THE EVALUATION OF THE TERMINATION OF PREGNANCY PROGRAMME IN MPUMALANGA PROVINCE

by

RAMAITE EDITH MOOKAMEDI

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UNIVERSITY OF SOUTH AFRICA

PROMOTOR: PROF SM MOGOTLANE

JOINT PROMOTOR: PROF JH ROOS

NOVEMBER 2011
DECLARATION

I declare that THE EVALUATION OF THE TERMINATION OF PREGNANCY PROGRAMME IN MPUMALANGA PROVINCE is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of references and that this work has not been submitted before for any other degree at any institution.

------------------------------------------     ----------------------------
RAMAITE EDITH MOOKAMEDI     DATE
ABSTRACT

The purpose of the study was to evaluate the impact of the Termination of Pregnancy (TOP) programme in South Africa, using Mpumalanga as focal area, with the view of developing guidelines to assist service providers in the implementation of the Choice on Termination of Pregnancy (CTOP), Act 92 of 1996.

The study was conducted in two phases. In phase 1, a qualitative, quantitative, contextual, explorative, descriptive and case study research design was utilised. The purpose was to explore and describe TOP service providers and facility managers' knowledge regarding the CTOP Act, as well as their experiences and feelings regarding TOP provision, and the feelings and experiences of health care consumers utilising TOP services. Records of attendance regarding the utilisation of the services were also reviewed. Data was collected using unstructured and semi-structured interviews.

Phase 2 of the study focused on the development of guidelines to assist in the translation of the CTOP Act to action at service level. The findings revealed that although the TOP programme was operating within the reproductive health for women initiative, TOP service providers and facility managers were not knowledgeable on other legislation that supports the CTOP Act to integrate its implementation. All the participants experienced emotional, physical and psychological discomfort in providing TOP services. Lack of support of the programme also posed a major challenge. These findings formed the basis for the development of the guidelines.

KEY WORDS

Facility managers; health care consumer; TOP facilities; TOP programme; TOP service providers.
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Dedication

This text is dedicated to my mother Lizzie MalebalaMonama who always encouraged and supported me in my studies. Marumo, you were always my pillar of strength and inspiration throughout my successes.
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<td>African National Congress</td>
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<td>Christian Lawyers Association</td>
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<td>Mpumalanga Termination of Pregnancy Implementation Policy</td>
</tr>
<tr>
<td>NSAIDs</td>
<td>Nonsteroidal anti-inflammatory drugs</td>
</tr>
<tr>
<td>RMP</td>
<td>Registered medical practitioner</td>
</tr>
<tr>
<td>SA</td>
<td>South Africa</td>
</tr>
<tr>
<td>SABC</td>
<td>South African Broadcasting Cooperation</td>
</tr>
<tr>
<td>SACBC</td>
<td>South African Catholic Bishops’ Conference</td>
</tr>
<tr>
<td>SADC</td>
<td>Southern African Development Community</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Programme for Social Sciences</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of pregnancy</td>
</tr>
<tr>
<td>UNISA</td>
<td>University of South Africa</td>
</tr>
</tbody>
</table>
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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

As early as 1975, South African (SA) women had the right to obtain legal abortion; but through its rigidity, the Abortion and Sterilization Act, 2 of 1975 tended to limit access to the termination of pregnancy (TOP) services (Makgaba 1999:15; Ratlabala, Makofane &Jali 2007:26). The process of obtaining permission to procure an abortion was often “lengthy, unpleasant, humiliating and always expensive” (Makgaba 1999:11; Sadie &Van Aardt 1995:88; Lee 1996:60). Furthermore, the process made it impossible for most, and in particularly black women to get permission for the abortion to be effected within the recommended period (Engelbrecht, Pelser, Ngwena& Van Rensburg 2000:5), because, in terms of the Act, only a medical practitioner in a hospital specifically designated by the Minister of Health (MOH) was allowed to perform the abortion. At that time, the Minister of Health designated hospitals servicing only white people to perform abortions, and Black, Indian and Coloured women did not legally have access to these hospitals (Makgaba 1999:15; Morroni, Buga& Myer 2006:37; Potgieter& Andrews 2004:21). Furthermore, financially secure upper and middle class white woman could go to other countries, such as England to terminate unwanted pregnancies if uncertain of privacy in the services provided in SA (Guttmacher, Kabadia, Te Water Naude& De Pinho 1998:192 &Engelbrecht 2005:59).

The Abortion and Sterilization Act, 2 of 1975 did not stipulate who was to give consent in the case of a married woman. This was at the time when the constitution regarded women as minors and among black Africans, the traditional view was that the husband should consent for anything requiring intrusive medical treatment. Abortion without his consent would accordingly constitute a crimen injuria to him, thereby exposing the doctor to court action for damages. This did not express a view of a shared “right to procreation” (Strauss 1991:211; Makgaba 1999:11) as the husband was given power over his wife (Varkey-Sanjani, Fon &Ketlhapile 2000:105). According to Freeman (cited in Makgaba 1999:12), women were robbed of their right to make decisions and the pregnant woman’s right to self-determination and autonomy was undermined.
Somebody had to decide for the woman, especially if married. This historic subordination of women tended to oppress them, giving their husbands the right to make decisions concerning their reproduction, including being pregnant and the use of contraception (Makgaba 1999:25). Dyer (1990:303) and Potgieter and Andrews (2004:21) consequently criticised the application of the 1975 Act as discriminatory.

After 1994, the new democratic dispensation in South Africa culminated in the restoration of the fundamental human rights and the adoption of democratic values, characterised by, amongst others, the principle of redress and equitable distribution of services (Mojapelo-Batka &Schoeman 2003:144; Cooper, Morroni, Orner, Moodley, Harries, Cullingworth& Hoffman 2004:72). Chapter 2 of the Constitution of the Republic of South Africa (1996) enshrines the right to health, including sexual and reproductive health. The South African Constitution therefore creates an enabling framework for the Choice on Termination of Pregnancy (CTOP) Act as follows:

- **Section 9:** The **right to equality** outlaws discrimination on the grounds of pregnancy as well as gender. Dhai, Moodley and O’Sullivan (2002:18) point out that in terms of this section, “everyone is equal before the law and has the right to equal benefits and protection of the law inclusive of women who wish to access TOP services in terms of the CTOP Act”.

- **Section 12:** The **right to freedom and security of the person** provides for a number of reproductive rights. Everyone has the “right to be free from all forms of violence from both public and private sources.” This clause guarantees women physical and psychological integrity which specifically includes the right to make reproductive decisions and to security and control over their bodies.

- **Section 15:** The **right to religion, belief and opinion** provides every person with the right to freedom of conscience, religion, thought, belief and opinion. Health professionals are protected in their decision to participate in performing TOPs. This right also protects women’s decisions to terminate or not to terminate their pregnancies (Naylor & O’Sullivan 2005:13).
• Section 27: The right to health care, water and social security provides for the right to access reproductive health services. The Constitution provides a regulatory framework which is interpreted to include a woman’s right to choose a safe termination of pregnancy. No one can be refused emergency medical treatment. Where the woman’s health is in danger due to pregnancy, she is entitled by legislation to the termination of pregnancy procured by a trained health care professional.

• Section 32: The right to access of information includes information about TOP. This section promotes women’s right to access information that is held by health professionals. In the present study, it includes the right of the TOP health care consumers to information on TOP, the procedure to be followed in the termination of pregnancy and the place where TOP is procured (Morroni et al 2006:38).

• Section 36 makes provision for the limitation of rights. According to Dhai, Moodley and O’Sullivan (2002:20) and Naylor and O’Sullivan (2005:11), no right is absolute and all rights can be limited in terms of a law of general application to the extent that the limitation is reasonable and justifiable. Health professionals’ right to freedom of conscience is limited by Section 10 of the CTOP Act, in that they may not prevent a TOP or obstruct access to the facility (South Africa [Republic] 1996a:6; DOH 2005:10).

In the area of health services, the above principles were specifically aimed at revisiting those issues that gave rise to discrimination and unequal and unfair health treatment to black pregnant women in South Africa.

In South Africa, the Democratic Nursing Organisation of South Africa (DENOSA) ensures that the standards of nursing professionalism and the well-being of nurses are safeguarded. Searle, Human and Mogotlane (2009:21) describe DENOSA as “a voluntary professional nursing association with a trade union division”. The organisation is also concerned with the “total development of its members, including socio-economic aspects, and bears the welfare of the community in mind whilst fulfilling its primary function of representing the interests of nurses and midwives” (Searle et al 2009:222).
With regard to the pregnant woman, DENOSA (1997:6) stipulates that nurses

“..have to respect the pregnant woman’s right to freedom of choice and maintenance of dignity. For example, not to judge the woman in terms of her choice to terminate the pregnancy, and not to unduly influence her to change her mind...”

With regard to the right of the nurse, DENOSA (1997:6) stipulates that a registered nurse/midwife

“...has the right to freedom of conscience. For example, nurses may not be denied employment, dismissed or victimised for either the choice to participate or not in the termination of pregnancy. Such an action constitutes unfair labour practice...”

Thus nurses

• may also not be coerced to participate in direct termination of pregnancies
• have the right to training and only trained midwives may be involved in the direct action of the termination of pregnancy (DENOSA 1997:6)

In relation to TOP, DENOSA (1997:6) stipulates that

• where the registered midwife does not wish to participate in direct termination of pregnancy owing to conscientious objections, she/he should make her/his viewpoint known in good time, preferably when employment is accepted, so that substitute staff can be arranged for the TOP
• the registered midwife has a professional and an ethical obligation to nurse the patient before and after the procedure in spite of conscientious objection to the termination of pregnancy
• the nurse acts as an advocate for the patient and therefore has an obligation to refer the patient to an appropriate institution for termination of pregnancy
• the registered midwife should recognise the need for counselling and should, where necessary, refer the woman to the relevant facilities
• where medical and/or surgical treatment of a female patient may lead to the termination of pregnancy, all reasonable measures must be taken to exclude pregnancy prior to such treatment

Presently the South African government has unequivocally committed itself constitutionally and legally to eradicating unfair discriminatory practices wherever these exist in order to provide equity with special emphasis on race, gender, social standing and sexual orientation (Seroka 1999:1; Mdleleni-Bookholane 2007:245). This could not happen without redressing the past imbalances, including the issue of reproductive health. Following the debate on legislation on “abortion on choice”, the Azanian People’s Organization (AZAPO), the African National Congress (ANC), the Women’s Health Project from the University of Witwatersrand and the Black Sash Movement called for the inclusion of a clause in the bill of rights which says “the right to life should not derogate from a woman’s right to choose abortion”. The consideration of this clause led to the promulgation of the CTOP Act, 92 of 1996 (Makgaba 1999:16).

