthcare institutions and exploring the interplay of doctor-patient relationships and the role all these factors play in women's miscarriage experiences.

2.6.3 Embodiment

> *"Our notion of human existence requires us to have a human body but that body is both an object body, a thing, and also a lived body, an experience. How we live in the world is manifest through our bodies: there is therefore a reciprocal relationship between the body 'social' and the body 'biological" - Draper (2003, p. 747).*

Shilling (2001) defines embodiment as a way in which people live through the experience of their bodies, the meanings they attach to their bodily experiences and their interactions with the socially constructed notions prescribing how their bodies should appear and function. Draper (2003) asserts that human bodies are both objects/things and lived bodies/experiences that manifest our existence,

hence a mutual connection between the 'social' and the 'biological' bodies. Draper (2003) states that we often take our bodies for granted in that we are not aware of our bodies until we experience changes in our bodies such as illness or tiredness. Draper (2003) points out to pregnancy as one of the changes that make women aware of their bodies, hence their embodied experience of pregnancy.

Social expectations of how women should display/embody their identity through pregnancy or motherhood remain central to women's lived experiences following a miscarriage. Biology has predetermined the place of women regarding childbearing, hence the primary role of women perceived as the bearing children. However, Wikler (1985) argues that this socially contextualised concept of reproduction has been unfavourable to women. Women are the most brutalised, exploited and manipulated group in the world, with a recognised value as sexual objects or breeders (Rowland, 1987). The social structures and cultural value systems have an impact on women's embodiment of feminine identities. Due to these social expectations, miscarriages are not addressed because there's no space within feminine gender identities for people who aren't able to have children. In addressing the role of social environment in the embodiment of pregnancy, Neiterman asserts that "the social contexts in which women experience their pregnancies, the meanings they attach to their transitions to motherhood, and their interactions with others resulted in each one doing pregnancy very differently" (2012, p. 372).

For this research, I utilised the approach used by Neiterman (2012) that pregnancy is an embodied experience through women's active and continuous 'doing' of pregnancy and that their social status is appraised on the basis of a perceived successful performance of pregnancy. Therefore, the event of a miscarriage distorts the continuation of the pregnancy script, and subjects women to the 'undoing of pregnancy' and an involuntary transition to the embodiment of a miscarriage. The embodiment framework will help explore how women make sense of their bodies and the experiences they have following a miscarriage and how they articulate their experiences based on the bodily, social and medical experiences of a miscarriage.

2.7 Definition of key terms

For the purpose of this research, following terms will be defined;

2.7.1 Miscarriage

Freidenfelds (2016) defines a miscarriage as a loss of pregnancy in the first half of pregnancy and before its viability. The World Health Organization, cited in Stirrat (1990), defines a miscarriage as "the

expulsion or extraction from its mother of an embryo or foetus weighing 500g or less" (p, 673). However, Lowdermilk, Perry and Cashion (2010) define a miscarriage as a natural pregnancy loss that occurs unexpectedly and without a known cause. Therefore, for this study, a miscarriage will be defined as an unexpected loss of pregnancy which happens within the first half of pregnancy before the full development of an embryo.

2.7.2 Health

Health is an essentially contested concept which is, and has always been, a significant value in people's lives. It's many, often conflicting meanings are socially constructed, context-dependent and vary over time. There is little consensus about what health is (Aggleton, 1990). For this thesis, I will explore definitions of health applicable to this study:

2.7.2.1 Health as an ideal state

The World Health Organization (2004) defines health as "the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (p. 28). This is a strong all-inclusive definition which branches off from the perception that health entails the absence of illness, bringing about a constructive, holistic notion of health. This definition is also flawed as it is not possible for one to be entirely healthy, and it fails to consider other dimensions of health such as the sexual, emotional and spiritual health (Sartorius, 2006).

2.7.2.2 Health as a commodity

According to Aggleton (1990), this contemporary idea connotes that health is sold, bought, given or lost. Aggleton (1990) argues that this implication is linked to the rise of modern medicine's claim of the ability to restore the health of the sick. However, this definition alienates health from an individual and has been criticised for comparing health to things that can be gained, subscribed from others as well as sold (Aggleton, 1990).

2.7.2.3 Health as ability / personal strength

This definition of health argues that health is an immeasurable resilience, strength and ability to positively adapt to the inevitable (Bircher & Kuruvilla, 2014). This definition is problematic as the strength and ability to adapt is difficult to achieve and its nature hardly defined (Aggleton, 1990).

2.7.2.4 Lay beliefs about health

Lay theories of health and illness, are individually, culturally and collectively adopted models to explain how to maintain one's health as well as the cause of illness (Kinsley, 1996). Lay concepts also integrate ideas of determining illness severity, suitable illness treatment, and management, as well as concepts informing the interpretation of an illness. Illness lay beliefs vary between socio-economic backgrounds and cultural groups (Helman, 1990). According to Kleinman (1988), lay beliefs locate the cause of illness outside an individual.

Health is a complex concept which is difficult to define with many existing different definitions and understandings. Lay and professional understandings of health may vary but they are both crucial in the development of an understanding of what health is and how it can be explored and maintained. For this research, although not entirely achievable, health will be defined as an all-encompassing state of physical, social, emotional, spiritual, sexual and mental well-being informed by resilience, social class, and cultural ideologies.

2.7.3 Illness

A definition by the World Health Organisation states that an illness refers to, "a person's own perceptions, experience and evaluation of a disease or condition, or how he or she feels. For example, an individual may feel pain, discomfort, weakness, depression or anxiety, but a disease may or may not be present" (WHO, 2004, p. 33). This definition implies that an illness may be present in the absence of disease and is subject to individualised perceptions, experiences and how they make sense of their condition or disease. For the purpose of this thesis, miscarriage as an illness will be defined as the as a distinctive interpretation of one's miscarriage event inclined a varied chain of experiences, feelings, and perceptions.

2.7.3.1 Illness Experience

Illness experience is how people define and adjust to perceived interruptions to their health (Scrambler, 2007). In relation to this research, I will define a miscarriage experience as a way in which women define and navigate through their day-to-day lives following pregnancy loss/miscarriage.

2.7.3.2 Illness narratives

Sick people have stories to tell regarding their illnesses and the impact it had on their lives (Scrambler 2007). Narratives come about in form of everyday stories emanating from dialogues with friends, family and colleagues, written stories, factual or documentary illnesses accounts (Hawkins, 1993 cited

in Scrambler, 2007). These illness narratives are essential in constructing and expressing one's life experiences following an illness. In relation to this study, illness narratives will be defined as the stories that women have to tell following a miscarriage experience.

2.7.4 Social environment

"The social environment includes the groups to which we belong, the neighbourhoods in which we live, the organization of our workplaces, and the policies we create to order our lives" (Yen & Syme, 1999, p. 88). For this thesis, I will define the social environment as the social groups from which the participants belong to and interact with in their day to day interactions.

2.7.5 Medical health care

According to the World Health Organisation, health care refers to "services provided to individuals or communities by health service providers for the purpose of promoting, maintaining, monitoring or restoring health" (2004, p. 28). In study, medical health care will be referred to as the services offered by the medical healthcare institutions in monitoring, promoting, maintaining and restoring health in the event of a miscarriage.

2.7.6 Feminine Identity

To understand what constitutes feminine identity, definitions of identity and femininity will be explored. Deleuze and Guattari, define an identity as "an object or form that we know from the outside and recognize from experience, through science, or by habit," (1987, p. 275 cited in Markula, 2006, p. 31), while Jantzen, Østergaard & Vieira assert that "Identity has two sides: a social side directed towards an external world of shared values and symbols, and an intra-psychological side directed towards an internal world of longings and bodily sensations," (2006, p. 177). The hegemonic heterosexuality context has been the basis of understanding femininity, with the dominant perception of appropriate femininity as 'being a mother' which has been normalised in different contexts. Laurie et al., argue that "these normalising processes often result in sanctions for those women or men who are deemed to be exhibiting 'deviant' or 'inappropriate' femininities …," (2014, p. 4). It is pivotal to point out the role of class, race, sex and context in the formation of feminine identities as argued that "femininities are also classed, racialised, sexualised, as well as being geographically and historically specific," (Laurie et al., 2014, p. 4). Drawing from these definitions of femininity and identity, for this research, the feminine identity will be defined as a perception of self, emanating from identifying with

being female through the learning and experience of shared values, the normalisation of motherhood, and the interplay of class, race, and context into what constitutes womanhood.

2.8 Conclusion

Literature shows that miscarriages are a widespread phenomenon not only affecting women who experience them but also extending to other people such as their spouses, partners, families, and friends. However, the literature reviewed touches on how miscarriages are always centered on women, and in most instances lacking the positionality of men in the miscarriage events, leaving a wide gap in the literature which should be explored but will be considered for future research studies due to the limitations of this study which is limited to women's experiences of miscarriage and how the construction of these experiences is influenced by the medical health care received and the social environment. This study has described the various implications of the miscarriage event and the nuances of the miscarriage journey such as the celebration of a validated pregnancy, the possible causes of a miscarriages, the emerging issues following a miscarriage such as emotional experience of a miscarriage, social support systems, medical care, coping mechanisms in dealing with the loss, identity formation as well as the cultural processes informing an understanding of the miscarriage event. This study is grounded on the feminist, the interactionist and the embodiment theoretical foundations. The next chapter describes the methodological approach, tools, sample, and ethical considerations as they relate to this study.

CHAPTER 3: METHODOLOGY

3.1 Introduction

Marshall (1996) asserts that qualitative studies are aimed at providing an understanding of complex psychosocial issues and are instrumental in answering the 'how?' and the 'why?' questions. Taking the nature of this study into consideration, this research utilized the qualitative methodology and employed a narrative inquiry method of study. Due to the sensitiveness of the area of study and the limited time frames of the study, the snowballing sampling technique has been utilised. In-depth interviews were the research technique employed in this research to grasp women's stories of their miscarriage experiences to deduct the role played by their social interactions and the quality of medical care received in shaping their miscarriage experiences. To garner insights into the standard procedures influencing practice and service delivery to women who have experienced miscarriages, in-depth interviews were conducted with the health care professionals who have worked and are still working in the maternal health care sector

3.2 Justification of the methodology and the paradigm

This study has made use of a qualitative approach and specifically the narrative inquiry, with an emphasis on the impacts of the personal, the social and the medical on the construction of illness experiences following a miscarriage. This approach will counterbalance some of the shortcomings of miscarriage studies, as Rowlands & Lee (2010) assert that most miscarriage studies have concentrated merely on the individuals but failed to undertake a thorough social analysis.

3.2.1 Narrative Inquiry

Georgakopoulou (2006) defines the narrative research as a diverse and a rich enterprise comprising of autobiographies, such as single past events and personal non-shared experiences. This study is based on narratives of women's miscarriage experiences. Narratives are stories covering women's personal experiences of miscarriage aimed at informing various learnings that can be taken into practice or influence practice. Exploring the narratives of women who have experienced miscarriages is significant for this study as it enables us to gain an understanding on the role played by the social, the cultural and the medical health care received in meaning-making following a miscarriage. While miscarriage experiences vary and not always involve trauma, there is a possibility that this may be the case, hence the importance of selecting a narrative inquiry as a method. According to Sturrock and Louw (2013), narratives are therapeutic for trauma recovery as they consist of the life experience 're-

storying', hence incorporating the traumatic event into the narrative, and restoring a sense of meaning and identity. This is pivotal for my study which aims at breaking the silence around miscarriage experiences among women and encourage women to talk about their experiences, hence shading light on the role of the social, the cultural and the medical health care interactions in shaping miscarriage experiences.

3.2.2. Snowball Sampling

Due to the sensitivity of the study topic, I employed snowball sampling and contacted women I knew had experienced miscarriages and shown interest in my study. This was the most effective sampling technique for this research. The snowballing sampling technique has been broadly used in sociological qualitative research (Biernacki & Waldorf, 1981). Kaplan et al. (1987) assert that the snowball sampling technique, which is based on recommendation chains and insider knowledge, is ideal for sensitive topics. As pointed out by Heckathorn (2011) that the snowballing technique is convenient for the study of populations that are not easily accessible, women who have experienced miscarriage are not an easily accessible population, hence the use of the referral system. This study seeks to explore the miscarriage experiences of women from different racial and cultural backgrounds, hence providing a well-grounded analysis of miscarriage experiences.

A sample of 10 women aged between 19 and 49 who have experienced miscarriages has been used for this study as shown in Table 1. The snowballing sampling techniques helped recruit about 15 women and the basis of the study as being voluntary participation, I only secured interviews with ten women. Five women could not be interviewed as they had not fully dealt with the loss and were not ready to talk about their experiences. The snowballing sampling technique has been further used to identify a sample of 3 medical health care professionals who have worked with women who have experienced miscarriages, as shown in Table 2. Participants' real names will not be used for this study and have been substituted with pseudonyms to fully anonymise the participants.