The CTOP Act, 92 of 1996 is aimed at improving women’s lives. The Act stipulates that every woman has the right to make choices about her own body and being pregnant. By allowing all women the right to choose whether to terminate their pregnancies within the specified parameters or not, South Africa is increasing access to safe abortion services for all women and is thus preventing morbidity and mortality associated with unsafe, illegal “back street” abortions. It also recognises the right of women to have access to reproductive health care including contraception and termination of pregnancy (Mashabane 2008:53).

1.2 INTERNATIONAL ABORTION LEGISLATION

Wherever abortion is allowed there are clear stipulations and these tend to be similar. In most countries the stipulations relate to the preservation of the health of the woman. The following table (table 1.1) summarises comparative aspects of TOP internationally:
Table 1.1: Comparative aspects of TOP internationally

<table>
<thead>
<tr>
<th>Comparative aspects</th>
<th>India</th>
<th>China</th>
<th>Nigeria</th>
<th>United States</th>
<th>Brazil</th>
<th>Germany</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saving woman's life</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Preservation of physical health</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Preservation of mental health</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Rape or incest</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foetal impairment</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Socio-economic reasons</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upon request</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

Adapted from Ngwena (2004:711)

According to table 1.1, The CTOP Act in South Africa addresses most of the aspects outlined in the table because it is aimed at:

- asserting the woman’s self determination: in South Africa TOP is done on request. In this instance, the request need not be justified as lack of reason for the request cannot be used to deny the woman the service requested
- preserving the woman’s health in cases of rape or incest, serious complications of pregnancy or gross foetal abnormalities

In all instances termination of pregnancy is performed before the end of twelve (12) weeks.

1.2.1 India

In India, the Medical Termination of Pregnancy Act, 1971 (the MTP Act) sets forth liberal grounds for the performance of abortion (http://www.echony.com/~jmkm/wotw/india.abortion.html). The MTP Act permits medical termination of pregnancy by a registered medical practitioner (RMP) in a variety of specified circumstances. In the case of a pregnancy that does not exceed 12 weeks, the medical termination of pregnancy is permitted if one RMP is of the opinion that:

- the continuance of the pregnancy would pose a risk to the life of the mother or place her at great risk of physical or mental injury.
• there would be substantial risk for the child to suffer physical or mental abnormalities with serious handicap.

The MTP Act specifies standards about where and by whom an abortion can be performed. The Act prohibits the performance of an abortion in any facility other than a government hospital or a facility approved by the government. In terms of the Act, any person, other than an RMP, who performs an abortion, is committing a criminal offence whether the procedure to save the woman’s life is necessary or not (http://www.echonyc.com/~jmkm/wotw/india.abortion.html).

The MTP Act attempts to protect the patient’s right. Unless the pregnant woman is a minor or mentally incompetent to make a decision (in which case a guardian must give consent), no pregnancy can be terminated. In South Africa the exception is that a pregnant minor can consent for TOP and in the amended version of CTOP Act, not only a midwife, but a registered nurse as well can perform a TOP. Although the Indian law permits women to obtain a legal abortion, on numerous occasions, access to services has been hampered by the low number of facilities and health professionals providing legal abortion services. (http://www.echonyc.com/~jmkm/wotw/india.abortion.html). This situation is also relevant to South Africa because when the study was conducted in Mpumalanga, TOP facilities were not evenly distributed, these were hospital based and there were none in the clinics; as such, some TOP health care consumers had to travel long distances to access the services. In Mpumalanga, there was also a significant low number of TOP service providers available to render the service.

According to the International Reproductive and Sexual Health Law Programme report (2008: i) in India, provider objection; lack of provider training, equipment and facilities; affordability and inadequate public funding; formal and informal procedural requirements; failure to respect confidentiality; stigma and discrimination as well as misinformation regarding the legality of abortion were cited by the report as barriers in accessing abortion services.
1.2.2 China

In China, abortion is generally available on demand and is governed by national and provincial laws (http://www.echonyc.com/~jmkm/wotw/china.abortion.html). National laws neither criminalise nor restrict access to the procedure.

In China, the 1994 Maternal Health Care Law, concerned with improving the quality of births, further specifies the conditions under which an abortion may be necessary. After prenatal diagnostic tests, doctors should give a medical opinion on termination of pregnancy under any of the following conditions:

- a serious hereditary disease affecting the foetus
- a serious deformity of the foetus
- a pregnancy that endangers the woman’s life

The 1994 Maternal Health Care Law makes provision for the reduction and waiver of charges for abortions and premarital medical check-ups for low-income women. To proceed with a pregnancy termination, a woman’s consent is required. If the woman is unable to consent, such consent must be obtained from her guardian.

The law also regards providers of abortion services as liable for the violation of its provisions. Unlicensed health care workers who terminate pregnancies are subject to a warning and fines. Furthermore, if an unauthorised health care worker conducts a termination of a pregnancy that results in the patient’s death or disability, that worker may face criminal charges. Persons who terminate pregnancies are required, by the law, to comply with family planning programmes. The Maternal Health Care Law is complemented by the Women’s Protection Law which prohibits a woman’s husband from applying for divorce until six months after pregnancy termination (http://www.echonyc.com/~jmkm/wotw/china.abortion.html).

Despite the law, provincial regulations in China continue to set forth the grounds for mandatory abortions. For example, Shaanxi Province’s family planning regulation recommends an abortion if a woman is unmarried or younger than the legal marriage age which is twenty one (21) years of age (http://www.echonyc.com/~jmkm/wotw/china.abortion.html).
A system of penalties or rewards assists provincial authorities in implementing abortion regulations. For example, regulations may suggest that failure to comply with local family planning regulations will result in the imposition of fines that may be refunded after the pregnancy is terminated. This type of regulation exists in Sichuan Province, China. Other incentives for terminating pregnancy include additional time to recover from abortion and contraceptive operations. In Jilin, a woman may get 14 days off from work after an induced abortion and 16 days if the procedure is accompanied by an intra-uterine device insertion (http://www.echonyc.com/~jmkm/wotw/china_abortion.html).

The law on TOP in China attempts to protect the patient’s rights, health status and her socio-economic status. This is similar in a way to the aims of TOP in South Africa. Furthermore, the South African, CTOP Act stipulates that only trained health professionals (Medical practitioners and registered nurses/midwives) are allowed to provide such a service. Violation of this stipulation constitutes a criminal offence as is the case in China (Naylor & O’Sullivan 2005:29; Daily Sun 2008:13).

1.2.3 Nigeria

In Nigeria, criminal law is applied differently in the South and in the North of the country (http://www.echonyc.com/~jmkm/wotw/nigeria_abortion.html). The Criminal Code applies to the Southern states and the Penal Code to the Northern states. In Nigeria performance of an abortion is a criminal offence unless it is performed to save the pregnant woman’s life. The laws supporting this are essentially similar in the South and North Nigeria but worded differently.

In the Southern states the Criminal Code states that any person, who, with an intent to procure an abortion, unlawfully administers or causes a pregnant woman to take any poison or other noxious things, or uses any kind of force, or uses any other means whatsoever, is guilty of felony, and is liable to imprisonment for fourteen (14) years. Similarly, a woman who with an intent to procure her own abortion or miscarriage unlawfully administers to herself any poison or uses any force of any kind or permits any such thing or means to be administered to her, is liable to seven (7) years’ imprisonment.
In the Northern states, however, the Penal Code states that any person who voluntarily causes a woman with child to miscarry is punishable by imprisonment. A woman who causes herself to miscarry is considered to be within the meaning of this provision, so, she is also punishable by imprisonment.

Both the criminal and penal codes impose a penalty of fourteen (14) years imprisonment for the performance of abortion.

Criminal law permits the performance of an abortion necessary to save a woman’s life. The criminal code stipulates that a person is not criminally responsible for performing, in good faith and with reasonable care and skill, a surgical operation upon an unborn child for the preservation of the mother’s life. Similarly, the penal code permits an abortion to save the life of a woman.

Laws cover other abortion-related offences. For example, in Southern Nigeria the criminal code provides that it is illegal to supply materials that may be used to terminate pregnancy.

The abortion law in Nigeria differs from the CTOP Act in South Africa because in Nigeria, the right of the woman to make a reproductive choice is not considered; TOP is only considered for the preservation of the woman’s life as determined by the medical practitioner).

1.2.4 United States of America (USA)

In the United States of America (USA), abortion is legal in all states. (http://www.echonyc.com/~jmkm/wotw/unitedstates.abortion.html). Women have a constitutional right to decide whether or not to terminate a pregnancy. The Supreme Court has further held that the state restrictions on abortion would be valid only if justified by a compelling state interest. At the same time, it is acknowledged that there is a need to strike a balance between women’s right to choose and the state’s interest in ensuring the health of the pregnant woman and protecting a potential human life. Thus the court has held that in the first trimester of pregnancy, abortion should be available without restrictions. In the second trimester of pregnancy only the state’s interest in the maternal health is sufficiently compelling to justify restrictions. After foetal viability, abortion is restricted
unless the procedure is necessary to preserve the woman’s life or health (http://www.echonyc.com/~jmkm/wotw/unitedstates.abortion.html).

Although many laws restricting abortion are still challenged in the courts, numerous states require pregnant minors seeking an abortion to obtain parental consent and/or delay their abortion for a period of 24 hours after receiving information intended to discourage abortion. According to Engelbrecht (2005:41) such laws provide for judicial bypass and the affected minor does not have to go to court and compromise confidentiality. This is different in South Africa, because pregnant minors need not consult parents even when advised to do so. They also are not required to go to court to seek permission to terminate a pregnancy, but instead can sign a consent for the procedure for themselves.

Despite the legal right to obtain an abortion, the Supreme Court has held that the government may deny funding for abortion services while providing pregnancy-related medical care, including childbirth. According to Gerber Fried (2000:178-179), women requesting abortion in the USA may have to pay to receive the service. Other challenges experienced in the USA include

- a critical shortage of abortion providers because of harassment to the point of murder by anti-abortion activists.
- societal disapproval, stigma and misinformation about the risks and sequelae of abortion for women who had an abortion (Littman, Zarcadoolas & Jacobs 2009:419).

These threaten access to abortion for low-income women and those living in peri-urban and rural areas (http://www.echonyc.com/~jmkm/wotw/unitedstates.abortion.html).

The above comments are relevant to the South African situation because even though TOP services, including maternal health services, are provided free of charge, the limited and/or geographical uneven distribution of TOP facilities require that women, especially in rural areas, travel long distances to access TOP services, meaning that savings made in the free services are lost in the travelling. Furthermore, at the time of investigation, TOP service providers were also few in number, and, as such, the choice to terminate a pregnancy, was not easily attainable. For example, in one facility, the
TOP service provider stated that she was the only one providing the service (SABC 3, 2006: Special Assignment 20:30). Another issue was the negative attitude of the community towards TOP service providers and TOP health care consumers alike. Nandipha (2008:14) found that there is still a stigma attached to the TOP service. Nurses providing the service worked under stressful conditions due to the community’s attitude to termination of pregnancy, especially in the rural areas where communities believed that TOP is a sin, describing it further as murder. Those participating in TOPs, both service providers and health care consumers, are said to lack morals. Nandipha (2008:14) adds further that under such circumstances, nurses who perform TOPs tend to withdraw their services after a few years because of lack of support from management in terms of debriefing sessions for those health professionals who experience ambivalence, anxiety and depression as a result of participating in the termination of pregnancies.

In Mpumalanga, where the study was conducted, all TOP service facilities are hospital based thereby making access and affordability difficult for rural women in terms of distance which invariably translated to costs.

1.2.5 Brazil

In Brazil, except under prescribed circumstances, the performance of an abortion constitutes a criminal act. An abortion is permitted only if performed to save the life of the pregnant woman and in cases of rape. In the latter circumstance, the pregnant woman is required to consent to the procedure. The Penal Code specifies that if a pregnant woman performs an abortion on herself or consents to its performance by another person, she is subject to a sentence of one to three years detention. An abortion performed on a woman without her consent carries a punishment of three to ten years imprisonment for those who perform the abortion, professionals or non-professionals.

Increased penalties are imposed for the performance of an illegal abortion on a woman who has consented under dubious circumstances. Hence, the punishment for the performance of such an abortion is increased from one to four years’ imprisonment if

- the woman is mentally ill or retarded
• the woman’s consent has been obtained by fraudulent means, severe threats, or violence

The penalties for the performance of an illegal abortion are also increased if the woman was injured in the process. Punishment is increased by one third if, as a consequence of the abortion, the pregnant woman suffers severe bodily harm. If the pregnant woman dies, punishment is doubled. Brazil’s abortion law appears to be in the process of reform. Although the civil code refers to the protection of the rights of the foetus from conception, the constitution does not set forth this right (http://echonyc.com/~jmkm/wotw/brazil.abortion.html).

In 1993, a proposed bill that would permit abortion up to the twelfth week of pregnancy was introduced. Abortion up to the twenty-fifth week of pregnancy would also be permitted for pregnancies resulting from rape and/or on the grounds that the foetus is severely deformed or the woman is a carrier of the AIDS virus (Error! Hyperlink reference not valid.).

The Brazilian abortion law differs from SA’s CTOP Act in that the right of a pregnant woman to choose whether to terminate or not to terminate the pregnancy is not considered.

1.2.6 Germany

Abortion law in Germany is based on a Federal Constitutional Court decision and the Penal Code (http://www.echonyc.com/~jmkm/wotw/germany.abortion.html).

Through the Basic Law, the Federal Constitutional Court protects the right to life of the unborn child. Recognition of women’s constitutional rights requires that abortion be permitted in exceptional circumstances. The Federal Constitutional Court decided that an abortion is not punishable if performed by a physician within the first 12 weeks after conception and if the pregnant woman asked for the procedure and certified that she had been counselled at least three days prior to the performance of an abortion. The court can also determine that abortion for medical and surgical reasons could be financed by health insurance.
In terms of the Penal Code, a pregnancy may be terminated if the

- continued pregnancy would endanger the life of the woman or pose injury to her physical and mental health
- woman has given informed consent
- foetus suffers from such irremediable damage that the continuation of the pregnancy cannot be of benefit to the pregnant woman. Abortion by a physician is permitted in the first 22 weeks of pregnancy. In such a case, the woman must first receive counselling at least three days prior to an abortion and then, in the case of the abortion not being performed by her physician, she must obtain written permission from her attending physician or public health officer for the performance of such.

Punishment for the performance of illegal abortion varies. If the pregnant woman herself performs an illegal abortion, she may be subject to imprisonment of up to one year or a fine. However, pursuant to a 1993 constitutional court decision, a woman may not be punished for receiving an abortion during 12 weeks after conception if she requested the procedure and received appropriate counselling. Providers who perform an illegal abortion are subject to imprisonment up to three years or a fine. Moreover, providers who attempt to perform an illegal abortion are subject to sanctions. Punishment is increased if a perpetrator acts against the will of the woman or recklessly puts the woman’s life in danger or causes serious harm to her health. The process for termination of pregnancy in Germany is similar to that of South Africa.

1.2.7 Roman Catholic and Islamic countries
Abortion is generally illegal in many Roman Catholic and Islamic countries. According to Engelbrecht (2005:49-50), in Southern Africa, countries whose abortion laws are based on Roman-Dutch Common law were cited as Lesotho and Swaziland. In these countries, TOP is not allowed, hence the influx of women from Lesotho and Swaziland into the Free State and Mpumalanga respectively seeking abortion. These laws, according to Engelbrecht (2005:49), “prohibit abortion except in case of necessity” As such the author asserts uncertainty in this regard. The other neighbouring countries, (Zimbabwe, Botswana, Namibia and Mozambique), have reported reform in the area of
abortion albeit at varying degrees based on their Common laws even though the conditions under which they operate are largely not different from those stipulated in the repealed Abortion and Sterilization Act, 2 of 1975 of South Africa.

Table 1.2 provides a summary outlining the grounds under which legal abortion is permitted in Southern African Development Community (SADC) countries.

Table 1.2: Grounds under which legal abortion is permitted in SADC countries.

<table>
<thead>
<tr>
<th>Country</th>
<th>To save the woman's life</th>
<th>To preserve physical health</th>
<th>To preserve mental health</th>
<th>Rape or incest</th>
<th>Foetal impairment</th>
<th>Socio-economic reasons</th>
<th>Upon request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
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<td>Botswana</td>
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<td>x</td>
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<td>Mozambique</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Namibia</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seychelles</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>X</td>
</tr>
<tr>
<td>Swaziland</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zaire</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zambia</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Ngwena, 2004:711

**Concluding remarks**

From the discussion above, South Africa seems to compare favourably with China, USA and Germany. In SADC, South Africa is the only country that provides for abortion on request. The challenge to this relates to:

- Accessibility: although many hospitals have been designated to provide TOP services, very few 66.3% are active.(see table 1.3)
• Distribution: the active facilities are unevenly distributed geographically
• Acceptability: Although TOP is legal in South Africa following the stipulations of CTOP Act, many people still disapprove of it on religious grounds. Rakhudu, Mmelesi, Myburgh and Poggenpoel (2006:58) and Nandipha (2008:14) found that religious stigma is attached to those terminating pregnancies. The religious stigma makes it hard for community members in need of the service to freely come forward and access the service.

1.3 TERMINATION OF PREGNANCY (TOP) IN SOUTH AFRICA: CHALLENGES

Despite the promulgation and the implementation of the CTOP Act, 92 of 1996, debate still continues, especially amongst religious organisations that are pro-life. For example, Father Emil Blaser, spokesperson for the South African Catholic Bishops’ Conference (SACBC), found the Act “incomprehensible” especially after the African National Congress (ANC), who had struggled for the recognition of human dignity, approved the taking of life in the form of abortion. Blaser described the Cabinet’s approval of the Act as “a sad day in the history of the country, which will be regretted for many years”. Blaser added that “termination of pregnancy (TOP) is a very controversial and sensitive issue that impacted negatively on communities’ values, socio-cultural, moral and spiritual backgrounds” (Clash 1996:60; O’Loughlin 1996:17). The CTOP Act, 92 of 1996 was one of the issues that created conflict between the personal, moral, legal and professional demands on health care workers (Harrison, Montgomery, Lurie & Wilkinson 2000:426; Makgaba 1999:2).

In 2005, septic abortion was found to be the third highest cause of maternal death in the west of Pretoria (Mbele, Snyman & Pattison 2006:1196). A total of 26 out of 43 reported perinatal deaths were due to self-induced septic abortions or abortions procured with the help of people outside the health care system. In addition, not all designated facilities performed and delivered TOP services, thus reducing accessibility (DOH 2002b:20; DOH 2005:22-23). Table 1.3 illustrates the number of active designated facilities that performed TOP in 2004 in South Africa.
Table 1.3 Active designated facilities that performed TOP in 2004

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>DESIGNATED FACILITIES</th>
<th>FACILITIES ACTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>33</td>
<td>21</td>
</tr>
<tr>
<td>Free State</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>69</td>
<td>20</td>
</tr>
<tr>
<td>Gauteng</td>
<td>75</td>
<td>72</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>28</td>
<td>8</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Limpopo</td>
<td>38</td>
<td>32</td>
</tr>
<tr>
<td>North West</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>Western Cape</td>
<td>72</td>
<td>56</td>
</tr>
<tr>
<td>Total</td>
<td>347</td>
<td>230</td>
</tr>
<tr>
<td>Percentage</td>
<td>100%</td>
<td>66.3%</td>
</tr>
</tbody>
</table>

Adapted from DOH (2005:22-23)

From table 1.3 it is evident that in 2004, only 66.3% of the facilities designated to perform TOP were active.