Table 1. Women who have experienced miscarriages (Group A)

Participant name	Age	Marital Status	Race	Occupation	Miscarriages Experienced	Years since last miscarriage experience
1.Rasheena Naidoo	49	Married	Indian	Teacher	2	7 years
2.Royalty Mkhwanazi	28	Single	African	Intern	1	2 years
3.Andiswa Mbatha	25	Cohabiting	African	Unemployed	1	7 months
4.Beauty Mahlangu	24	Single	African	Domestic Worker	1	3 years
5Menyiwe Msipha	27	Single	African	Student	1	1 year
6.Tricia Brown	31	Single	Coloured	Cleaner	2	1 year
7.Lungelo Phakathi	30	Married	African	Unemployed	2	2 years
8.Khanyi Molape	35	Single	African	Manager	6	1 year
9.Omphile Moloi	32	Cohabiting	African	Retail worker	1	6 years
10.Nolly Dube	38	Married	African	Business woman	1	8 years

Table 2. Medical Health Care Professionals (Group B)

Participant Number and Name	Age	Race	Years Of service	Status
Mrs Sekgoto	62	African	29	Retired Professional Nurse
Ntombi Mohlapa	59	African	37	Professional Nurse
Mrs Khumalo	35	African	6	Professional Nurse

3.2.3 In-depth interviews

Also referred to as unstructured interviews, in-depth interviews in qualitative research are one of the key data collection techniques (Legard, Keegan & Ward, 2003; Coombes, Humphrey & Neale, 2009), and are often considered as having a conversation form (Lofland & Lofland, 1995 cited in Legard et al., 2003). Coombes et al. (2009) assert that in-depth interviews are useful for sensitive topics and the informal structure of the interviews paves a way for relationship building between the participant and the researcher. This is useful for this study as the study seeks to probe into women's personal accounts of miscarriage and since this is a sensitive topic to discuss, in-depth interviews will be instrumental as they are meant to resemble day to day conversations.

The conversation structure of in-depth interviews will enable women to open up and be comfortable to share their experiences. By utilizing in-depth interviews this research sought to explore how women construct their illness experiences and how these miscarriage events are articulated by their feminine identities. This is supported by an assertion that in-depth interview, "reproduces a fundamental process through which knowledge about the social world is constructed in normal human interaction" (Rorty, 1980 cited in Legard et al., 2003, p. 138). However, despite the realistic form of in-depth interviews, their similitude to everyday conversations remains limited, (Legard et al., 2003). Coombes et al. (2009), Legard et al. (2003) point out to the combination of structure and flexibility as one of the key features in in-depth interviews and further argue that in an in-depth interview, the interviewer is guided by the themes they anticipate covering and responds to the issue raised spontaneously by the participants. This assertion speaks to this study as the interview questions were guided by themes of

the study in a flexible manner that accommodated the fluidity of the conversation and issues that participants raised.

I conducted interviews for this study in English except for one case where the interview was conducted in Zulu, transcribed in Zulu and interpreted to English. I did the interpretation as I am fluent in both languages. I will thus use the translated version for this study. Research interview questions have been tailored to guide women's illness narratives in such a way that they touch on their social and medical health care interactions following a miscarriage and these will be useful in deducing the role of the social, cultural and the medical care in shaping miscarriage experiences.

3.3 Interview stages

As noted by Legard et al. (2003) in-depth interviews consist of various stages and the researcher must usher the participants through these stages and ensure to complete all the stages before partying ways with the participant. In-depth interview stages include the arrival, introducing the research, beginning the interview, during the interview, ending the interview, and after the interview stages (Legard et al., 2003). I will discuss these stages below;

3.3.1 Arrival

Legard et al. (2003) assert that as soon as the researcher steps into the doorstep of the participant, marks the beginning of an interview and while keeping the guest status the researcher must use this time to develop a relationship with the participant and to prepare the participant for the interview. This applied to this study, although the interviews were not limited to participants' residences, but places of convenience preferred by participants such as quiet coffee shops, restaurants, workplaces, and two participants preferred that we conduct interviews telephonically which had to be respected as the participant safety and preferences were among the guiding principles of the study. Upon meeting with the participants or upon starting a telephonic conversation, ice-breaking conversations were utilised, such as general compliments on their dressing or make-up, general talk about the weather, news or sitting together and deciding what we can eat while chatting or while ordering a cup of coffee. All this was crucial in building a relationship with the participants and preparing them for an interview. Since this study probes into the personal and sensitive issue that could raise emotions, Interviews started shortly after ensuring the participants were at ease and well prepared for the interview.

3.3.2 Research Introduction

Legard et al. (2003) assert that only when the participant is ready for the interview the researcher may go ahead introducing the research to the participant, clearly stating the research topic, the research nature, and purpose and addressing the confidentiality issues. I followed this procedure in this research as stated above. I prepared participants for the research through ice-breaking conversations and only starting the interview process when the participants were at ease and seemed ready for the interview. All the participants for face to face interviews were handed the information sheet which detailed the research question, objectives of the study, the guiding principles of the study such as complete anonymity and the voluntary participation of the study, the free counselling services that women can use whenever the need arises due to the possibilities of the study to raise emotional reactions in cases of traumatic and painful experiences. Upon agreeing to go ahead with the interview, I handed the consent form to participants to sign consenting to either the interview or the tape recorder use or both. All the questions that participants had concerning the research were fully answered before the commencement of the research. For instance, some participants were concerned with the ability of the research to fully anonymise them. As a result, participants were assured that no personal information tracing their identities will be used, thus pseudonyms to be used in place of their names, healthcare institutions attended and healthcare institutions that health care professionals work (ed) in.

3.3.3 Beginning the interview

According to Legard et al. (2003) it is essential to start the interview by asking the factual background information such the participant's age, occupation, marital status, and so on to get the participants acquainted with their role to open-up and respond in full, as asking about these in the middle of the interview might disturb the flow of the interview conversation. This process applied to this study, all the interviews with women who have experienced miscarriages and the health care professionals started with a question asking for a brief introduction. This included their age, marital status, occupation, years of service, number of children they had, but women were not limited to the listed factual information given at hand and were given liberty to go on and on about the information they deemed interesting for me as a researcher to know. By doing so, I would say women were at ease to open up about their personal spaces and that enabled them to talk about their miscarriage experiences.

3.3.4 During the interview

As the interview proceeds, the researcher shapes the interview and guides the participants through the main interview structure guided by the themes of the study and engaging follow-up questions and enquiries on the issues raises by the participants to gain a deeper understanding of the participants' feelings, thoughts, and ideas, (Legard et al., 2003). For this study, this applied as I guided the participants throughout the interview process and utilized the follow-up questions to gain deeper understandings on the issues raised by participants. Follow-up questions were individually crafted and influenced by participants' narratives.

3.3.5 Ending the interview

Legard et al. (2003) point out that the researcher must hint the end of the interview just towards the end of the interview to the participants, to allow participants to come back to a day to day social interaction level and the researcher has to pay attention to unresolved feelings, emotions, and issues that participants might still struggle to deal with. For this study, the interview process was difficult to round off due to unresolved issues, feelings and emotions that participants still experienced. For instance, some participants were still in pain and struggling to cope with the loss. This was evident in fidgeting, shaking movements, changing of voice tones / trembling voices. Some participants' voices would crack signalling an emotional breakdown, while some participant would actually break down when recalling and describing their experiences. In such instances, participants were offered words of comfort and as a researcher, such encounters compelled me to share my experiences of a miscarriage. My experiences in relation to other women's narratives helped in shaping a common ground, offering grounds of genuine empathy and fostering a healing processes. I encouraged participants to make use of the recommended counselling services whenever they felt a need to do so.

3.3.6 After the interview

Legard et al. (2003) stipulate the relevance of what happens once the interview ends, and the tape recorder is switched off. The researcher is advised to politely thank the participants, help them navigate back from the interview atmosphere to a more relaxed social mode by highlighting on how their contribution is crucial for the research, re-assure them on confidentiality, shift from the research to a more general conversation and make sure participants feels well after the interview, (Legard et al., 2003). In this study, after the conclusion of the interviews, participants were cordially acknowledged for their contribution and reassured that the contents of the interview will be handled with complete confidentiality and their identities entirely anonymous. To end the interviews, I

gradually made a shift from the interviews to more general conversations and I made sure participants were in a good space before I could leave.

3.4 Research procedures

For this research, the following procedures were adhered to;

3.4.1 Data Collection

Data collection begun after the approval of the study and the issuing of ethics clearance by the ethics committee of the University of Witwatersrand. As stated above, in-depth interviews were the data collection tool for this study. The data collection journey hasn't been an easy one for this project. Since this project seeks to document the miscarriage experiences of women, it is crucial to note that these are vulnerable subjects and their readiness for the interview sessions imperative for the success of this study.

Due to the sensitivity of this study and ethical considerations on anonymising the respondents, I sought verbal consent from participants before interviews and before digital tape recorder use. Interview guiding questions along with follow-up questions were used for clarifications and precision on narratives. The recorded data was transcribed before data analysis.

All interviews were conducted in spaces of convenience to participants. I gave participants liberty to choose interview venues convenient to them, where they will be comfortable, relaxed and be able to openly talk about their experiences. As a result interviews took place in participants' homes, workplaces, my house, the park, and eateries. English language was used in most interviews except in one case where the participant preferred to be interviewed in IsiZulu. Due to the sensitivity of the study, I kept interviews short (about 30 minutes) but due to the conversation nature of interviews, a few interviews lasted a bit longer (approximately 60 minutes).

3.4.2 Data processing

I transcribed all the recorded data. An interview conducted in IsiZulu was transcribed in IsiZulu, translated to English and the English translated version of the Interview used for this study. The transcribed data was manually coded into themes and the thematic analysis used as an analysis tool of this study.

3.4.3 Data Analysis

Narrative analysis has been utilised in accordance with the themes and objectives of this study. This is useful for my research as stipulated by Sturrock and Louw (2013) that the narrative analysis preserves the form and the context of individual stories, hence maintaining the perspective of the narrator. As stated in chapter 2, the feminist, interactionist and the embodiment frameworks were used in the data analysis process as the main lenses through which this research will operate on. Transcripts from interview sessions were studied and analysed using the thematic analysis approach through a coding process aimed at "examining narrative materials from life stories by breaking the text into relatively small units of content and submitting them to descriptive treatment" (Sparker 2005, cited in Vaismoradi et al., 2013, p. 400). In accordance with the objectives of the study, crucial sections were selected from the transcripts and themes were generated through pinpointing the frequently used phrases and words. I then organized data into themes from which the conclusions were drawn. Data analysis was done by the researcher with no external help. To anonymise research participants and the health care institutions attended, pseudonyms are used in place of actual names.

3.4. 4 Ethical considerations

De Vaus (2001) asserts that when conducting a research ethical issues must be taken into consideration and points out ethical problems that researchers are likely to be confronted with, which may include issues of deception surrounding the identity of a researcher which may threaten the internal validity of the study. My identity as an academic researcher was explicitly articulated to the participants. Apart from being an academic researcher, this study is closer to home as it touches on my personal experiences. Having experienced a traumatic miscarriage experience myself, I opened-up to my participants for them to understand my positionality in the study as a student academic researcher who has been through a miscarriage experience although my experiences will not be deliberated in this study.

The other issue of ethical concern pointed out by de Vaus (2001) and applicable for this study is confidentiality. Confidentiality has been of optimum importance for this study. To ensure the complete anonymity and to protect the respondents', I have used pseudonyms in place of respondent's real names. I will keep names of health care facilities attended confidential as well since this study only seeks to understand the role of health care received in the construction of miscarriage experiences and is not a medical institution-based study.

Due to the sensitivity of the study and its possibilities to trigger negative emotions due to the trauma experienced following the miscarriage event, this study did not bind respondents to compulsory

participation. This study has been based on continued informed consent and voluntary participation. Participants were advised to withdraw from the study with no explanation whenever they wished to do so. Free counselling services were recommended to the participants in case a need arises at any point or on the aftermath of the study.

3.4.5 Post research.

According to Janesick (2000), after the completion of research studies, the cooling down process allows one to analyse and record their findings, and this is achieved through maintaining contacts and a continued interaction with participants. I have achieved this process through the continued interaction with the study participants although certain boundaries still apply. Cooling down also comprises prolonged farewells while helping participants until the relationships end (Janesick, 2000). This has applied to this study. I have maintained contact with my participants for continued emotional support. The study might have ended but contact will be maintained and free counselling services recommended to women in need.