1.4 TERMINATION OF PREGNANCY (TOP) IN MPUMALANGA, SOUTH AFRICA

In Mpumalanga, TOP is part of sexual and reproductive health service (MDOH 2009a:7). The TOP programme was introduced in Mpumalanga in 1997 to address gender issues where women are supported to enhance self-determination. As a government initiative and commitment, the programme further aims to reduce the morbidity and mortality due to unsafe abortion practices. To assist in the implementation of the TOP programme, the province developed a policy known as the Mpumalanga Termination of Pregnancy Implementation Policy (MTOPIP) (see annexure D).

The vision of the MTOPIP (MDOH 2009a:7) is that, as part of a comprehensive sexual reproductive health service, “women in Mpumalanga shall have access to quality termination of pregnancy when faced with a need to terminate a pregnancy”.

The provision of TOP service is based on the following national legislation (MDOH 2009a:7-8):

- The CTOP Act, 92 of 1996, as amended, which enables all women of child-bearing age in South Africa to access safe and legal termination of pregnancy
services within the first twelve weeks on demand and from thirteen to twenty weeks under specified circumstances (see annexure A).

- The Constitution of the Republic of South Africa Act, 108 of 1996, which provides reproductive rights and the right of access to reproductive health care.
- The Acts, rules and regulations that govern the practice of nurses and medical personnel:
  - Nursing Act, 33 of 2005
  - Medical and Dental and Supplementary Health Service Professions Act, 56 of 1974
  - Medicine and Related Substances Act, 101 of 1965, as amended
  - Regulation 2598 of 1984 as amended, on the scope of practice of nurses and midwives
  - Regulation 888 of 1987 as amended, on the Acts and Omissions in respect of which the South African Nursing Council may take disciplinary steps
  - Regulation 2488 of 1990, on the practice of a midwife
  - Regulation 2418 of 1973 as amended, on keeping, supplying, administering or prescribing medicines by registered nurses

As one of its priorities, the MDOH (2009a:8-9) planned to increase the number of hospitals implementing the TOP programme to twelve (12) in 2008/2009. To this effect, the government planned to:

- conduct value clarification workshops to assist in reducing the stigma attached to TOP services, facilities, providers and consumers
- conduct ongoing training for manual vacuum aspiration to increase the number of TOP service providers
- conduct debriefing sessions for those involved in TOP service provision
- revisit the funding for the TOP programme
- consider a retention plan for the TOP service providers
- identify and remove barriers restricting clients from accessing TOP services
- decentralise TOP services to PHC level
The MTOPIP (MDOH 2009a:8-9) further stipulates that:

- TOP services shall be provided free of charge in all designated facilities.
- An enabling environment for the provision of TOP shall be created.
- TOP services shall be provided through a well-defined system with clear referral pathways.
- All facilities shall respect and promote human and reproductive rights for each client seeking TOP services.
- Staff in non-designated facilities should assist in referring clients to facilities providing TOP services when this is required.
- The department will develop facility based TOP protocols that are in line with the MTOPIP.
- Management in the designated facilities does not have the right to refuse the implementation of TOP services where the trained TOP service provider is available.

Furthermore, monitoring and evaluation of the MTOPIP shall be the responsibility of the Department of Health in consultation with the stakeholders (MDOH 2009a:10). Therefore the following shall take place:

- Relevant process and outcome indicators should be developed.
- Facilities shall submit monthly statistics, using the relevant forms.
- Hospital management shall conduct internal audits quarterly.
- The districts/province shall conduct external audits twice a year.
- Feedback will be given to the facility within one month of the audit.
- Remedial action will be taken, when necessary.

The process in the TOP programme (MDOH 2009a:11) is as follows:

- Pregnancy may only be terminated upon request by the woman during the first 12 weeks of gestation.
- Only a medical practitioner or a registered nurse who has completed the prescribed training course may carry out the termination of a pregnancy.
• Non-mandatory and non-directive counselling must be available prior and after termination of the pregnancy.

• The termination of the pregnancy may only take place with the informed consent of the pregnant woman. In case of a pregnant minor, a medical practitioner or a registered nurse shall advise such a minor to consult with her parents, guardians, family members or friends before the pregnancy is terminated, provided that the termination of the pregnancy shall not be denied because such a minor chooses not to consult these.

• The person concerned shall inform the woman requesting termination of pregnancy of her rights under this Act.

• The identity of the woman who has requested or obtained termination of pregnancy shall remain confidential at all times unless she herself chooses to disclose the information.

The MTOPIP (MDOH 2009a:11) further stipulates that, irrespective of any conscientious objection, a nurse must provide the following to the clients who have had an abortion:

• Nursing care assessment, planning, implementation, monitoring and evaluation.

• Basic assistance with activities of daily living while in the facility.

• Emotional, physical and psychological support.

• Comfort and pain relief measures.

In Mpumalanga, where the study was conducted, all facilities designated to provide TOP services are hospital based. In 2007, the number of designated facilities to provide TOP was increased to 28, of which 9 were active (see table 1.4).

Table 1.4 Number of facilities providing TOP services in Mpumalanga, 2004-2010

<table>
<thead>
<tr>
<th>YEAR</th>
<th>NUMBER OF ACTIVE FACILITIES PROVIDING TOP SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>8</td>
</tr>
<tr>
<td>2005</td>
<td>5</td>
</tr>
<tr>
<td>2006</td>
<td>11</td>
</tr>
<tr>
<td>2007</td>
<td>9</td>
</tr>
<tr>
<td>2008</td>
<td>9</td>
</tr>
<tr>
<td>2009</td>
<td>9</td>
</tr>
<tr>
<td>2010</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: MDOH 2010:1
Table 1.4 indicates that the province has never had the full complement of all the designated facilities providing TOP services. In fact, at the beginning of 2010 only seven (7) were actually active, showing the decrease in this regard.

Since its implementation in 1997, the CTOP Act has encountered legal challenges. The first legal challenge was heard at the Constitutional Court in July 1997. The Christian Lawyers Association (CLA) argued that TOP violates the right to life and the Act that supports this must therefore be repealed. The claim was dismissed by the Constitutional Court in July 1998 based on the fact that the foetus did not have a constitutional right.

In 2001 the CLA challenged the condition laid for the provision of TOP to the minor client in the High Court. The CLA argued that there should be no circumstances whereby a minor could consent to TOP without parental or court consent. On 28 May 2004, the Pretoria High Court dismissed the claim on the basis that the Constitution protects all women including those under the age of 18 (DOH 2005:17).

In 2005, the CTOP Amendment Act was passed by Parliament. In terms of the amendment (Hoffman, Moodley, Cooper, Harries, Morroni, Orner, Constant& Mathews 2006:1056):

- Clinics offering a 24-hour maternity service need no longer obtain special approval to conduct abortions.
- Clinics conducting abortions are required to keep and submit statistics relating to abortions procured.
- Registered nurses who have completed special training on TOP may also conduct abortions.

The amendment of the CTOP Act in 2005 was challenged in the Constitutional Court by Doctors for Life International on the basis of inadequate public participation prior to the promulgation of the amendment Act. In August 2006 the Constitutional Court declared that the amendment was indeed unconstitutional on those grounds, but suspended the invalidation for 18 months during which time Parliament would have to ensure proper public involvement (http://en.wikipedia.org/wiki/abortion_in_South_Africa).
After public consultation on the stipulations of the invalidated CTOP Amendment Act of 2005, the CTOP Amendment Act, 1 of 2008 was promulgated stipulating the contents of the invalidated Act of 2005 (South Africa [Republic] 2008:2-8) (see annexure A).

1.5 STATEMENT OF THE PROBLEM

The provision of reproductive health services, especially TOP services, was identified as a national priority in South Africa due to escalating morbidity and mortality rates as a result of unsafe backstreet abortions. Backstreet abortions were not only illegal, but these were also indecent and inhuman and therefore criminal (De Pinho& Hoffman 1998:786). According to Morroni, Myer and Tibazarwa (2006:1.5), an average of 1000 legal abortions were granted annually in South Africa under the very restrictive discriminatory old Abortion and Sterilization act, 2 of 1975, while at the same time an estimated number of 200 000 unsafe abortions were performed resulting in an estimated 45 000 hospital admissions and more than 400 deaths from septic abortion.

According to records in the Department of Health, the government had spent approximately R18 million prior to the inception of the CTOP Act, to treat complications associated with unsafe termination of pregnancies (MDOH 2009:6; DOH 2005:19). The promulgation of the CTOP Act, 92 of 1996, was another initiative by government to support the constitution of the country and an extension of the human rights initiative to include women with a special focus on reproductive issues.

Although the CTOP Act was introduced in 1996; in Mpumalanga Province, the TOP programme has not been evaluated to establish its impact on the quality of life. Since its inception, the programme has been clouded by debates and controversy against its implementation (Engelbrecht et al 2000:6; Dickson-Tetch& Billings 2002:145 &Engelbrecht 2005:4).

Engelbrecht (2005:4), further asserts that the poor organisation of the health system in relation to referrals, geographic distribution of facilities offering TOP, the lack of trained TOP service providers as well as the negative attitude and stigmatisation of TOP service providers and TOP health care consumers alike by communities have all contributed to the poor service delivery in this regard.
To support the above, contents of a disturbing television documentary are presented. On the 23 June, 2002, at 12h00, there was a television documentary in a television programme, *Carte Blanche*, entitled *DIY Abortions* (SABC, MNet 2002). In the documentary, women who had come for TOP were not assisted properly. They were put in a ward and each bed was screened. The nurse responsible was shown to periodically instruct a woman to dispose of her soiled sanitary pad or empty the bed pan contents in the toilet. She did not keep any record nor was she shown administering any medication. She looked agitated all the time she was there. The documentary showed one nurse and a bed occupancy of more than six, depicting the shortage of staff in these units (SABC, MNet 2002).

Two years prior to this eventful documentary, a medical practitioner had reported that women were sent with their own products of conception to the incinerator. According to the television programme *Carte Blanche* (DIY Abortions on 23 June 2002 at 12:00), this kind of treatment was also said to have happened in other hospitals in the province (SABC, MNet 2002.)

In Mpumalanga, service utilisation has fluctuated, with recent statistics declining (see table 1.7). Although all the hospitals have been designated to provide TOP services, only 7 were found to be active in 2010 at the time of investigation (see table 1.5 and 1.6). An evaluation of the TOP programme is necessary because the government has invested human and financial resources to manage the programme and its continuation should be based on positive outcomes. Table 1.5 reflects the status of TOP service provision in Mpumalanga.

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>NUMBER OF FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of health facilities in Mpumalanga</td>
<td>237 Clinics</td>
</tr>
<tr>
<td></td>
<td>36 Community Health Centres</td>
</tr>
<tr>
<td></td>
<td>28 Hospitals</td>
</tr>
<tr>
<td>Total number of facilities designated to provide TOP service in</td>
<td>28 Hospitals</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td></td>
</tr>
<tr>
<td>Total number of facilities not active in 2010 in the provision of</td>
<td>21 Hospitals</td>
</tr>
<tr>
<td>TOP services in Mpumalanga</td>
<td></td>
</tr>
<tr>
<td>Total number of designated health facilities active in the</td>
<td>7 Hospitals</td>
</tr>
<tr>
<td>provision of TOP service</td>
<td></td>
</tr>
</tbody>
</table>

Source: MDOH (2009b:1)
Table 1.5 indicates that 100% of hospitals in Mpumalanga are designated to provide TOP services but only 25% of those designated facilities provide the service. A similar situation was reported by Mendes and Basu (2010:614) when they indicated that the district facilities that provided TOP services in Johannesburg decreased in 2008/2009. Table 1.6 indicates the distribution of these facilities in Mpumalanga.

Table 1.6  Distribution of facilities active in the provision of TOP services

<table>
<thead>
<tr>
<th>FACILITY</th>
<th>DISTRIBUTION IN DISTRICTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Hospitals</td>
<td>Ehlanzeni District</td>
</tr>
<tr>
<td>2 Hospitals</td>
<td>GertSibande District</td>
</tr>
<tr>
<td>1 Hospital</td>
<td>Nkangala District</td>
</tr>
<tr>
<td><strong>Total:</strong> 7 Hospitals</td>
<td>3 Districts</td>
</tr>
</tbody>
</table>

Source: MDOH (2009b:1)

The following table (table 1.7) also provides statistics of pregnancies terminated in the earlier years of the inception of the TOP programme. The figures show a significant fluctuation from 2002 (see table 1.7).

Table 1.7: Number of TOPs and annual accumulated increase/decrease in Mpumalanga, 1998-2008

<table>
<thead>
<tr>
<th>YEAR</th>
<th>NUMBER OF TOPs</th>
<th>PERCENTAGE INCREASE/DECREASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>1642</td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>1893</td>
<td>15.28%</td>
</tr>
<tr>
<td>2000</td>
<td>2344</td>
<td>23.82%</td>
</tr>
<tr>
<td>2001</td>
<td>3802</td>
<td>62.20%</td>
</tr>
<tr>
<td>2002</td>
<td>3151</td>
<td>-17.12%</td>
</tr>
<tr>
<td>2003</td>
<td>2767</td>
<td>-12.18%</td>
</tr>
<tr>
<td>2004</td>
<td>1962</td>
<td>-29.09%</td>
</tr>
<tr>
<td>2005</td>
<td>1381</td>
<td>-29.61%</td>
</tr>
<tr>
<td>2006</td>
<td>3735</td>
<td>170.45%</td>
</tr>
<tr>
<td>2007</td>
<td>3772</td>
<td>0.99%</td>
</tr>
<tr>
<td>2008</td>
<td>1687</td>
<td>-55.2%</td>
</tr>
</tbody>
</table>

Source: MDOH (2009b:1)
From table 1.7 it is evident that TOP service provision in Mpumalanga is not stable. The decrease in 2005 was at 29.61%. In 2006, however, the figure doubled to 3 735 compared with the initial figure of 1 642 clients in 1998. This figure was still low compared to other provinces. According to a television documentary on *Special Assignment* (SABC 3, 2006), an unnamed province performed a total of 8 300 terminations of pregnancies to teenagers in a year. Since 2008 the number of service users has declined drastically in Mpumalanga.

The researcher also compared the number of TOPs performed (see table 1.7) with the women: year protection rate (see table 1.8), namely the rate of women using pregnancy protection measures and the profile of women of child-bearing age. Tables 1.8 and 1.9 provide the rates and figures for pregnancy protection measures and of women of child-bearing age respectively.

**Table 1.8** Women: year protection rate in Mpumalanga, 2002-2008

<table>
<thead>
<tr>
<th>YEAR</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>21.4%</td>
<td>20.9%</td>
<td>21.5%</td>
<td>22.1%</td>
<td>24.3%</td>
<td>26.7%</td>
<td>27.5%</td>
</tr>
</tbody>
</table>

Source: MDOH (2009b:1)

**Table 1.9** Profile of women of child-bearing age in Mpumalanga, 2002-2008

<table>
<thead>
<tr>
<th>AGE CATEGORY</th>
<th>YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2002</td>
</tr>
<tr>
<td>15 yrs</td>
<td>39 301</td>
</tr>
<tr>
<td>16 yrs</td>
<td>38 701</td>
</tr>
<tr>
<td>17 yrs</td>
<td>38 068</td>
</tr>
<tr>
<td>18-19 yrs</td>
<td>73 435</td>
</tr>
<tr>
<td>20-24 yrs</td>
<td>168 567</td>
</tr>
<tr>
<td>25-29 yrs</td>
<td>152 952</td>
</tr>
<tr>
<td>30-34 yrs</td>
<td>121 185</td>
</tr>
<tr>
<td>35-39 yrs</td>
<td>97 762</td>
</tr>
<tr>
<td>40-44 yrs</td>
<td>83 294</td>
</tr>
<tr>
<td>45-49 yrs</td>
<td>69 849</td>
</tr>
<tr>
<td>Total</td>
<td>883 160</td>
</tr>
</tbody>
</table>

Source: MDOH (2009b:1).
An attempt at sourcing the fertility rate of women in Mpumalanga was not successful.

Based on the above information, the researcher considered it imperative to conduct the study to evaluate the impact of the TOP programme because:

- The above statistics do not provide a clear picture of the impact of the TOP programme. For example, in 2003 the female population of child bearing age increased to 896 776, the protection rate was 20.9% while the number of TOPs decreased by 12.18%. In 2006 and 2007, the number of TOPs increased to 3 735 and 3 772, respectively, whilst the protection rate also increased to 24.3% and 26.7%, respectively.

- The researcher found no evidence or findings to indicate that the TOP programme in Mpumalanga was ever evaluated.

The study was conducted to evaluate the impact of the TOP programme in Mpumalanga, South Africa, and, based on fluctuating statistics, develop guidelines on the implementation of the CTOP Act, 92 of 1996 as amended.

1.6 SIGNIFICANCE OF THE STUDY

Reproductive health service is a key area of service provision in the country and, as such, should be given priority. Inherent in the reproductive health services is the TOP programme which contributes to the recognition of women’s right and to self-determination in line with the constitution of the country as outlined in chapter 2 (Republic of South Africa, Act 108 of 1996) and the reduction of infections and maternal deaths that may follow illegal abortion. Apart from self determination for women and the reduction of indecent unnecessary deaths due to unsafe TOPs, the programme was also introduced to reduce government expenditure on health care in this regard (MDOH 2009:6; DOH 2005:19). It is reported that, prior to the inception of the CTOP Act, government had spent approximately R18 million to treat complications associated with unsafe termination of pregnancies (MDOH 2009:6; DOH 2005:19).

Mpumalanga Province has developed a policy, the Mpumalanga Termination of Pregnancy Implementation Policy (see annexure D) to operationalise the national Act on TOP, ie, Choice on Termination of Pregnancy Act, 92 of 1996. This study will
contribute to policy implementation and assist the provincial government in improving service delivery, with special emphasis on women’s health, while supporting national imperatives on human rights.

The Mpumalanga Department of Health (MDOH 2009b:2) estimates the cost of managing TOP programme as approximately R750 000.00 annually while the training of an individual costs R15 700.00. The study will assess the impact of the TOP programme in Mpumalanga to justify the budgetary allocation in this regard. The presentation of the findings will be such that these can be applied nationally and the study replicated whenever and wherever required.

1.7 PURPOSE OF THE STUDY

The purpose of the study was to evaluate the impact of the TOP programme in South Africa, using Mpumalanga as a focal area and develop guidelines to assist service providers in the implementation of the CTOP Act. Mpumalanga was chosen because it is one of the provinces where many facilities are designated to provide TOP services but very few are active (see tables 1.5 and 1.6).

1.8 OBJECTIVES OF THE STUDY

In order to achieve the purpose, the study was conducted in two phases.

Phase 1 focused on the evaluation of the impact of the TOP programme in Mpumalanga. The objectives were to

- explore and describe the experiences and feelings of TOP health care consumers in accessing the TOP service at the designated facilities
- explore and describe the knowledge of TOP service providers and TOP facility managers regarding the CTOP Act (92 of 1996) as amended
- explore and describe the experiences and feelings of TOP service providers and TOP facility managers regarding TOP service provision
- review records of attendance to determine utilisation of the TOP services
Phase 2 focused on the development of guidelines to assist in the translation of the CTOP Act to action at service level. The objective was to:

- develop guidelines to assist in the interpretation and implementation of the CTOP Act (92 of 1996)

1.9 RESEARCH QUESTIONS

The research question which directed the study was:

What is the impact of the TOP programme in Mpumalanga?

In order to determine the impact, the study wished to answer the following questions:

- What is the nature of services provided to clients in the TOP programme?
- What is the knowledge of TOP service providers and TOP facility managers regarding the CTOP Act (92 of 1996) as amended
- What are the experiences and feelings of TOP service providers as well as of managers of the facilities providing TOP services?
- What are the experiences and feelings of TOP health care consumers regarding TOP services in Mpumalanga, South Africa?