3.5 Conclusion

This research is a qualitative research based on a narrative inquiry. This research seeks to explore women's miscarriage experiences, and the role played by the medical health care received and the social environment in shaping their miscarriage experiences. For this research I interviewed 10 women who have experienced miscarriages. I also interviewed three medical health care professionals who have served women who have experienced miscarriages in the maternal health care sector for their expert knowledge on the standard procedures in dealing with miscarriages in medical healthcare settings. For this study, I used the snowballing sampling technique which is the most effective technique for sensitive topics and for participants who are challenging to locate. In-depth interviews were the useful tool for this study due to their semi-structured and flexible form, resembling to day-to-day conversations. The interviews were voluntarily based and confidentiality guaranteed. The recorded interviews were transcribed, and the interview conducted in Zulu was transcribed in Zulu and translated to English. The transcribed data was coded according to themes. Thematic analysis was used for data analysis. I will discuss the research results and the analysis in the next chapter.

CHAPTER 4: FINDINGS AND DISCUSSION

4.1 Introduction

This chapter will present the findings of the study according to the themes of the study. Participants will be described in detail, findings on women's miscarriage experiences will be presented in accordance to the themes of the study, and the expert knowledge of the medical health care professionals will be used to either justify, confirm or validate issues that women presented regarding their experiences in the medical healthcare institutions.

4.2 Participants

Participant details will be outlined and presented. Participants will be fully described. This study consists of thirteen participants all of which are female participants. Of the thirteen participants, ten are women who have experienced miscarriages and three are the healthcare professionals. Of the ten women who have experienced miscarriages, one is an Indian South African woman, one is a Coloured South African woman and eight are Black South African women. All three healthcare professionals are Black South African women. I identified these women through a snowballing sampling technique and they are women outside my inner circle of friends and relatives.

4.2.1 Outline of Participants

This study explored two respective groups as illustrated in Table 1 and 2 in chapter 3. Group A comprises 10 women who have experienced miscarriages at any point in their childbearing journeys. Group B participants are health care professionals who have worked and some still working in the maternal health care sector in close contact with women who have experienced miscarriages.

4.2.2 Participant Overview

Table 3 below presents a summary of Group A participants. In this research, I aim to uncover the miscarriage experiences of South African women between the ages of 19 to 49. I have allocated numbers to each participant for distinct identification purposes.

Table 3: Group A Participant Overview

Age	24-49 years
Average participants age	31.9 years
Relationship status	
Married	3 participants (p1, p7, p10)
Single and dating	3 participants (p2, p5, p6)
Single and not dating	2 participants (p4, p8)
Cohabiting	2 participants (p3, p9)
Employment status	
Full time	4 participants (p1, p4, p8, p9)
Part time	3 participants (p2, p5, p6)
Student	3 participants (p1, p2, p5)
Self Employed	1 participant (p10)
Unemployed	2 participants (p3, p7)

P, stands for study participant

4.2.3 Participant description

Table 4 presents a summary description of Group A participants. Participants will be described and a glimpse into their experiences unfolded. Due to the sensitivity of the study and the ethical consideration of completely anonymising the participants, real names are not used for this study, hence the use of pseudonyms.

Table 4. A Summary of Women Who Experienced Miscarriage

Participant 1. Rasheena Naidoo A teacher by profession. Indian. Married. Aged 49. Has two children. Experienced 2 miscarriages at ages 33 and 42. Attended private hospitals
Participant 2. Royalty Mkhwanazi Aged 28. An Intern. African. Single and dating. Has no children. Experiences a miscarriage at the age of 25. Sought medical health care at a Public hospital.
Participant 3. Andiswa Mbatha Aged 25. Unemployed. African. Cohabiting with boyfriend. Has no children. Experienced a miscarriage at age 24. Got treatment at a private hospital.
Participant 4. Beauty Mahlangu Aged 24. African. Domestic Worker. Single and not dating. Has no children. Experienced miscarriage at age 21. Got medical treatment at a public hospital.
Participant 5 Menyiwe Msipha Aged 27. African. Student. Single and Dating. Has no children. Experienced a miscarriage at age 26. Got medical treatment from a General Practitioner.
Participant 6. Tricia Brown Aged 31. Coloured. Cleaner. Single and Dating. Has one child. Experienced two miscarriages at ages 24 and 30. Got treatment at a public Hospital.
Participant 7. Lungelo Phakathi Aged 30. African. Unemployed House Wife. Has one child. Experienced two miscarriages at ages 27 and 28. Sought medical treatment at a public hospital.
Participant 8. Khanyi Molape Aged 35. African. Manager. Single and not dating. Has no children. Experienced 6 Miscarriages at ages 21, 22, 24, 29, 31 and 33. Has received treatment from both the private and public hospitals.
Participant 9. Omphile Moloi Aged 32. African. Retail worker. Has no children. Experienced miscarriage at age 26. Single and dating. Received treatment at a public hospital.
Participant 10. Nolly Dube Aged 38. African. Business Woman. Married. Has two children. Experienced miscarriage at age 30. Received treatment at a private hospital.

Participant 1. Rasheena Naidoo

I met with Rasheena for the interview over a cup of coffee. I was happy to finally meet with her as she had travelled for holidays and her contribution to this study was of optimum importance. She was friendly, cheerful and bubbly, that made it a lot easier to connect with her. When I met Rasheena by the coffee shop, I thought she would grab a cup of coffee and we will then go somewhere more quiet and secluded considering the sensitivity of the area of study, but she asked to see the participant information sheet which I handed over to her along with the consent form for her to sign if she wished to go ahead with the interview. Her open-mindedness and warm heart put me at ease and I was sure she was ready and prepared for the interview.

Rasheena Naidoo is a woman of Indian descent aged 49 and is a teacher by profession. She is married and has two beautiful children. She experienced two miscarriages at ages 33 and 42. Her family is in Durban. She married her husband when she was 29 and they lived in Durban for the first two years. She moved to Johannesburg about 17 years ago when her first daughter was born. After marrying her husband, he got a job in Johannesburg and she stayed in Durban for a while because she was teaching there. A year after her husband moved to Johannesburg, he still couldn't get a job in Durban and it didn't look promising and then she moved to Johannesburg with him. On the entire duration of her first pregnancy and the first year of her first daughter's life, they were apart. She mentions that;

> *"I stayed in Durban and he stayed here, I didn't want to lose my job and he didn't wanna lose his job, so we moved between two cities and then we got here. So, then I taught for a long while and then I then I went into consulting and then I wanted to spend more time with my kids and I started thinking that I wanna have a second child. I was actually still teaching but I was playing with the idea that if I have another child I'm not gonna manage a full-time job. Yeah thus me."*

In describing her miscarriage experiences, Rasheena revealed that she had experienced two miscarriages. She experienced the first miscarriage at age 33 while trying for the second child. Rasheena reports that a week leading to the miscarriage event, she didn't feel like she was pregnant anymore as all the signs of pregnancy had vanished. When she experienced bleeding thus when she went to the hospital where the gynaecologist confirmed that she had a miscarriage and that the foetus heartbeat had probably stopped a few days ago. The miscarriage experience was a traumatic and a painful one for Rasheena, and she reports having been hysterical and crying out loud without stopping for the entire time she was at the hospital. Rasheena immediately tried for another baby soon after

experiencing the miscarriage, she had a successful pregnancy and she gave birth to a healthy baby girl. However, Rasheena recalled being warned about trying for another baby soon after the miscarriage but she never adhered to the warning. She reports being quite depressed as she had given herself time to grieve and had not fully dealt with her the loss. However, she found comfort in her family, her faith and her yoga practices.

At 42, Rasheena tried again for the third child as her children wanted an additional sibling and she wanted to build her family. Rasheena mentions going to the Buddhist temple earlier on the day with a friend and she remembers feeling that something was not right, and she told her friend about it. Later that evening, she started bleeding, she rushed to the hospital where the miscarriage was confirmed. She mentions having feelings of anger and depression, hence consented to ligation during the Dilation and Curettage process (D & C) aimed at removing the contents of conception from the uterus (Nakao et al., 2008). The gynaecologist performed the ligation which she later regretted and is still angry about. She took the life-changing decision while at the lowest point of her life; this still hurts her, and she mentions that she will never forgive the gynaecologist who later offered to reverse the ligation process. However, she chose not to go through the process again although her children wanted and still want a sibling up to date. As a part of coping and dealing with the loss, she later volunteered at a children's home to assess her adoption options but decided that she no longer wanted a child as she was looking forward to pursuing her studies.

While narrating her experiences, I could pick up the pain she went through from the tone of her voice and facial expressions. This made me realise that I was not as strong as I thought I will be, hearing Rasheena's narration of events surrounding her miscarriage experiences aroused my emotions, I felt her pain and had to hold my tears throughout the interview process. It has been seven years since Rasheena's last miscarriage experience, but she could remember all the dates and times off heart. Despite what she had gone through, Rasheena's strength is visible in her emotional experiences, impromptu choices made due to pain, anger and frustration, the support system she had and her ability to pick up the pieces and move on.

Participant 2. Royalty Mkhwanazi.

Royalty Mkhwanazi is a 28-year-old Ndebele woman who is working for a media company as an Intern. She is also pursuing part-time studies in Media and Communications at one of the tertiary institutions in Pretoria, but she stays in Johannesburg. Royalty preferred we meet up by her workplace in

Bryanston during her lunch hour. I took a taxi there, and I arrived early. I waited for her by the reception and kept myself busy browsing through a few magazines. When she finally arrived, she took me to the lawn garden at the back of their office which was quiet and peaceful. Since she had limited time, we had to get along with the interview. She was 25 years old when she experienced the miscarriage and in a complicated relationship by the time as she dated two men at the same time. The second man knew about her relationship with the first man and he had no problem with it, but the first man never knew about her ongoing relationship with the second. According to her, she cheated on her boyfriend because he was also cheating on her. Royalty had visited her sister who stays in another province when she discovered about her pregnancy. She kept it to herself as she wanted to first sort out the paternity dilemma she was faced with. She narrates her story as follows;

> *I received the news with mixed feelings, the other part of me was disappointed because I was involved with two guys and one had to be the father and I was confused on who to break the news to and what do I say to the other. Then I decided to instantly call my then best friend who was also heavily pregnant at the time. Upon hearing that I was pregnant, the first thing she said to me was, 'congrats my friend.' That statement instantly changed my attitude, I never cared about anything more or the paternity of the baby, what mattered was that I was carrying a soul inside of me, my child! I was going to be a mother. The feeling and the thought of it all was priceless*

When she finally made peace with her pregnancy despite the depression she had gone through regarding the paternity dilemma she faced, Royalty reported always feeling bloated and having extreme cramps. One morning she woke up bleeding, she went to the clinic where the miscarriage was confirmed, and was referred to the hospital as her condition was deteriorating. Royalty narrates her ordeal at the hospital when she got admitted to the maternity ward with women who had given birth, holding their babies and frequently asking where her baby was. She had to explain that she had lost the baby. Dealing with the loss while seeing other women holding their healthy babies was the most painful experience for Royalty. She narrates that although she had a hard time accepting the pregnancy; she had accepted and bonded with her baby when the miscarriage happened, hence the paternity dilemma couldn't outweigh the pain, the trauma and the suffering she went through during the miscarriage event. She pointed out having experienced extreme depression after the miscarriage event and at some point, she thought she was mentally disturbed. She mentions having developed

extreme anger and broke up relationships with both boyfriends. She narrates how she struggled to accept the loss. She couldn't stand the sight of babies and even stopped going to church. Royalty is still struggling to deal with the loss. She received no counselling from the hospital after her experience. She was denied her contraception options, because according to the nurse 'she was too young', 'not married', and to not have sex. She never informed her family about the miscarriage since she comes from a Christian home in fear of being criticised for not living to the expectations of Christian values. She suffered in silence and only found solace in her sister and a few of her closes friends.