1.10 PARADIGMATIC PERSPECTIVE OF THE STUDY

Many explanations and descriptions of a paradigm have been given by a variety of authors. A paradigm is a belief system in the way things are done or a model of how things should be done. A paradigmatic perspective relates to the view on how things are done. Neuman (2000:65) and Monama (2009:15) describe a paradigm as a manner of thinking, observing and interpreting what is seen and includes assumptions, questions, solutions and process. According to Holloway and Wheeler (2010:24); De Vos, Strydom, Fouchè and Delport (2011:41), a paradigm gives philosophical ideas on which the research is based. Furthermore, it is regarded as a “pattern containing a set of legitimate assumptions and design for collecting and interpreting data” (De Vos et al 2011:513). Polit and Beck (2012:11) and Guba (1990) cited in Brink (2001:28) provide an extensive description of a paradigm as a world view or a set of assumptions about
reality (ontology), knowledge of that reality (epistemology) and how that reality can be made known (methodology). In research, these assumptions guide and influence the process of the study and need no empirical proof to be regarded as true. Another important view on the paradigm is given by Bailey (1994) cited by Monama (2009:15) where a paradigm is referred to as a mental window through which researchers view reality allowing them to focus on a phenomenon and present it in the way they perceive it. Therefore, it is possible for two researchers to describe the nature, presentation and exploration of the same phenomenon differently, hence Bogdan and Biklen (2007:24), affirm the description of a paradigm as a loose connection of logically related assumptions, concepts, or propositions that inform thinking and research in general.

Research studies can be conducted within two paradigms, positivism and constructivism or naturalistic perspectives where positivists believe in objectivity while naturalists in multiple mental construction of phenomena.

1.10.1 Positivism perspective

Imenda, Nkonyana and Lebitso (2001:14); describe positivism as a philosophical position that assumes that the goal of knowledge is to objectively describe, explain and predict the phenomenon being experienced whether qualitatively or quantitatively. Positivism attempts to get at the truth in order to understand reality as it exists (ontology) well enough so that it can be controlled by a process of prediction and where possible measured quantitatively (Henning, Van Rensburg & Smit 2004:17; Polit & Beck 2008:14). According to De Vos et al (2011:6), positivists strive for objectivity so that personal biases can be avoided. According to Polit and Beck (2012:12), positivists believe that phenomena have a cause and research is directed at understanding this underlying cause and its effect.

Bocher and Ellis (2002:26); Denzin & Lincoln (2003:256); Parahoo (2006:40) point out that in positivism the intent is to look for explanations in empirical data and reduce a big idea into small, discrete sets of ideas that can be tested.

In this study, the interest was in the participants’ experiences, feelings and attitudes about the provision of TOP services and the utilisation of services based on the knowledge of the CTOP Act, 92 of 1996. The quantitative data was limited to the
demographics of participants and utilization of the facility in relation to the number of TOPs performed per month in each facility visited.

1.10.2 Constructivism or naturalistic perspective

The constructivism paradigm perspective involves the discovery of knowledge (epistemology) that is created through interaction between and among researchers and respondents (Monama 2009:17). In this perspective it is assumed that knowledge of reality is dynamic and it is gained through social reconstruction of ideas when the many facets of reality are explored (Denzin& Lincoln 2008:647). The goal of the constructivist is to understand through analysis of descriptions or discourse that people construct, the complex world of lived experience from the point of view of the people themselves (Schwandt 2001:14). Hence, it is through these assumptions that Polit and Beck (2012:12) assert that the voices and interpretations of participants (the interaction between the researcher and participants) are crucial to the understanding of a phenomenon.

In this study, a qualitative and constructivist perspective was used in order to understand the participants’ experiences of the TOP programme. In-depth interviews were conducted with TOP service providers and TOP facility managers to discover their knowledge regarding CTOP Act as well as their experiences regarding the provision of TOP services in the designated and selected facilities. In-depth interviews were also conducted with TOP health care consumers to understand their experiences towards TOP services received.

The following were the perceived assumptions of the study

1.11 ASSUMPTIONS OF THE STUDY

An assumption is a principle that is taken for granted or accepted as being true based on logic or faith without proof or verification (Polit& Beck 2012:12,720). Often in research assumptions are made to justify methodological strategies which have not been tested. In the present study, the researcher assumed that the implementation of the CTOP Act through the TOP programme in Mpumalanga was presenting a problem and as such was not as effective as intended. She further assumed that the said TOP
programme has not been put under scrutiny to evaluate its impact, especially in improving the quality of life among women as indicated in the constitution and in the CTOP Act, 92 of 1996. It therefore became necessary that these assumptions are made explicit for further discussion and to guide the study. The identified assumptions included the following:

1.11.1 Ontological assumptions

As indicated, ontological assumptions relate to the nature and meaning of reality as perceived by the individual. Qualitative researchers believe that the person’s description of the lived experience is the unique reality of the lived world for that person (Polit& Beck 2004:14). According to constructivists, reality refers to the subjective reconstruction of phenomenon from the many views of several participants. This study was based on the assumption that, the information elicited from the interviews reflected the realities of the lived experiences of the participants in relation to their knowledge, feelings and experiences regarding CTOP Act, its interpretation and implementation in the TOP programme as well as the service provided and received in the TOP programme.

1.11.2 Epistemological assumptions

Epistemological assumptions are concerned with how individuals determine what is true (Streubert& Carpenter 2007:458). De Vos (2001:214) describes epistemology as the relationship of the researcher to reality and the road followed in the search for the truth. Linguistic epistemology refers to the way of knowing the truth through the spoken word. According to constructivists, researchers in a qualitative research, interact with participants by word to construct meaning from diverse perspectives as presented by participants. In this study, therefore, the researcher conducted interviews with the TOP service providers, managers of TOP facilities, and Top health care consumers to ascertain their own perceptions as provided in the description of their lived experiences with TOP service provision. The information elicited assisted in the evaluation of the TOP programme.
1.11.3 Methodological assumptions

Methodology refers to the way knowledge is obtained (Polit & Beck 2012:13). Methodological assumptions relate to the research process and design selected to conduct the study with the research instruments aligned to the paradigm. In this study, a qualitative approach to describe the knowledge of TOP service providers and managers of TOP facilities regarding the CTOP Act as well as to explore and describe the feelings and experiences of these health professionals and TOP health care consumers regarding the TOP programme and its implementation was used. An interview schedule was used to conduct in-depth interviews to source qualitative data which provided rich descriptions of the feelings and experiences of participants.

1.12 CONCEPTUAL FRAMEWORK

A conceptual framework is a unique way of organising knowledge schematically in terms of a model to show or visualise a relationship between and among constructs and/or concepts critical in the explanation or understanding of a phenomenon. A conceptual framework is an imagined frame on which the study is developed. Polit and Beck (2012:145) point out that there are theoretical as well as conceptual frameworks. A theoretical framework is based on propositional statements resulting from an existing theory and it provides an orientation to the study (Henning, van Rensburg & Smit 2004:25). A conceptual framework refers to a framework that the researcher develops through identifying and defining concepts and proposing relationships between these concepts. Furthermore, a conceptual framework enables the researcher to link the findings of the study to the body of knowledge and conceptualise this in practice (Burns & Grove 2009:147). In qualitative research a conceptual framework provides for the basis of the study and supports meaningful data collection and arrangement for analysis.

In this study, a conceptual framework was developed based on the Integrated Model of Programme Evaluation (IMPE) as presented by De Vos, Strydom, Fouché and Deport (2006:369) to address key elements applicable in the evaluation of a programme. These included the characteristics, activities and outcomes of the TOP programme. The model was adapted to provide for:
**Needs assessment.** This is the phase of the model which articulates the reasons for the programme and should also outline the aims and objectives thereof. In this study the aim of the TOP programme was to implement the stipulations of the CTOP Act which, of importance, provided for reproductive rights which amongst others embraced recognition of the basic human right of women to decide freely on whether or not to have a child (Engelbrecht 2005:27). The need for these services was expressed in the increasing morbidity and mortality due to backstreet abortions. The programme aimed at providing professional services in the termination of pregnancies regardless of the reason.

**Conceptualisation and design of the programme.** This phase describes the characteristics of the programme. These must corroborate with the needs to be addressed. The CTOP Act aims to give every woman the right to choose to have an early, safe and legal TOP. In terms of the Act, the right to reproductive and sexual health is grounded in a woman's right to life and right to choose. The Act makes provision for all women (irrespective of age, location and socio-economic status) to choose to terminate unwanted pregnancies.

In South Africa, the design of the TOP programme is informed by the CTOP Act and the Constitution of the Republic of South Africa (Act 108 of 1996). The programme outlines the following:

- Types of services to be provided to clients
- Who should provide the services
- Requirements to be met in order to provide or access the services
- Facilities where services are provided
- How the programme is organised

In Mpumalanga, the TOP programme’s objectives are well defined and the procedure to be followed for the provision of services is outlined in the MTOPIP in accordance with the CTOP Act, including the functions of the TOP programme, people responsible for providing the service, where the service will be provided and the penalties involved should the rights of the TOP health care consumers be violated.
Implementation of a programme. According to Rossi et al (2004:170-179), implementation of the programme implies the operation of the programme, known as programme process. This entails systematic engagement in activities to address identified needs in line with the nature of the programme (design). Implementation of the programme is guided by objectives and desired outcomes.

In this study the implementation of CTOP Act was based on the objectives of the TOP programme and the benefits included:

- Capacitating TOP service providers
- Creating support systems for TOP service providers
- Decentralising service facilities
- Accessing target populations as a result of decentralisation of services in districts
- Defining clear referral pathways
- Identifying and removing of barriers which prohibit clients from gaining access to the programme

From its inception, the performance of the TOP programme was monitored (see table 1.7) in terms of the number of TOPs procured. In this study, the experiences of the TOP health care consumers regarding the TOP service received and those of TOP service providers and managers of the TOP facilities will support the statistics presented.

Programme outcomes (impact assessment). De Vos et al (2006:381) state that impact assessment is designed to determine the effects a programme has on those for whom it was designed. In this study, impact assessment referred to the extent to which the TOP programme attained its outcomes in improving the women’s health including reproductive health, their self-determination and empowerment. Thus from the institution’s point of view, the following were considered:

- Service utilisation according to records
- Number of personnel providing the service
- Resources at the facilities
From the TOP health care consumers’ point of view, the following were considered:

- Information about the programme
- Accessibility of services/participation in the programme
- Experiences in the TOP services received

From the TOP service providers’ and TOP facility managers’ point of view, the following were considered:

- Knowledge of the CTOP Act and other supporting legislation
- Knowledge of MTOPIP
- Experiences in TOP service provision and management

Maternal morbidity and mortality rates in Mpumalanga were also reviewed against the benefits of the programme.