Participant 3. Andiswa Mbatha

Andiswa Mbatha is a Zulu woman aged 25. She is unemployed and cohabiting with her 50-year-old white boyfriend. Andiswa experienced a miscarriage at the age of 24 and got treatment at a private hospital. The Interview was conducted five months after the miscarriage occurred. Memories were still fresh for Andiswa and she was struggling to cope and had not fully dealt with the loss. Initially, Andiswa had preferred that I talk to her boyfriend as she couldn't bear talking about the miscarriage. The interview was to be conducted in their flat and that meant Andiswa will be around somewhere in the house while I spoke to her boyfriend about the miscarriage. I spoke to her boyfriend who was also still hurt and emotional. When I started the interview, I told him about my experience so he understands that miscarriages are common experiences for women and that I closely relate to their experience. Two days after the interview with Andiswa's boyfriend, Andiswa informed me that she was ready for the interview and that she had gathered strength from eavesdropping hearing me talk about my experience made her realise she needed someone to talk to, someone who had experienced what she went through. She was still emotional throughout the interview. Andiswa was 3 months pregnant when she experienced the miscarriage, she narrates her story as follows;

> *It was bad! … One morning wake up crying, I'm having pain, ran to the bathroom, blood! Run to the hospital, hospital say no miscarriage, baby is out. At the hospital they done whatever they can do, clean, whatever. Came back, cry cry for about a month everyday crying. I couldn't stop crying.*

Andiswa was treated at the hospital and was discharged on the same day. Her boyfriend was with her all the time. She received no counselling at the hospital, and she couldn't cope with the loss. Her boyfriend booked private counselling sessions for her at a medical tower close to their house, and that

helped her a lot. She got herself a teddy bear which she held all day and would feel better. Her boyfriend insisted on trying for another baby right away but she resented any sexual activity with him. She puts this into perspective in following sentiments;

> *Sex died between us because every time we think we gonna try for a baby it comes back to my mind, 'I'm gonna lose it again' and many times I'm emotional, especial on the date like December now because in December the baby should have been born. I'm emotional, I cry, I don't enjoy anything.*

Andiswa explained how the miscarriage is linked to her family's cultural practices. She said this regarding her grandmother's response when she informed her about the miscarriage. Her grandmother confessed to having performed a traditional ritual on her to prevent Andiswa from carrying a successful pregnancy before marriage. That called for a traditional cleansing ceremony that is scheduled for April.

Participant 4. Beauty Mahlangu

Beauty is a 24-year-old Zulu young woman who experienced a miscarriage at the age of 21. She is single and has not dated since the miscarriage experience. Beauty is a domestic worker, she stays in her employer's house and only gets a few off days a month. Meeting up with Beauty given her work conditions proved to be a challenge and she opted for a telephonic interview instead. Beauty scheduled the interview for 6 O'clock in the evening, mentioning that it would be after work and she will be in her room by that time. I had to send her the participant information sheet beforehand, so she familiarises with the research and get to decide if she wants to continue with the interview. When I called her, she was happy to be part of the study and suggested we proceed with the interview right away. She also consented to the use of the tape recorder. Beauty preferred that we conduct the interview in IsiZulu as she would express herself better in IsiZulu than in English.

Beauty was working at a restaurant in Centurion when she experienced a miscarriage. She wasn't aware of the pregnancy due to irregular menstrual cycles. She realised something was amiss when she experienced abdominal pains which were much more severe than period pains. The following day when she got to work, she bled profusely. She narrates her experience as follows;

I was bleeding heavily. I said ok its fine, I told one of the lady waiters at work that I did not feel well, and I could not stand up straight, and I kept on banding over. At that time, I was cleaning, and a watery substance gashed out. I saw it and said no! And then? I called this lady waiter into the bathroom and she said 'yoh!' … the lady went out of the bathroom door screaming and told me I have had a miscarriage and I did not know I was pregnant. They called an ambulance and took me to the hospital.

Beauty narrates how the nurses at the hospital forced her to see the feotal remains even though she had declined to do so. This experience had traumatized her and is still haunting her to date. Beauty received trauma counselling from the social workers at the hospital and she found support from her family and colleagues. She broke up with her boyfriend after the miscarriage as he kept on blaming her for the miscarriage.

Participant 5. Menyiwe Msipha

Menyiwe is a Ndebele woman aged 27. She is a student and has a part-time job as a promoter. Menyiwe is single and in a relationship. She experienced a miscarriage when she was 26 years old. Menyiwe preferred coming to my house for the interview as she was sharing an apartment with friends and was not comfortable discussing the miscarriage in a space where someone might walk in or eavesdrop on the conversation we might be having. She came to my place; I had to make sure she was comfortable and relaxed for the interview; we had a little chat and played music while I prepared food for her. We sat down, had lunch while she browsed through the participant information sheet. She was open, visibly less emotional compared to other participants.

She narrated that she was not ready for the pregnancy and she had hinted to her boyfriend that she was not yet ready to be a mother. Menyiwe mentions that the miscarriage happened before she could weigh her options about keeping the pregnancy. She was undecided and the chances of her keeping the pregnancy were slimmer. Menyiwe was only three weeks pregnant when she experienced a miscarriage. She consulted a general practitioner but could not go through with the surgical cleaning of the womb as she preferred the body's natural way of cleaning itself and her family supported her decision. She, however, got a few prescriptions from the doctor to help her through the process. She mentions having a hard time convincing her partner and her sister that she had suffered a miscarriage.

This was because she didn't celebrate the pregnancy and had hinted about her openness to terminate the pregnancy. However, she eventually got the support from her boyfriend and they are still together.

Participant 6. Tricia Brown

Tricia is a Coloured woman aged 31. She works for an agency as a cleaner. She is single and in a relationship. Tricia is an open-spirited person, and she preferred we go to the park for our interview. We arranged and met by the park on a weekend. An interview with Tricia was both emotional and hilarious. She is naturally a fun person to be around and likes joking around. Her attitude made the interview process interesting and the fun stories she had to tell overshadowed all the emotional expressions. Tricia experienced two miscarriages at ages 20 and 30. She is a domestic violence survivor, her two miscarriages from different relationships happened after physical violence. Tricia had her first child when she was 14 years old. She and her boyfriend tried for another baby, she fell pregnant; they were all happy and looked forward to the second baby. However, on her 6th week of pregnancy Tricia's boyfriend came home in the morning after a night out drinking and when she confronted him, he attacked her with almost everything he could lay his hands on. Tricia then went to her sister's house where she took a nap but started bleeding shortly after. Her sister called an ambulance, she was rushed to the hospital where the miscarriage was confirmed. She moved out of her boyfriend's house, took her child to her mom and rented a room close to her sister's complex. She got involved with another man, but she couldn't conceive for about 7 years following the miscarriage event. Unfortunately for Tricia, the cycle of violence continued with her new boyfriend. She fell pregnant again, but neither was she nor her boyfriend aware of the pregnancy until he physically assaulted her and bleeding happened shortly after. She was rushed to the hospital again, and a miscarriage was confirmed to have taken place. Although her boyfriend showed remorse after the incident, Tricia moved on from the relationship and is now in a relationship with someone else. Tricia received support from her family and friends.

Participant 7. Lungelo Phakathi

Lungelo is a Zulu woman aged 30. She is an unemployed housewife to a Zulu man with whom she shares one child. Lungelo experienced two miscarriages at ages 27 and 28. Lungelo is originally from Kwa-Zulu Natal but she lives in Johannesburg with her husband. For the interview Lungelo preferred we meet up at an upmarket restaurant in Johannesburg town as she needed some time out of the house. She chose her favourite spot, and I was happy because she was familiar with the place and that helped in easing and preparing her for the interview. We ordered some food and while waiting for the

order I took her through the participant information sheet and she was happy to be part of the study. She mentioned a need for a change in the treatment of women in the hospitals and for miscarriages to be prioritised such that women find solutions. Having experienced two consecutive miscarriages, she states that all her experiences were painful, she was looking forward to expanding her family, and at least bear an heir to carry on the family name. Lungelo and her husband are Christians, but she comes from a traditional family that believes in consulting traditional healers and having cleansing ceremonies to appease the ancestral spirits whenever something unpleasant happens. Lungelo finds herself caught in between as she tries to detach herself from her family's ways of doing things contrary to her Christian beliefs. Lungelo and Royalty were at the same hospital and had a similar experience of being placed in the same wards as women who had given birth. Lungelo narrates her stories as follows;

> *When I arrived there to my surprise there were women holding their new born babies on the same ward that I was placed in. it wasn't just me but a couple of women who had experienced miscarriages. I was given a bed, nurses came to check on the files, give pain killers and continue with the examinations. I was a bit worried as we were with women who had just given birth. That particular arrangement was too hard for me but there was nothing I could do about it, I had to be strong…*

Participant 8. Khanyi Molape

Khanyi is a Sotho woman aged 35. She is a manager at a financial institution. She is single and is not dating. Khanyi doesn't have a child and has experienced 6 miscarriages at ages 21, 22, 24, 29, 31 and 33. As busy as she is Khanyi is a fun-loving woman, bubbly and sociable. I had a hard time securing an interview with her as she was not keen on talking about her experiences. I had to ask the person who referred me to her to put in a good word for me and I had to give her a participant information sheet beforehand to familiarize her with the research. She finally agreed to meet although she kept on postponing the interview citing a busy schedule. She preferred that I come to her house on a weekend. Upon arrival, Khanyi gave me a warm welcome to her home, and kept on and on about her job demands and how she was single as a result but could still go out for drinks with friends. The conversation got heated, and I felt as if I had known her for some time before our meeting. Her social skills were impressive, and I learnt a lot about her from the pep talk we had. Khanyi narrates that she has everything, she has money; she has a good job; she has a big house; she has a nice car, but all that meant nothing to her since she had six miscarriages and had no child. Unfortunately, the miscarriage

experiences were traumatic for her and she felt so much pain such that she preferred not to get into too much detail about each experience but to comment on her overall experience. She had this to say about her experience;

> *I am not going to say everything, u know this this is haunting me! I have done everything I could, I mean I have money, I can afford almost anything, how come I can't have something that I need so dearly, I mean what's the point of having all this without a child to enjoy all my hard work. I need a child, I have tried but I have to accept that I can't carry a baby to term. I know you won't believe me, but at some point I had to throw the remains of the baby in a dust-bin, I was so tired of trying and going through the same process over and over again…, uhm, you know some people are just so lucky, I can't deal with anything or anyone without taking it personal…, I take depression tablets, I'm always drinking and partying when I'm not at work to forget about everything, I've gone through so much pain…,I feel defeated and worthless, I've tried everything!*

Participant 9. Omphile Moloi

Omphile is an African (Tswana) woman aged 32, and she experienced a miscarriage at age 26. She is a retail worker. She is single and in a relationship. I met Omphile while on my weekend job; I was doing a trade activation and overhead someone talking on the phone about a woman who had a miscarriage. Omphile and I were standing side by side and we both overheard the conversation. I noticed a change in her face and I asked if she was ok and she pointed out how painful it was to experience a miscarriage. I had to engage with her on the issue and when I told her I was doing my research on miscarriages, she volunteered to be a part of the study. I carried a tape recorder with me all the time and she was ready to talk after work. I knocked off earlier, and I had to wait for her a little while. Omphile revealed that prior to the miscarriage event, pregnancy hormones were getting the better of her. She couldn't control her anger and emotions and that pushed her boyfriend away until one day when she fought with her boyfriend and her boyfriend broke up with her and headed back to Pretoria where he stayed and worked. After the breakup, Omphile was heartbroken, stressed, and felt unusual stomach cramps. When she went to the bathroom, she discovered that she was bleeding, and she called her friends who took her to the hospital where she learned that she had a miscarriage. Omphile reconciled with her boyfriend and they have since moved in together.

Participant 10. Nolly Dube

Nolly is a Zulu woman aged 38. She is a businesswoman specialising in cross-border trading. She is married and has two children, a boy, and a girl. She experienced a miscarriage at age 30 while trying for the third child. Nolly got a partial stroke on her right hand due to the complications of the miscarriage and she is still attending physiotherapy classes monthly. Nolly points out she was three months pregnant when she experienced a miscarriage, she passed out while talking to a customer on one of her stands in the township and she woke up at the hospital, confused and in pain, then she learned that she had a miscarriage and her right side was numb as she had experienced a partial stroke. Nolly had to deal with a miscarriage and a stroke at the same time and it was a difficult and a painful experience for her. She narrates that this was the hardest time of her life;

> *I can say I'm lucky to be alive after what happened to me! I remember waking up at the hospital…, I couldn't remember the details, so when I woke up, my family was surrounding my bed, I thought it was that thing of the movies…, I was so confused but nobody wanted to tell me what had happened. I just felt numb and I had drip on…, uhm, I think, after about a day or so, thus when I got to learn that I fell unconscious while talking to customers by my stand and I that I had a miscarriage. At that point, I didn't know what to do, I was crying inconsolably…, being sick is something but losing a baby and almost dying in the process is something else…, I will never forget what I went through, up until now, my hand still reminds me that I almost died but thank God, he was with me*

Participant 11. Mrs Sekgoto

Mrs Sekgoto is a Tswana woman aged 62. She is a Retired Professional Nurse who has worked with women at the maternal health care sector for a long time. Mrs Sekgoto is a warm-hearted, motherly and soft-spoken woman. I met her by her house, she went out of the way to make me feel at home and comfortable. She had prepared food for me. We conducted the interview by the couches while she browsed through her book to educate me on types of miscarriages and the difference between a miscarriage and abortion and a thin line between the two. Mrs Sekgoto retired at 60, she trained at a hospital in Johannesburg from 1982 and she started working there in 1987. Her initial training was auxiliary training, she would complete as a staff nurse. In 1987 she was transferred to another hospital and in 1991 she started a bridging course that was being issued out by the government as a 3-year diploma until she trained as a midwife. In 1996, she was a qualified professional nurse. In 2006 she

was transferred to a clinic next to her home, and she was deployed at the midwifery department until she retired.