**Programme efficiency (efficiency assessment).** According to Rossi et al (2004:332-67) programme efficiency is based on expenditure compared to the benefits derived from the programme. The cost of managing the TOP programme in Mpumalanga has been estimated at R750 000 annually while the training of an individual professional has been estimated at R15 000 (MDOH 2009b:3). These amounts do not support the urgency of the need. But what was learnt during the study, was that in Mpumalanga there was no dedicated budget allocation to the TOP programme; and the programme was funded within the Primary Health Care, and even though identified as a priority, often other PHC needs superceded those of the TOP programme. In this study, efficiency was assessed against utilisation of services as indicated in the attendance records, duration of patient stay in the facilities, supplies, equipment and medications used for each patient.

Figure 1.1 provides the schematic presentation of the Integrated Model of Programme Evaluation (IMPE) (De Vos et al 2006:369).
Figure 1.1  Adapted Integrated Model of Programme Evaluation (IMPE)
Adapted from: De Vos et al (2006:370)
1.13 RESEARCH DESIGN AND METHODOLOGY

According to Polit and Beck (2012:741), research methodology refers to the ways of obtaining, organising and analysing data. It outlines how the study will be conducted following its logical sequence. In line with Burns and Grove (2009:219), research methodology is described as the plan or process for conducting a specific study. Henning et al (2004:36) further describe research methodology as a coherent group of methods that complement one another and have the ability to deliver data and findings that will reflect the research question and suit the purpose of the study.

As indicated earlier, the researcher used both qualitative and quantitative approaches in the study. In qualitative research, people are perceived as conscious, self-directed beings that are continuously constructing, developing and changing their everyday interpretations of their worlds in order to make sense of their lives. Qualitative research relies heavily on the inductive reasoning process and seeks to examine and understand the whole phenomenon (Polit& Beck 2012:11; Henning et al 2004:36).

According to Polit and Beck (2004:15-17), in qualitative research the investigation of a phenomenon is typically in-depth and holistic, through the collection of rich narratives from the experiences of individuals. The focus is on understanding the human experience as it is lived. In this study, in order to conceptualise the participants’ experiences, the researcher required an approach that would capture the insider’s view expressed freely without boundaries, hence the choice of the qualitative approach.

The quantitative approach was also thought to be appropriate in some sections of the study to support narration. Burns and Grove (2009:717) refer to quantitative research as a formal and objective, systematic process to describe, test relationships and examine cause and effect interactions among the variables. To evaluate the TOP service providers’ and TOP facility managers’ understanding of the content of the stipulations of the CTOP Act, the researcher used a quantitative method. This was in response to Mokgethi, Ehlers and Van der Merwe (2006:36) who stated that health professionals lack knowledge about the content of the CTOP Act. Quantitative approach would provide, where possible, numbers or the extent to which knowledge was lacking.
1.13.1 Design

A design relates to a plan of action or a blueprint that guides the planning of the whole study (Burns & Grove 2005:735). According to Denzin and Lincoln (2005:14), it is a “flexible set of guidelines that connect theoretical paradigms to strategies of enquiry and methods for collecting empirical materials”. The nature of the problem and data determine the research design and methods (Leedy & Ormrod 2005:144). Burns and Grove (2009:237) point out that the research design directs the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal. The researcher selected to use a case study design to contextualise, explore and describe the phenomenon. A case study as a design reflected the reality of the phenomenon under study (Yin 1989:25). The TOP programme was the case; the CTOP Act was the unit of analysis. The health facilities where TOP was performed together with TOP health care consumers, TOP service providers and managers of facilities served as embedded cases of the case study. Interviews were conducted to allow for participants to describe their feelings and experiences regarding TOP services. All the participants were key informants as they presented different experiences and core information for the conceptualisation of the impact of the TOP programme on individual, community and country.

1.13.2 Setting

In research, the context is significant as the description of the phenomenon relates to the environment in which the study takes place as well as the culture of the participants thereof. The researcher must therefore be sensitive to the context in which the research is undertaken, as this will enhance the understanding of the participants’ point of departure and will maintain the natural setting where phenomena occur (Streubert & Carpenter 2007:28), that is, in this study, where TOP services are provided. The research study took place in those facilities designated to provide TOP services in Mpumalanga, South Africa. These comprised of seven (7) hospitals in the three districts of Mpumalanga (see table 1.6).
1.13.3 Population

The empirical phase of research commences with the identification of the population from whom the participants are selected (De Vos 2001:198). Polit and Beck (2012:738) define a population as an aggregate of all the individuals or objects to be studied with some common defining characteristics. In research, the target population is the entire population that qualifies for the research and the accessible population is a portion of the target population to which the researcher has reasonable access for data collection (Burns & Grove 2009:687). The sample is obtained from the accessible population.

In this study, there were four populations, namely the TOP health care consumers as people who utilised the service; the TOP service providers; the managers of the facilities providing TOP services in Mpumalanga, and lastly the records of attendances for TOP service utilisation.

1.13.4 Sample and sampling technique

A sample is a subset/portion of a population sharing the same characteristics and attributes for inclusion in the study. It is a fraction of a whole, selected to participate in the research project (Polit& Beck 2008:758).

A sampling technique is an approach through which a sample is selected. Probability sampling refers to random selection of participants where each participant has an equal chance of being selected. This sampling technique is used in quantitative research, where statistics are used to present results (Polit& Beck 2008:758). A non-probability technique is a non-random selection of participants where selection is based on the contribution of participants in the provision of data required in the study. Examples of this sampling approach include convenience, purposive or judgemental, and snowball sampling (Polit& Beck 2008:758).

In this study, non-probability sampling was used to purposively select facilities which were active in the provision of TOP, records of attendance for the utilisation of TOP services, TOP service providers as well as managers of facilities which provided TOP services. Convenience sampling was used to select TOP health care consumers who participated in the study. The selected sample provided the desired information.
1.13.5 Sample size

In qualitative research, the researcher need not decide on the number of people to interview because the quality of data determines the point at which the data collected can be considered to be adequate. It is therefore, not possible to state how many participants will be ideal for the study as qualitative researchers are more interested in the quality of data collected and the thick descriptions of the phenomenon than in the quantity and the extent to which the data can be generalised to the population (Streubert & Carpenter 2007:31; Struwig & Stead 2001:124). Consequently, in this study the sample size was not predetermined and data collection continued until data saturation was reached.

1.13.6 Data collection

Data are pieces of information obtained by the researcher during the investigation process to answer the research question which addresses the problem statement. According to Polit and Beck (2004:26); Burns and Grove (2009:695), data collection refers to a precise, systematic gathering of information relevant to the research problem.

1.13.6.1 Data-collection method

Data collection is the precise and systematic gathering of information relevant to a research problem using prescribed methods such as interviews, questionnaires, observation or examination of written texts or artefacts (Polit & Beck 2004:27; Burns & Grove 2009:695).

In this study, the researcher collected data by interviewing the participants and reviewing records on the utilisation of TOP services. These methods were considered suitable to explore and describe the participants’ feelings and experiences as well as evaluate the impact of the TOP programme.

1.13.6.2 Data-collection instrument

Research data collection instruments are tools used to collect data. The tools include interview schedules and guides, questionnaires, observation sheets, field notes,
reflective journals, reports and the researcher (Parahoo 2006:325). Interview instruments can be structured or unstructured. For example, interview schedules are structured and interview guides are said to be unstructured. Structured interview schedules or questionnaires consist of sets of questions, carefully worded and arranged. The questions may be closed and/or open-ended. In open-ended questions, participants can supply their own words, thoughts and insights (Holloway 2005:39). Flexibility is more or less limited (Patton 2002:342).

Unstructured interview tools or interview guides consist of a core question relating to the topic under investigation and probing questions, which differ according to participants’ responses. Flexibility in probing is more in response to individual differences and situational changes (Patton 2002:343).

In this study, interview schedules were considered appropriate to provide demographic information as well as open-ended questions. The demographic information provided quantitative data while the open-ended questions provided for qualitative narratives.

Two interview instruments were developed to focus on the purpose of the study. For TOP service providers and managers of the TOP facilities, the questionnaire was divided into three sections:

- Section 1 elicited the participants’ demographic data.
- Section 2 explored the participants’ knowledge regarding the CTOP Act.
- Section 3 explored and described the participants’ experiences and feelings. The purpose was to discover the participant’s feelings, thoughts and perceptions regarding the TOP programme. In this way the researcher avoided imposing her own assumptions as much as possible.

For TOP health care consumers, the questionnaire was divided into two sections:

- Section 1 obtained the participants’ demographic data.
- Section 2 explored and described the participants’ experiences, perceptions, thoughts and feelings regarding the TOP programme.

For the records, the protocol covered:
• Statistics in relation to the trained TOP service providers, TOP providing designated hospitals,
• The average number of patients who procured TOP monthly.

1.13.6.3 Pre-testing of the instrument

Pre-testing provides an evaluation of the content of the instrument to be used in the collection of data in terms of comprehension, sensitivity of language and duration. It also tests the appropriateness of the data collection method (Botma, Greeff, Mulaudzi & Wright 2010:275). In this study, the researcher conducted a pre-test with one TOP service provider and two TOP health care consumers who were not part of the main study. The instruments were then amended according to the feedback received. A tape recorder was also used to give the researcher practice in the correct usage of the equipment. Records (admission registers, agendas and minutes, bed letters, consent forms, human resources register, duty roster, protocols) and artefacts in the form of utility packs were also reviewed as secondary sources of data to support the performance of TOP.

1.13.6.4 Data analysis

Polit and Beck (2008:751) describe data analysis as the process of organising and integrating narrative information according to emerging themes and categories. In qualitative studies, data analysis begins simultaneously with data collection whereby researchers keep and constantly review records to discover additional findings while conducting interviews (Streubert & Carpenter 2007:46).

The process of data analysis goes through organising and ordering the data. This commences with the listening to audiotapes, transcribing, reading through the material transcribed over and over again, sorting out field notes and to add to transcriptions, coding and categorising data collected, building themes and describing a phenomenon. Thus immersing oneself in the data (Holloway & Wheeler 2010:281).

In this study, the researcher used Tesch’s (1992:94-97) method of data analysis for qualitative data (see chapter 2). Quantitative data was easy to analyse and this was
done by the researcher and it was reported using tables and presented in frequencies and percentages (see chapter 3).