Participant 12: Ntombi Mohlapa

Ntombi is a Pedi woman and a professional nurse aged 59. She has been serving as a professional nurse since 1981. She trained at a hospital in Johannesburg as a midwife and then worked with a hospital in the South of Johannesburg and after that, she worked at a clinic as a registered nurse. She also worked at another clinic in the North of Johannesburg and eventually worked at a government clinic in 2003 until she was transferred to a government hospital in 2008 where she works as a midwife until now. Ntombi mentioned closely working with women who have experienced miscarriages and that despite that she deals with miscarriages on a daily basis, she still finds her job challenging.

Participant 13: Mrs Khumalo

Mrs Khumalo is an African (Zulu) professional nurse aged 35. She started training in 2007 and started working in 2012 as a professional nurse at a public hospital. Mrs Khumalo has been working at the same hospital in the maternity department up to date. She is closely working with women who have experienced miscarriages and as having had a miscarriage experience herself, she explains that it makes it easy for her to closely relate to her patients and that makes her do her job better.

4.3 Themes.

This study seeks to explore how women construct their illness experiences following a miscarriage experience. The role of the medical health care received, and the social environment on the construction of miscarriage experiences are the core themes of the study. The core themes of the study are further narrowed down into sub-themes namely; the emotional experiences, belief systems or alternative healing systems, partner/spousal relationship following a miscarriage experience, femininity embodiment, as well as reaction triggers.

4.3.1 Emotional experiences

Hannebaum (2014) asserts that miscarriages put women at greater risks of developing mental disorders such as depression and anxiety. This is true and evident in this research as all women reported having gone through some negative emotional experiences following a miscarriage event

irrespective of whether or not the pregnancy was planned, as the thought of losing a baby was too much to bear. Women reported being hysterical, experiencing moderate to extreme depression, failing to cope, anger with self, god and the world following a miscarriage event. For instance, Rasheena indicated that both miscarriage events triggered negative emotional experiences with the description of the first miscarriage experience as follows;

> *I remember laying on the bed, and he scanned, and he just said, 'I'm so sorry, there is no heartbeat.' I just remember, I was absolutely hysterical. I just cried and cried and cried and cried and cried…, it's hard to explain to somebody coz people kind of think that because you are only 12 weeks, you don't feel anything or thus not really real for you but I think your whole life changes, everything changes, your plans, your what you gonna do, your career, from the day you find out it's just like it's not something you can go back to. So, it was very difficult, I remember coming out of the ward and my husband being there and I think, I don't know, there was somebody else in the ward with me and I just felt very sorry for them, coz I don't think for the 12 hours that I was there that I ever stopped crying. It wasn't that normal crying it was heaving hysterical kind of crying, I just could not stop. And then we had to go home, we had to tell my daughter, she's actually, she's a very uhm, a smart little kid. She knew exactly and understood what was going on … she was very upset, and she cried…, I think it was really hard to see everyone initially and I was actually quite depressed for quite a while afterwards, it was just difficult, not an easy time.*

As someone who had looked forward to a successful pregnancy, Rasheena connotes that a miscarriage is a difficult life-changing event characterised by emotional turmoil such as depression and anxiety as purported by Hannebaum (2014). The need to explain to her daughter to make her understand what had happened further fuelled this. Other women also reported negative emotional experiences. For instance, Beauty wasn't aware of the pregnancy when the miscarriage occurred as she had a history of inconsistent menstrual cycles. Even though Beauty was not financially and emotionally ready for the pregnancy, the miscarriage was an emotionally painful event for her, and she describes it as follows;

It was painful cause every time I thought about it, I would cry out and say, 'I do not want this thing in my life.' Anytime I saw a baby, I would imagine myself carrying my own. The worst part is that I did not know I was pregnant.

Royalty mentioned not being ready for the pregnancy upon discovery and being caught in between paternity issues after discovering about her pregnancy. Despite the problems that came along with the pregnancy, she eventually accepted the pregnancy and planned towards motherhood. In narrating her miscarriage experience, Royalty reveals that the miscarriage devastated her and that the miscarriage was the worst thing that had ever happened to her. She reveals her emotional experiences in the following sentiments;

…, and the doctor confirmed that I had lost the baby. There my world fell apart, I felt all the castles I had built in the air crumbling on me. I was crying, I had to tell my sister what had happened, and the doctor had to call an ambulance for me right away as my condition was deteriorating, I was catching fever, my pulse and blood pressure were getting unreasonably high…, it's the worst thing that has ever happened to me. I don't want to imagine going through a similar experience.

Menyiwe got pregnant when she least expected it and had initially wanted to do an abortion. She mentioned it to her partner as she was not yet ready to be a mother. In the wake of events, Menyiwe, experienced a miscarriage, however despite her initial cards playing out for her, she describes the miscarriage experience as devastating and a stressful experience for her in the following sentiments;

It was so devastating…, Yeah it was really a bad experience…, it was a stressful experience.

Andiswa mentioned that she had always wanted a baby of her own as her boyfriend already had three kids with his first wife. Andiswa revealed that the miscarriage event was an emotional and a traumatic experience for her. She reveals this in the following sentiments;

It was bad! I wake up crying, I'm having pain, ran to the bathroom, blood! Run to the hospital, hospital say no! Miscarriage, baby is out… Came back, cry cry for about a month everyday crying. I couldn't stop crying.

Khanyi who had experienced six miscarriages mentioned that her inability to carry a successful pregnancy has depressed her to a point of not being able to maintain a romantic relationship. She further reveals that she still finds solace in drinking and partying and reveals her experiences in the following sentiments;

I know you won't believe me, but at some point I had to throw the remains of the baby in a dustbin, I was so tired of trying and going through the same process over and over again… I take depression tablets, I'm always drinking and partying when I'm not at work to forget about everything, I've gone through so much pain…,I feel defeated and worthless, I've tried everything!

Tricia mentioned going through an emotional meltdown after experiencing the miscarriages. Tricia endured physical abuse and her two pregnancies ended in miscarriages as a result. Although Tricia mentions feeling relieved as she was in toxic relationships that doesn't overshadow the pain she endured when she suffered miscarriages and her sentiments are as follows;

I lost my pregnancies… I was broken Inside, I only have one child … the miscarriage is not nice, I am scared of trying again, and I am scared of dying … I am fine.

Nolly defines herself as having defied death after experiencing a miscarriage which left her right hand paralyzed up to date. She mentions that her experience was the most traumatic as she never thought she would recover and had to deal with a miscarriage and paralysis concurrently. As she narrates the trauma she went through, she reveals that she has healed emotionally except for her right hand which remains paralyzed. Nolly narrates her ordeal as follows;

I am lucky to be alive… I remember waking up at the hospital… I had a miscarriage… I was crying inconsolably… being sick is something but losing a baby and almost dying in the process is something else…, I will never forget what I went through, up until now, my hand still reminds me that I almost died but thank God…

Despite the negative emotional connotations represented by all the participants on a miscarriage as a traumatic, painful, sad and highly depressing experience four out of ten women also reported that the miscarriage brought relief as they were not ready for the pregnancy, did not plan the pregnancy or had relationship problems during the miscarriage event. Therefore, it is pivotal to note that despite the miscarriage being a traumatic event for most women, it can also be a liberating experience for some women, to a certain extent. Yet, although some women mentioned the liberating aspects of a miscarriage they still experienced the negative emotional attributes, hence the pain of going through a miscarriage although not similar, remains a common factor among women. Women who experienced more trauma and depression had either initially planned for their pregnancies, were in committed relationships or had looked forward to having successful pregnancies. An assertion by Letherby (1993) that miscarriage implications are determined by how one perceives the event, remains to be challenged as some women further indicated having suffered from depression or indecisiveness about keeping the pregnancy before the miscarriage experience, however, they still cite their miscarriages as a painful experience.

4.3.2 Medical care

Letherby, (1993) states that a miscarriage as a medical event can be articulated by the fact that most women seek medical health care after the occurrence of a miscarriage, which is followed by the biological process characterised by bleeding leading to the excretion of conception products. However, in other cases, miscarriages occur in the absence of vaginal bleeding as stipulated by Everett, (1997). Despite these biological variations in miscarriage experiences, women's experiences in their interactions with medical healthcare institutions also shape their miscarriage experiences. This is evidenced in the findings of the study as women narrated their interactions with the healthcare settings. In trying to garner more understandings of the health care procedures on women who have experienced miscarriages, expert knowledge was sought from 3 medical health care professionals who stated that a woman presenting a miscarriage either at a clinic or a hospital is treated as a case of an emergency as complications such as loss of consciousness might arise due to prolonged loss of blood. In their description on the desirability of what a medical care should be, and also driven by the

professional solidarity that shields healthcare professional from disclosing or making a public criticism, medical health care professionals had this to say;

Normally a woman who has experienced a miscarriage we usually treat her as an emergency. So as an emergency we have to put her in a private space, where there is privacy, and then we do the vital check-ups, we check and maybe she tells you that I have had a miscarriage, maybe I have been pregnant for two months and then after that you treat the vital signs. After treatment the vital signs you summon the doctor, after that the doctor will check the patient to see how much blood she has lost and then after that you just sign the consent form, the consent form that the patient signs is for the D and C – ***Mrs Khumalo (Professional Nurse)***

Health care procedure for those who have experience a miscarriage when they arrive at the hospital, they are being handled by a gynaecologist in casualty, right there in casualty. They will be admitted in a gynae ward. As it happens with the miscarriage, the mother must be shown remorse and sympathy and at the same time a midwife and the doctor who are handling this case because there is pressure at the hospital or clinic, Shortage of staff and there and there but at least the words of comfort must be given to the mother after everything has been done, clean, showing the baby, maybe if the father is there they must let the father in and explain what could be the possible cause of a miscarriage but if it's in the clinic, the mother is going to be referred the following day to the hospital or immediately, the mother must be referred to the hospital and at the hospital they are going to do what we call D & C. D & C procedure is done in theatre, they are going to give the mother an injection and they will be cleaning the mother. The uterus must be cleaned, and they must make sure that the clots and everything are not there. Must be cleaned because it's warm our bodies are hot inside and if there are clots, there may be complications in the near future for the mother, - ***MRS Sekgoto Retired Professional Nurse***

Women who experienced miscarriage had different stories to tell regarding their interactions with the medical healthcare system. Nine out of ten women reported that health care professionals were helpful and nice to them and the following sentiments stood out;

> *At the hospital, I found nice people. I found nice people, who treated us well, I never had a problem…, yes, the social workers were there, they gave me counselling and that helped a lot* ***– Beauty***

> *The treatment was fine, the nurses and the doctors were friendly, but…* ***– Royalty***

> *The treatment was great* ***– Menyiwe***

> *The attitudes of the health care workers were fine just at the hospital it's like they didn't do enough* ***– Andiswa.***

> *I mean, it was good, the nurses and everything, they were all fine. My gynae as well, he was wonderful, he was kind, and he was very very sympathetic but yeah* ***– Rasheena***

> *They were fine, I mean the nurses were there to do their job, they were nice, sympathetic and all* ***– Tricia***

> *At the hospital, the treatment was fine, considering what I had gone through, they really helped to stabilise me and all went well after that...* ***– Omphile***

While women commended the health care professionals for their hard work and ethic in dealing with miscarriages, despite all the good that was done, seven out of ten women complained about the treatment they received at the hospital and further stated that the treatment received impacted negatively on their illness experiences. Two women (Royalty and Lungelo) who were admitted at the

same hospital cited being placed at the same wards with women who had given birth. They state that this left them hurt and traumatised, thus they had a hard time dealing with the loss.

The decision-making process seemed flawed and biased in the medical healthcare as women presented cases where professionals would decide on their behalf. This was the case, especially with younger participants. For instance, Royalty was 25 when she experienced a miscarriage and she mentioned that a health care professional (elderly nurse) denied her contraceptives on the basis that she was younger and not married. However, Ntombi (professional nurse) condemned such behaviour and attitudes by health care professionals as not serving the best interests of women and commended professionals to serve to the best interests of patients. On a similar case, Beauty reported that she had a negative experience as the health care professionals forced her to see the remains of the embryo despite repeatedly declining to do so and this negatively affected her. In her ordeal, Beauty states that her experience was overall satisfactory except for an encounter which left her traumatised and she had a hard time dealing with the loss.

Medical health care for Rasheena was great. She received treatment at a private hospital and she had a gynaecologist assigned to her. However, despite the satisfactory treatment she received, Rasheena also mentioned her dissatisfactions particularly on her second miscarriage experience, specifically with the way her gynaecologist handled a life-changing decision she took while in an emotional state after experiencing a miscarriage. She narrates that as she was about to go for a D & C surgery, the gynaecologist asked if she would like to do the ligation as a contraception method which she consented to without hesitation. She regrets opting for the ligation process as she still wanted to build her family and her kids wanted an additional sibling. The ligation affected Rasheena negatively, and she took over two years to make peace with it. She mentions that she will never forgive the gynaecologist for allowing her to make a life-changing decision while in an emotional and vulnerable state she was in. She expresses her experience in following sentiments;

> *And I said to him, 'I want to have a ligation,' and he kept asking me, 'are u sure? It's a very big decision, you won't be able to have children anymore' And I was so angry, so angry with God and the Universe and the world and everything, I was just. I don't think I could see properly, I think I was so emotional and so completely overwhelmed and angry that I just said, 'yes' … But I think the biggest thing for me about this second miscarriage, which to this day, I regret, and I will never in some ways forgive the doctor for, is I should have never had a ligation. I think, you know, afterwards after speaking to people, after wards all my friends my medical friends,*

I have a lot of friends who are doctors and they were like, 'you never, ever make a life changing decision when you are that vulnerable.' And as nice as he was, he should have never, he shouldn't have listened to me, he shouldn't have given me the choice... It happened and that was a horrible, horrible, horrible decision coz I spent the next two years, just being incredibly angry about it and uhm, wanting a baby still and it didn't take away the desire to still have a child and my children still wanted a sibling I went to therapy after that and I took a very long time to get over it… I would say really only probably when I was 46 or 47 that I really got over it..., I don't think I will ever forgive him for that.

While all the participants reported having physically recovered from the miscarriage, Nolly was left paralyzed following a miscarriage experience. She states that she still carries the scars of the miscarriage event with her as she still can't use her right hand due to the partial stroke she suffered. This validates the notion of a miscarriage as a potentially life-changing event, as stipulated Letherby (1993).

Other women reported having experienced the desire for closure regarding the likely causes of a miscarriage and to be educated in ways in which they can avoid future miscarriages. Women's desire for closure and failure by the medical healthcare sector to meet such needs affected them negatively. Edozien and O'Brien (2017) point out that self-blame following a miscarriage experience may be mitigated by closure on the cause of a miscarriage. Andiswa reveals her need for closure as being coupled with confusion and a quest for what she might have done wrong to trigger the miscarriage experience, she reveals this in the following sentiments;

… It happened there, I lost it. I don't know how, the doctors can't explain to us how because I never picked up heavy things or stress.

On the other hand, Omphile also explains how her quest for closure has also been closely associated with self-blame;

I was asking myself what's wrong with me. Why did my pregnancy fail? I looked for all the answers, but no one could explain to me, even at the hospital no one told

me anything, I just kept on blaming myself for failing my child and trying to think of what I might have done wrong.

Out of ten respondents, only one respondent (Beauty) received trauma counselling after the miscarriage experience. Two respondents, Rasheena and Andiswa had to seek external counselling services as they couldn't cope with the loss. Seven participants had to deal with the loss through other coping mechanisms and some reflected as having resorted to drinking and partying to cope and deal with their grief. Women who received counselling at the hospital or sought for external paid counselling services following a miscarriage experience coped with the loss in the best way and dealt with the grief in a much better way as compared to women who had no form of counselling following a miscarriage. This illustrates that most hospitals do not offer therapeutic counselling services to cater to the psychological needs of women following a miscarriage experience noting the above description of a miscarriage by most women as a painful experience. This emerges despite the assertions by the interviewed health care professionals that counselling services are a standard procedure at hospitals following a miscarriage experience. Medic health care professionals also stressed the importance of compulsory counselling and attributed the absence of counselling services in most medical healthcare facilities to the pressure at the hospitals due to the shortage of staff. This is clear in their following assertions;

As it happens with the miscarriage, the mother must be shown remorse and sympathy and at the same time a midwife and the doctor who are handling this case because there is pressure at the hospital or clinic, Shortage of staff … but at least the words of comfort must be given to the mother after everything has been done. - ***Mrs Sekgoto (Retired Professional nurse)***

She has to be referred for counselling in anyway because she might look strong and all that, but she can be depressed" ***- Ntombi (Professional nurse)***

Women who reported positive experiences either stated that health care professionals were nice to them and they had received trauma counselling while negative experiences were fuelled by the failure by the medical healthcare professionals to grant closure, absence of counselling services place to address the psychological impacts of the miscarriage, potentially damaging decisions made by

healthcare professionals on behalf of patients such as denying patients access to contraceptives, forcing women to view the foetal remains, and acting on life-changing decisions made by women while at their emotional and vulnerable state such as performing the ligation. It is crucial to note that the medical healthcare sector as the primary care provider for women who have experienced miscarriages plays a pivotal role in impacting on the illness experiences of women following a miscarriage experience. Edozien and O'Brien (2017) point out that a holistic approach in dealing with the miscarriages in the healthcare sector should cater for women's various needs such as granting closure for the loss and offering emotional support.

4.3.3 Social Networks

As evidenced in the literature, women going through miscarriages are not separate entities, but they function within social networks which have a potential of either reducing or increasing stress as these networks contribute to one's physical and mental health (Corbet-Owen, 2003). This assertion points out to the importance of one's social interactions in recovery and meaning-making following a miscarriage event. House et al., 1988 cited in Corbet-Owen (2003) further stipulate on the significance of social support in reducing psychological distress in stressful times through speeding up recovery and stimulating healthy behaviours and habits in the event of illness. I will discuss these themes below;

4.3.3.1 Social support systems (family, friends, spouse)

Women who have experienced miscarriages reported receiving support from their families, spouses, children and a circle of close friends. As purported by Hannebaum (2014) that during the occurrence of miscarriage, the entire family is affected, and coping becomes a crucial part of healing. This is evident in the role played by women's families, friends and children in the healing journey following a miscarriage experience. The support and sympathy garnered from women's social interactions played a crucial part in their healing journey and sped up the healing process. Women who received a more holistic and positive support from their families presented fewer signs of distress and depression following a miscarriage event as compared to women who received minimal social support.

However, Richards (1997) brings about the irony tied to the social support systems by pointing out that despite the caring and nurturing effect of social interactions, they can also be a source of conflict, criticism, and rejection. This is evident in this study as some women narrated being judged by their families, friends, and spouses due to a thin line between miscarriages and induced abortion. For

Instance, Menyiwe reported having a fall out with her partner following a miscarriage experience as he suspected her of having aborted the pregnancy as she had hinted on it before the miscarriage experience. Beauty also revealed that her partner gave her a hard time dealing with the miscarriage by demanding answers on how and why the miscarriage had occurred. The pointing of fingers is also evident in women's experience of miscarriage and this affected women's coping with the loss and the healing process negatively.

Having experienced 6 concurrent miscarriages, Khanyi reported being at the receiving end of insults and name calling from some of her family members and colleagues. She narrates having been called 'an infertile woman' and a 'witch' due to her inability to carry successful pregnancies. As a result, Khanyi has grown to be a bitter person who can't maintain romantic relationships and has resorted to a self-disrupting behaviour of heavy drinking and partying whenever she is not at work. Khanyi also reported suffering from depression and is on medication due to the pain and suffering she has been subjected to regarding the miscarriage experiences. This brings us to the debate surrounding empathy as stipulated by Hartman (1997) on the statement that empathy represents one's projection onto another to comprehend the other better by making one's suffering your own. I this regard, Hartman (1997) gets to question the cold-heartedness and the uncertain nature of empathy, the oppressive effects of empathy and calls for the eradication of 'otherness' and asserts that for suffering to be perceptible and comprehensible, the suffering of the other necessitates the positioning of one's body in the place of the other's body. In this regard, Rasheena argues that people who haven't experienced a miscarriage will never comprehend the complexities of the miscarriage experience and they will never fully relate to the actual feelings embedded in experiencing a miscarriage. Social support systems play a pivotal role in the construction of miscarriage experiences and essential for the healing process and coping with the loss despite the cold-heartedness and the uncertainties of empathy that leave a lot to be desired.

4.3.3.2 Opening up about the miscarriage

The American Pregnancy Association (2013), cited in Hannebaum (2014), shows that women are often more open in speaking about their miscarriages and seek support from others. Despite this assertion, most women are still struggling to openly talk about their miscarriage experiences because miscarriages have for a long time been regarded as private issues, hence not for open for discussions with people outside one's immediate network of association. This is evidenced by the struggle I had to secure the interview appointments. Some women were reluctant in talking about their miscarriage experiences and I had to persuade them to open-up through sharing my miscarriage experience with

them. While some women needed more time to be ready for the interview they still experienced difficulties in talking about their miscarriage experiences. For instance, Andiswa revealed whenever she talks about the miscarriage experience she gets emotional and cries. This was because she was still recovering from the loss as she had experienced miscarriage seven months before the interview.

Adolfsson (2004) puts everything into context in stating that, other than talking about their miscarriage experiences, most women bottle up their experiences due the stigma that has been attached to women who have suffered miscarriages on assumptions they may have terminated their pregnancies or may have done something to attract the unfortunate event. This evident in the study, for instance, Lungelo couldn't inform her mother about the miscarriage due to their contrasting beliefs regarding the occurrence and the treatment of miscarriages. Royalty also mentioned not informing her family about the miscarriage since she comes from a Christian family and would less likely to receive support but highly likely to be judged and reprimanded for not living according to the expectations of Christian values. Some women were open about their experiences, and they acknowledge the therapeutic attributes of sharing their experiences. For instance, Rasheena mentioned that if the miscarriage conversation pops up, she is open to talking about the experience and that she often offer pep talks to expectant mothers regarding the complications and challenges they might come across during pregnancy.

4.3.4 Belief systems

Belief systems inform our meaning-making and they are a pivotal part of our everyday lives. Cultural elements informing the interpretation of a miscarriage event are central to women's everyday lives. In juxtaposition to the cultural/lay explanations of miscarriage, medical literature points out that STIs, HIV infection and other chronic diseases and medical conditions increase the likelihood of miscarriages (Collier et al., 2013; Manavi, 2006; Dudgeon & Inhorn, 2004). In the same sense, various cultural and lay ideologies have helped to inform the interpretation of the miscarriage event. While taking a walk to buy artchar with a friend one afternoon, we couldn't help but join the heated conversation that the artchar vendors were engaging in. One elderly lady narrated how someone she grew up with had no kids but had always experienced miscarriages all her life due to a misunderstanding she had with her sister over a man. According to her, the miscarriages were the punishment this lady had to endure for marrying her sister's husband. She explained how the tears of the lady's sister were bringing about misfortune in a form of miscarriages. Such cultural beliefs exist, and they continue to inform people's understanding and interpretation of the miscarriage events. This stipulation attributes a miscarriage

to a misfortune which places women who have experienced miscarriages at the receiving end of Karma, bewitchment, and punishment from deviation from acceptable values.

In the narration of her miscarriage experiences, Andiswa stated that after experiencing a miscarriage, her grandmother confessed having performed a traditional ritual on her and supernaturally tied her ovaries, to make it impossible for her to have a child before marriage. She revealed that her grandmother further warned her that as long as she is not officially/customarily married she will not have a child of her own. According to Andiswa's family, the miscarriage necessitated a traditional cleansing ceremony to cleanse her from all the bad luck associated with pregnancy loss. Andiswa confirmed that things were not going well for her because of the bad luck brought about by pregnancy loss and she believed the traditional cleansing ceremony was necessary. Lupton (2013) states that certain cultures use cleansing ceremonies and bereavement rituals to commemorate the foetal life that was lost, and this is crucial to those who have experienced a miscarriage.

Apart from cultural elements informing meaning-making and the interpretation of miscarriages, some women's belief and value systems such as Christianity and Buddhism were pivotal in grieving, healing and coping. For instance, Rasheena mentioned visiting the Buddhist Centre and feeling at peace. Nolly, Omphile, Menyiwe and Lungelo's faith in God was as an essential part of their healing. They had a belief that God was in control of their lives and that the miscarriage happened as part of God's plan concerning their lives. Such beliefs carried them through and kept them going following a miscarriage event.

While belief systems were an essential part of women's miscarriage experiences, it is pivotal to note that some women's vulnerable state following a miscarriage and their quest for closure and a solution subjected them to further pain and suffering. For instance, Rasheena mentions being referred to a psychic healer by a friend and when she got there psychic healer told her about a boy child who was roaming about and wanting to come back home. The psychic reading referred to the child Rasheena had miscarried, and this further depressed and hurt her. Despite the negative impacts of some belief systems to women's experiences, women remained in control in embodying their identities following a miscarriage experience as they used various coping mechanisms to help them deal with the loss. McGreal et al., (1997) stipulates that women will more likely seek spiritual support, use wishful thinking and tension reduction methods and look for support from people with similar experiences of loss. This is evident in this study, for Instance, Andiswa bought a Teddy Bear to cuddle up, emulate the real baby she could have been holding and thus relieve the pain. Andiswa revealed that cuddling a Teddy Bear helped calm down her emotions whenever she thought about the miscarriage. Rasheena mentioned finding solace in her yoga practices and talking to her daughter about the miscarriage and

her daughter would always cheer her up by telling her that the child was very happy in heaven, playing with their pet dogs that had died.

4.3.5 Partner or spousal relationship

McGreal et al., (1997) assert that grieving pregnancy loss for parents may involve strong emotional distress and may implicate the quality of relationships among partners. This assertion is of optimum importance for this study. Women touched on the impacts of the miscarriages on their relationships with their partners. Married women revealed that the miscarriage also affected their husbands, and the husbands were always there to offer much-needed support. The spousal support was as an essential part for healing and coping. Women who were cohabiting with the partners also mentioned that their partners were there for them and the miscarriage strengthened their bond. Four women alleged that they separated from their partners following the miscarriage event. In exploring the causal factors for the varied implications of a miscarriage event to women's relationships with their partners, the married couples had to stand together as per 'for better or for worse', the cohabiting partners' bonds strengthened as they mentioned having planned for the pregnancy before the miscarriage occurrence, however the relationships that ended were characterised by physical abuse, pointing of fingers following a miscarriage, extreme depression always leading to fights within a relationship and in another case the lady only wanted a baby and not a life partner.

4.3.6 Miscarriage vs Desire for fertility and motherhood

As depicted in the literature that in some communities, women's ability to bear an offspring remains a determinant of their social standing, individual recognition, and the ability to a have a stable relationship (Laher et al. 2009). According to Laher et al., (2009) and Watson, (2006) childbearing as a measure of womanhood has been and is still evident in several Sub-Saharan African Countries, South Africa included. From a tender age, women are taught to nurture and prepare for motherhood and marriage. This portrays the societal values linked to motherhood and fertility. Women who displayed more desire for motherhood were the married, the older, those who cohabited with their partners, and those who had planned for the pregnancies as they looked forward to starting and expanding their families. This is evident in their sentiments;

*My body failed me – **Rasheena** … I'm a failure – **Omphile** … Why me – **Andiswa** …I'm failing my duty as a woman – **Lungelo** … I feel worthless and less of a woman – **Khanyi** …I have failed – **Nolly***

The practice of the ability to bear children as a measure of womanhood remains problematic in our societies, such that women who experience miscarriages are likely to be viewed with contempt and are considered as 'others', hence the voiceless subalterns of the female hierarchical social structure. This is evident in the revelation made by Khanyi on having been insulted and called names such as an 'infertile woman' and a 'witch' as she had experienced six miscarriages and had never carried a successful pregnancy. This resulted in severe depression and feelings of worthlessness. Wikler (1985) argues that the socially contextualised concept of reproduction has been unfavourable to women. This necessitates a discussion for societies to break all the barriers set to define the identity of women but give necessary support to women following a miscarriage event.

However, contrary to these notions of desire for fertility and motherhood and feelings of worthlessness reported by some women, some women were open-minded and revealed that the miscarriage had no effect on how they embodied feminine identities as their feminine identities are not defined by their ability to bear children. Some women reported celebrating their bodies following a miscarriage event despite the conflicting emotional reactions. They mentioned that despite the miscarriage experience, they still carried successful healthy pregnancies either before or after experiencing a miscarriage. However, some women were of the idea that despite the miscarriage experience, they are still women and 'life goes on'. Some women who had not planned for their pregnancies had given little thought to the implications of their miscarriages to their identity as women as they had no desire for motherhood at the time of the miscarriage experience.

4.3.7 Reaction triggers

Women reacted differently to miscarriage experiences. Some women narrated being hysterical, angry, depressed and hurt by the miscarriage event while some were less emotional and relieved by the miscarriage event. Women's reactions to their miscarriages are tied to various factors during the occurrence of a miscarriage such as age, financial stability, pregnancy knowledge and planning, and marital status. Women who had knowledge of their pregnancies showed higher levels of depression and took longer to cope with the loss. Women who had planned their pregnancies presented more depression, anger, and frustration in the event of a miscarriage as compared to women who had not planned for the pregnancies. Married women were the most affected by the miscarriage event as

compared to single women due to a need to grow their families. Older women presented more desire for motherhood as compared to the younger ones. Women who were more financially stable and had financially prepared for the pregnancy and the baby presented higher levels of pain, depression, and anger and had a hard time accepting the pregnancy loss as compared to women who were not financially prepared for having a child.

4.4 Conclusion

The findings of this study point out that that women's illness experiences following a miscarriage are embedded on their social environment, social support systems/ interactions, cultural elements informing the interpretation of miscarriage experiences, as well their interactions will the medical health care system. It is pivotal to note that meaning-making following a miscarriage experience is reliant on several factors such as; women's emotional experiences, the quality of medical care received and their interactions with the medical health care professionals, social support systems available to them, belief systems informing their meaning-making, relationships with their spouses or partners, the embodiment of feminine identity and factors peculiar to individuals such as age, pregnancy knowledge and planning, financial stability, marital status and desire for motherhood. Women who had positive social support systems as spousal support and the support of family and friends and women who received the best medical care reported positive illness experiences following a miscarriage event as compared to the women who had none or little support from their social circles and had received poor medical health treatment.

CHAPTER 5: CONCLUSION

5.1 Introduction

Many women experience a miscarriage in their childbearing journeys. The likelihood of a miscarriage among women of a childbearing age is a global problem and impacts women's health, hence deserving of sociological analysis. Miscarriages are a less researched area of study in South Africa, this study seeks to add on to the existing body of knowledge and bring about positive contributions to the study of miscarriages in South Africa. As a study probing into an understudied phenomenon, this study has opened the silence around miscarriages, explored and brought into light the invisibility of the miscarriage experiences and explored how these events interact with women's subjective roles and desires in an intimate space. A miscarriage can be a devastating experience for some women and a liberating experience for some. This thesis has explored women's miscarriage experiences in South Africa paying attention to the role of the medical health care received and the social environment in the construction of these experiences. Women's experiences were extracted from the stories that women had to tell regarding their experience of a miscarriage. This is a qualitative research which employed a narrative inquiry for a glimpse into women's miscarriage experiences. 10 women who had experienced a miscarriage and 3 medical health care professionals who have worked closely with women who have experienced miscarriages were interviewed. In-depth interviews were an instrumental tool of the study due to their flexible and conversational nature. The interviews were recorded, transcribed, coded into themes, presented as findings and discussed in relation to the objectives of the study. A set of conclusions applicable to this study will be presented below.

5.2 Conclusions about each theme

Conclusions will be presented according to the themes of the study.

5.2.1 Emotional experience

Women's emotional experiences following a miscarriage are an essence of how they articulate their miscarriage experiences and navigate through their feminine identities following a miscarriage experience, hence a need for women's emotional needs to be met and highly prioritised following a miscarriage event. Most women reported the experience as being a painful and a traumatic one despite the interplay of factors such as pregnancy duration, knowledge and planning, desire for motherhood, and the liberating aspects of a miscarriage. Despite the nuances surrounding the miscarriage event, the experience of a miscarriage is painful and life-threatening.

5.2.2 Medical health care received

Maternal health care in South Africa has transformed for better over the years although miscarriages still account for maternal deaths. Medical health care has been as a primary source of health care for most women in an event of a miscarriage. Women's interactions with healthcare institutions, including one-on-one interactions with healthcare professionals, play a pivotal role in women's miscarriage experiences. The medical healthcare sector is doing a commendable job in treating the physical symptoms of a miscarriage, however many negative experiences that were reported resulted from the failure by the institutions to attend to the emotional aspect of the experience. It clear that there are still loopholes in the healthcare sector calling for a holistic approach in dealing with miscarriages in such a way that addresses the root causes of the miscarriage, grants closure to women on the causes of a miscarriage and how future miscarriages can be mitigated and address the psychological impacts of a miscarriage. Doctor-patient relationships as presented in the study are commendable but point out to a need for grounded professional, ethical, non-judgemental manner of service, serving the best interests of women. Feminist theorists have criticised the biomedical involvement in female reproductive matters as shifting women's control over their bodies and subjecting them to docile biomedical medical control. This study concurs with this critique as women still lack a voice in their interactions with the medical healthcare institutions as they are subjected to passive medical healthcare which violates their right to reason and will, hence negatively affecting their miscarriage experiences.

5.2.3 Relationship with partner

Women's relationships with their partners or spouses following a miscarriage event is essential for recovery, healing, and coping. Experiencing a miscarriage affects women's relationship with their partners. For some women, a miscarriage experience brings them closer to their partners and strengthens the bond of their relationship while for some couples a miscarriage breeds conflict, bitterness, misunderstandings, eventually leading to break-ups. Some conflicts are brought about by the nature of a miscarriage. In instances where women did not know about the pregnancy before the miscarriage event, assumptions are drawn regarding the possibility of an unintentional induced miscarriage. The woman's indecisiveness about keeping the pregnancy before the miscarriage event precipitates assumptions that women might have aborted their pregnancies due to a thin line between a spontaneous miscarriage and an induced abortion. Domestic violence against women resulting in a miscarriage increases chances of a break up following a miscarriage event. Maintaining healthy and supportive relationships and breaking away from toxic relationships following a miscarriage event impacts positively in women's miscarriage experiences.

5.2.4 Social Interactions

Looking back at the frequency of miscarriage experiences, support systems play a fundamental role in health recovery, grieving processes, and in coping with the loss. Support from people one cares about, be it family, spousal support and support from one's inner circle of friends and social associations, and is essential in shaping up women's miscarriage experiences. Women's social interactions play a major role in meaning-making and the embodiment of their illness experiences following a miscarriage. Women's social interactions play an essential role in enabling to openly talk about their experiences. Sometimes, social interactions hinder women from freely talking about their miscarriage experiences which is a vital component for dealing with the loss and essential for coping. As a result, some women still suffer in silence and fail openly talk about their miscarriage experiences due to the stigma attached to issues related to pregnancy loss such as induced abortion, infertility and childlessness. Despite the fact that social interactions are likely to be caring and nurturing, they can also be a source of conflict, criticism, and rejection. This implies that social interactions do not always impact positively on women's miscarriage experiences but can equally have some damaging impacts too. My experiences of pregnancy and miscarriage helped in establishing reliability and negotiating a connection with the participants of the study. Discovering having experienced some similar experiences with the participants such as unexpected pregnancy, trauma and pain following a miscarriage experience enabled me to facilitate the interview sessions in a conversational manner, paying attention to fundamental sensitive issues. I also learnt that the informality and the flexibility of the interview process and my desire to build a relationship with the participants by sharing my experiences helped build trust, create a sense of belonging and cultivate reciprocated empathy, hence interviews not only served as sources of data gathering but also served as a therapeutic ground.

5.2.5 Belief systems

Despite the medical explanations of a miscarriage, cultural interpretations and value systems still play a role in informing women's understandings of a miscarriage. The link between miscarriages and a punishment for wrongdoing or deviation from certain values is evident in the study. Value systems emanating from the cultural, religious and individualistic ideologies provide a support system from which women navigate through their experiences. Traditional cleansing ceremonies, Buddhist temple visits, and Christian faith were instrumental in women's understandings of a miscarriage and essential in healing and coping following a miscarriage. Despite the triumphs and positive contribution of belief systems to women's illness experiences following a miscarriage, some belief systems are detrimental as they subject women to further pain and suffering.

5.2.6 Femininity embodiment

Motherhood and fertility are universal embodiments of the feminine identity in most societies based on the biological predisposition of women to childbearing. Most women are socialised to this kind of feminine embodiment from a tender age, hence subjected to societal notions of identity formation tied around women's ability to produce an offspring. The older, the married, those who cohabited with their partners, and those who had planned for the pregnancies and looked forward to starting and expanding their families present more desire for fertility and motherhood as compared to the younger, single, and women who did not plan for the pregnancies. Women are at the receiving end of scorn and name calling based on childlessness and women who embody these feminine ideologies experience self-enacted feelings of worthlessness. Feminist ideologies challenge this patriarchal enforced notion of childbearing as a measure for womanhood and advocate for a society where women are valued and treated with respect despite the ability or a choice to bear an offspring. There is a need for societies to break all the barriers set to define the identity of women but give necessary support to women following a miscarriage event.

5.2.7 Reaction Triggers

Women's reactions to their miscarriage events are tied to various factors at play during the occurrence of a miscarriage. Factors such as age, financial stability, pregnancy knowledge, and planning as well as marital status are linked to the way women react to the miscarriage event. Women who had knowledge of their pregnancies showed higher levels of depression and took longer to cope with the loss. Women who had planned their pregnancies presented more depression, anger, and frustration in the event of a miscarriage as compared to women who had not planned for the pregnancies. Married women were the most affected by the miscarriage event as compared to single women due a need to grow their families. Older women presented more desire for motherhood as compared to the younger ones. Women who were more financially stable and had financially prepared for the pregnancy and the baby presented higher levels of pain, depression, and anger and had a hard time accepting the pregnancy loss as compared to women who were not financially prepared for having a child.

5.3 Conclusions about the research problem

Miscarriages affect a large number of women at some point of their childbearing journeys and are a widespread phenomenon not only affecting women but also affecting their relationships and social circles. For long, the feminine identity has been tied around women's ability to bear children. This has influenced how women construct their miscarriage experiences and embody their desire for motherhood following a miscarriage experience. Women's experiences in their interaction with the medical health care institutions and their interactions with their social environment are essential and play a major role in how women construct and navigate through their illness experiences following a miscarriage event. The experience of a miscarriage itself was hard for all women despite dynamics such as planning for pregnancy, marital status, age, financial stability and a desire for motherhood. Meaning making and identity formation following a miscarriage event dependent on support structures available to women following a miscarriage experience. To ensure women's smooth transition from the embodiment of pregnancy to the embodiment of pregnancy loss, it is pivotal for the medical health care settings to be conducive and serve to the best interests of women not only in treating the physical symptoms of the miscarriage but implement a holistic approach that caters for addressing the root cause of a miscarriage, recovery and dealing with the loss, and emotional healing. There is also a need for social support systems such support from women's families, friends and partners, belief systems and cultural ideologies informing women's understanding of miscarriages to be more inclined on offering positive contributions on how meaning make sense of their experiences and how they articulate their feminine identities following a miscarriage event.

5.4 Implications for theory

The existent theories, the embodiment, the feminist and the interactionist frameworks have been useful in uncovering how women construct their illness experiences. Through thematic analysis, this study had revealed that women are still subjected to the patriarchal scripts of femininity performance characterised by the ability of women to produce an offspring. As a result, some women embody feelings of worthlessness in failing to embody the 'desired femininities.' Despite the damaging feelings of worthlessness, women are still celebrating their bodies and find solace in their social interactions. Support and empathy from one's family, friends or partner is a crucial aspect of recovery, healing and coping with the loss. An interlink of these theories in unveiling the construction of women's miscarriage experiences plays a significant role in this study. The general systems theory couldn't work for this study as its notions of a need for a course of action couldn't be implemented due to the nature of the study serving an academic purpose.

5.5 Implications for policy and practice

This study pointed out women's experiences through their interactions with the medical health care sector in the construction of the lived miscarriage experiences. Experiences by women in the medical health care sector leaves a lot to be desired in terms of service delivery, doctor-patient relationships, exercise of power by health care professionals and the polices regulating standard procedures to be followed in dealing with miscarriages. As the most common and possibly a life-threatening event, affecting many women throughout the world and South Africa included, miscarriage experiences necessitate a woman centred health care system which prioritises the needs of women following a miscarriage experience. There is a need for a holistic medical health care approach which does not only focus on treating the physical symptoms of a miscarriage but also address the emotional aspects of a miscarriage and address the root causes of miscarriages.

5.6 Limitations

Due to the time and scope limits, this study hasn't been able to fully tackle the gendered notions of miscarriage experiences as the focus is placed on women's experiences of a miscarriage, hence the voices of men's miscarriage experiences remain unheard. Due to the sensitive nature of the study, women could have withheld information they deemed too personal or the information that would likely to have triggered traumatic experiences. As a result, these limitations might affect the authenticity of the stories, hence limiting the findings of the study. The study seeks to explore the experiences of South African women from different racial and cultural backgrounds; due to the snowballing sampling technique, participants were recruited based on referrals, and their willingness to talk about their miscarriage experiences, hence the sample couldn't entirely represent the desired population. As a person with a shared experience with the study participants, this added value to my study as I closely related with the issues that emerged and I empathised with women at a more personal level. I further assume that my personal experience of a miscarriage being a traumatic one also limited the research to a certain extent. I avoided asking more sensitive questions regarding women's experiences of a miscarriage and rather focused on the content that women were comfortable discussing without triggering their emotions. This is linked to my positionality in the study as I had not fully dealt with some issues of my experience. Despite these limitations, this study draws from women's experiences to teach us how to support women who have experienced miscarriages and to help advocate for women centred practices for the positive experiences either socially, culturally or in the reproductive healthcare facilities.

5.7 Further Research

This study could not cover all the areas that could have been a positive contribution to the body of knowledge in miscarriage studies. Further research can be directed into the impacts of miscarriages on:

i) Men in heterosexual relationships.

ii) Homosexual individuals in cases of IVF treatment procedures.

iii) IVF patients in general.

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Annex 1: Ethics Clearance

school of SOCIAL SCIENCES

SOSS Human Research Ethics Committee

Clearance Certificate

Protocol Number:	SOC170806
Project Title:	'Breaking the taboo through the constructionism of illness experiences from the social and medical health care lens: A study of Miscarriage experiences'
Investigator's Name:	Ms Nobukhosi Ncube
Department:	Sociology
Date Reviewed:	December 2017
Decision of Committee:	Approved / Unconditionally
Expiry Date:	12 December 2019
Date:	12 December 2017
Head of School	Professor Mucha Musemwa
CC supervisor:	Professor Lorena Nunez Carrasco

Declaration of Investigator

To be completed in duplicate and one copy to be returned to Ms. Sarah Mfupa in the School of Social Sciences, Room 152, 1st Floor, Robert Sobukwe Block.

I fully understand the conditions under which I am authorised to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. If any departure from the research procedure as approved, I undertake to resubmit the protocol to the committee.

Student Signature

Date

Annex 2: Participant Information Sheet

Research Title: Study of Women's Experiences of Miscarriage in South Africa

Good Day

My name is Nobukhosi Ncube. I am a Master of Health Sociology Student at the University of the Witwatersrand. I am conducting a Masters research on the role of the social environment and the medical health care received on women's experiences of miscarriages.

The expected benefits of the research

This study has academic purposes and seeks to identify support systems in need of improving miscarriage experiences. This study advocates for a more women centered health care system. Therefore, there are no monetary gains associated with this study. Participants will not be offered any monetary incentives for their participation.

Participation

Participation in this research project is voluntary. You may withdraw at any point of the project without any warning or explanation if you wish to do so. Participation in this project will involve telling of miscarriage experiences.

Risks

This study may bring back difficult memories; if there is a need of support I can refer you to counselling services. If you feel at any stage that you prefer to not continue with the interview you will be free to withdraw from the study. You are urged to notify the researcher in any case you need counselling services, either prior to, during, or after the interview process. Free counselling services may be sought from **Sophia town Community Psychological Services, Address:** 4 Lancaster St, Westdene, 2092,

Tel: +27 11 4828530, **Fax:** +27 11 4828530 and **LifeLine Johannesburg**, **Phone:** 011 728 1331**, Toll Free:** 0861 322 322, **Fax:** 011 728 3497, **Email:** lifeline@lifelinejhb.org.za, **Address:** 2 The Avenue, Cnr, Henrietta Street, Norwood, Johannesburg, **Crisis:** 011 728 1347

Confidentiality

Interviews will be conducted in spaces where participants feel safe and secure. Verbal consent will be sought prior to the beginning of interviews and tap-recorder use. Information provided will not be discussed with anyone else. Findings will be presented in ways that ensure anonymity. Participant identities and the names of the health care institutions attended will be replaced with pseudonyms. Data collected will be secured and stored in a password protected computer for the duration of the study and be destroyed thereafter.

Feedback

Research results will be written into a Master of Arts Research Report. The Research Thesis will be accessed by the public from the Wits University Library after publication. However, copies of the research will be made available to participants upon request.

Privacy Statement

This research involves the collection, access and/or use of your personal information. Your personal information may be used in the publications/reports arising from this research. Any personal information collected is confidential and will not be disclosed to third parties. A copy of this data may be used for other research purposes and publications. However, your anonymity will at all times be safeguarded, except where you have consented otherwise.

Questions / further information

For any questions and more information regarding the project feel free to contact me on +27 74 386 0832 and on email nobukhosi2303@gmail.com . For any additional information or queries regarding this research project kindly contact my supervisor Professor Lorena Nunez Carrasco on +27 11 717 1000 and on email address Lorena.NunezCarrasco@wits.ac.za.

Thank you for your support and willingness to participate in this project.

Kind Regards

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University of Witwatersrand
C: +27 74 386 0832
E: nobukhosi2303@gmail.com

Annex 3: Verbal Consent Sheet

By agreeing to participate, you will be confirming that:

- You understand what participation in this research entails
- You have had any questions answered to your satisfaction
- You understand that if you have any additional questions or any further information regarding the research project you can contact the researcher Nobukhosi Ncube on +27 74 386 0832 and on email nobukhosi2303@gmail.com
- You understand that your participation is confidential, voluntary and that you are free to withdraw at any time, without explanation or penalty.
- You understand that you can contact the Research Supervisor Professor Lorena Nunez Carrasco on +27 11 717 1000 and on email address Lorena.NunezCarrasco@wits.ac.za for any queries or any additional information regarding the research project

Declaration

I the research participant (*optional pseudonym*) …… **Agree / Disagree** *(please tick)* to be part of Nobukhosi Ncube's research project. I have read and understood the information sheet and I am voluntarily willing to participate. I **Agree / Disagree** *(Please tick)* to the use of tape recorder during interviews.

Annex 4: Interview Guidelines

Group A Participants: Women who have experienced miscarriages

- Tell me a bit about yourself.
- Describe the nature of your miscarriage experience.
- What did the miscarriage mean in terms of your identity as a woman?
- How did you partner react to the miscarriage event?
- How did they treat you in the healthcare institution, and how did this treatment affect you?
- Do you think the way you reacted to your miscarriage relates to the moment in your life at which it happened? For instance, your age, you being in a particular relationship or financial status?
- How did your social interactions shape your miscarriage experience?
- Did your relationship with your parents, friends or partner change after the miscarriage event? If yes, in what way?
- What do you think should have been done better to improve your miscarriage experience?
- How can you describe your overall experience?

Group B Participants: Reproductive health care professionals

- Briefly introduce yourself. You may touch on your age, gender, race, years of service and people you serve (d) and work (ed) with.
- What is the health care procedure on women who have experienced miscarriages?
- How do you think the type of medical health care received impacts on the illness experiences of women after a miscarriage event? You can touch on assessment waiting periods, admission wards, doctor patient relationships, addressing psychological impacts, granting closure and addressing the root cause of the problem.
- What are the merits and the loopholes in the health sector that need more attention for the improvement of experiences of women after a miscarriage event?

Annex 5: Interview Schedules

pseudonym	Sex	Age	Race	Occupation	Interview Date	Time
Andiswa Mbatha	F	25	African	unemployed	10/01/ 2018	10:00
MRS Sekgoto	F	62	African	Retired Professional Nurse	11/01/2018	06:30
Beauty Mahlangu	F	24	African	Domestic Worker	12/01/2018	17:30
Royalty Mkhwanazi	F	28	African	Intern	13/01/2018	14:00
Menyiwe Msipha	F	27	African	student	13/01/2018	17:00
Khanyi Molape	F	35	African	Manager	15/01/2018	11:00
Nolly Zikhali	F	38	African	Business Woman	21/01/2018	16:00
Rasheena Naidoo	F	49	Indian	Teacher	26/01/2018	09:00
Tricia Brown	F	31	Coloured	Cleaner	28/01/2018	15:30
Ntombi Mohlapa	F	59	African	Professional Nurse	28/01/2018	22:00
Omphile Moloi	F	32	African	Retail worker	28/01/2018	12:00
Mrs Khumalo	F	35	African	Professional Nurse	03/02/2018	17:00
Lungelo Phakathi	F	30	African	Unemployed House Wife	05/02/2018	10:00