1.14 TRUSTWORTHINESS

Streubert and Carpenter (2007:460) define trustworthiness as “establishing the validity and reliability of research findings”. Qualitative research findings are trustworthy when they accurately represent the experiences of the participants. Trustworthiness endeavours to establish confidence in the truth of the findings and determines the degree to which the findings or the enquiry may have applicability or replication in other contexts. In this study, the research design met the following criteria for trustworthiness:

- **Credibility.** This refers to the judgement of the credibility of the research findings from the participant’s perspective. Credibility is ensured through triangulation (use of multiple data collection methods and sources), prolonged engagement with the data to intensify understanding thereof, peer review, and member checking into the findings (giving feedback on the results from the participants and verifying information with the participants).

- **Applicability/Transferability.** This refers to the extent to which the results of the study can be transferred or generalised to other settings, contexts or populations. In this study, the researcher enhanced applicability by providing thick descriptions of the methods and contexts as well as an audit trail so that anyone interested in replicating the study would have a base of information.

- **Dependability/Consistency.** This refers to whether the findings would be similar if the study was replicated in similar contexts (De Vos et al. 2006:346). Holloway and Wheeler (2010:299-303) emphasise that dependability is parallel to reliability in qualitative studies. To ensure dependability in this study, careful review of the process of data collection, data analysis and research findings was done. Silverman (2000:187) and Holloway and Wheeler (2010:303) point out that one way that a study may show dependability and consistency, is in the documentation of the process followed, known as an audit trail.
The dense descriptions of the methodology were presented in an audit trail to enable other researchers to scrutinise the methodology and interpretation of results and be able to replicate these should it be necessary. Data were coded, categories developed and emerging themes identified. The research promoter and co-promoter audited the data analysis, and examined and compared the intensity of methods used to collect data.

- **Confirmability/Neutrality.** This refers to the extent to which the findings are a true reflection of the enquiry. According to Polit and Beck (2008:539) neutrality in research should consider the neutrality of data rather than that of the investigator. The findings should be free from researcher biases and should be able to be confirmed by others. In this study, triangulation of data collection methods, member checking and reflexivity were used to ensure neutrality of data collected.

### 1.15 ETHICAL CONSIDERATIONS

Ethical considerations relate to the moral values and standards that the researcher should uphold at every stage of the research process. The researcher should therefore adhere to professional, legal and social obligations during the research and the participants are respected and appreciated for their participation (Polit & Beck 2004:641). To this effect:

- The research proposal was reviewed by the Research and Ethics Committee at the University of South Africa and in the Province of Mpumalanga to ensure that the required ethical standards were maintained and approval was granted for the research to proceed (see annexure B and C).
- Permission to conduct research in the facilities designated to perform TOP by the Department of Health was sought and approval was given by the authorities in the Department of Health, Mpumalanga Province (see annexure B).
- Approval to conduct the research in the hospitals that participated was sought and obtained from the Chief Executive Officers of those hospitals after an intense scrutiny of the research proposal (see annexure B).
- The purpose of the research was explained to the participants and voluntary participation was emphasised. The participants were assured of anonymity,
privacy and confidentiality and that the data would only be used for the purpose of the study. The participants then gave informed consent (see annexure E).

The success of the interviews depended on the researcher’s communication skills and establishment of rapport with the participants, thereby helping them to feel at ease. The researcher also respected the rights of those participants who were approached but did not want to participate.

The interviews were tape-recorded after permission to do so was obtained from the participants. The interviews were transcribed without disclosing any participants’ names or associating any of the participants with any information collected. This tendency to maintain privacy and anonymity will continue even with planned publications resulting from the study.

1.16 DEFINITIONS OF TERMS

For the purpose of this study, the following terms are used as defined below:

- **Experience**: *Little Oxford English Dictionary* (2006:241) defines experience as actual observation or practical acquaintance with facts or events. In this study, experiences refer to the participants’ perceived feelings about TOP services.

- **Evaluation**: *Longman’s Dictionary of Contemporary English* (2001:347), defines evaluation as “calculating or judging the value or degree of something”. In this study, evaluation refers to the process whereby the impact of the TOP service programme in Mpumalanga was judged by programme monitoring and impact assessment. The evaluation was done by interviewing TOP service providers and TOP facility managers in TOP facilities as well as TOP health care consumers.

- **TOP health care consumer**: A TOP health care consumer is any person using the products of the TOP health facilities. In this study, a TOP health care consumer refers to any female of childbearing age requesting termination of pregnancy in the facilities designated to provide TOP services in Mpumalanga.
• **Impact:** *Little Oxford English Dictionary* (2006:344) defines impact as “a noticeable effect or influence” of an event or something. In this study, impact refers to the effects of the TOP service programme on the health of women, in Mpumalanga as well as the country as a whole.

• **Programme:** *Longman’s Dictionary of Contemporary English* (2001:675) defines a programme as “a descriptive notice of a series of aspects or events”. In this study, programme refers to the Termination of Pregnancy (TOP) programme in South Africa in which health professionals offer TOP services to women upon request, on the basis of conditions that might be dangerous to the life of a pregnant woman or the foetus as well as on the basis of choice by the affected woman to enhance the woman’s self-determination.

• **Termination of pregnancy:** The CTOP Act (92 of 1996) defines termination of pregnancy as “the separation and expulsion (by medical or surgical means) of the contents of the uterus of a pregnant woman”. In this study, termination of pregnancy means assisted expulsion of the contents of a pregnant uterus by a medical practitioner or a registered nurse trained in TOP in accordance with the stipulations of the CTOP Act (92 of 1996).

• **TOP service provider:** According to the CTOP Act, medical doctors and registered nurses including midwives trained to provide TOP services are referred to as TOP service providers. In this study, TOP service providers are registered nurses trained and delegated in terms of the stipulations in the CTOP Act, (92 of 1996) to procure TOP. Managers in charge of facilities that provide TOP services are also trained in TOP but are not referred to as TOP service providers.
1.17 OUTLINE OF THE STUDY

Chapter 1 briefly discusses the research problem and the significance, purpose and objectives of the study.

Chapter 2 describes the research design and the methodological framework used in the study.

Chapter 3 covers the data analysis and interpretation in detail.

Chapter 4 discusses the findings with reference to the literature control.

Chapter 5 describes the development of the guidelines to assist in the interpretation and implementation of the CTOP Act, 92 of 1996.

Chapter 6 discusses the conclusions and limitations of the study and makes recommendations for further research.

1.18 CONCLUSION

This chapter provided an introduction to the study. It discussed abortion and abortion laws as they apply nationally and internationally. Stipulations of the CTOP Act, 92 of 1996 were presented with specific reference to the MTOPIP which puts the Act into context. The chapter also provided information on the position of DENOSA in relation to TOP. It outlined the research problem and its significance, the purpose of the study, its objectives, research design and methodology, including population, sample, and data collection and analysis. The conceptual framework was outlined and the model to evaluate the impact of the TOP programme displayed.

Chapter 2 covers the research design and methodology.
CHAPTER 2
RESEARCH DESIGN AND METHODOLOGY

2.1 INTRODUCTION

Chapter 1 presented an overview of the study. This chapter describes the research setting, design and methodology, including the study population, sample and sampling techniques, data collection and analysis, trustworthiness of data collected and ethical considerations in the research process to support phase 1 of the study.

Polit and Beck (2012:741) describe a research design as the researcher’s “overall plan for addressing a research question, including specifications for enhancing the study’s integrity”. Research methodology refers to the manner in which the research is planned, structured and executed in order to comply with specific criteria.

2.2 RESEARCH SETTING

The setting is selected because it holds elements which are relevant to the study. As stated earlier, the research setting provides an environment in which the research takes place. The setting should, therefore, contain a rich mix of processes, people and interaction structures that may be part of the research question (Polit& Beck 2004:28). The present study took place in a naturalistic setting, namely in the facilities that provide TOP services in Mpumalanga Province. This notion is supported by Patton (2002:280) who emphasised that good studies are undertaken in a natural setting so that participants’ experiences are put into context.

Mpumalanga Province, where the study was undertaken, is in the eastern part of South Africa. It is divided into three districts namely Gert Sibande, Nkangala and Ehlanzeni. According to Monama (2009:23-24), in the western side, the province is bordered by Gauteng, southern side by Kwa-Zulu Natal and Free State; Limpopo in the north and also shares international borders with Mozambique and Swaziland on the eastern side. Furthermore, the province serves people from diverse cultural spheres. Languages spoken include Tswana, Pedi, Zulu, Swazi, Tsonga and Southern Sotho. The culture is
also influenced by the influx of people from neighbouring provinces and cross border countries which further have an impact on the utilisation of TOP services and how abortion is perceived. The province has a variety of facilities to provide services to the population, including public and private hospitals, community health centres, primary health care clinics and medical doctors in private practice. In the public sector there are 28 hospitals (some are district while others regional) serving a population of 3,399,000, of which 52% of the inhabitants are women and 32% of these women are of child-bearing age (MDOH 2009b:1; DOH 2005:69).

Although all the public hospitals in Mpumalanga are designated to provide the service in terms of the CTOP Act, at the time of the study only seven of these were actively participating in procuring TOP services (see chapter 1, table 1.6 for hospitals that provide TOP services per district). Mpumalanga has never had the full complement of designated areas providing TOP services and their distribution is uneven. As such some women have always had to travel approximately 120 km to access TOP services as the seven operational TOP facilities are far apart.

According to the DOH (2005:72), 55% of health workers were trained on the provision of TOP services between 1998 and 2001 in preparation for the implementation of the TOP programme. A total of 15% of those trained were based in Mpumalanga Province. The national report also indicates that 42% of those trained was on counselling while 12.5% was on manual vacuum aspiration. Irrespective of the training, the DOH already reported a relatively small number of nurses who were involved in TOP service provision and committed to do so as some had withdrawn from service provision (DOH 2005:72).

The MDOH (2009b:1) reported that between 2005 and 2008, ten thousand, five hundred and seventy five (10,575) TOPs were performed, indicating an average of 220 TOPs per month, in the Mpumalanga Province.

2.3 RESEARCH DESIGN
Burns and Grove (2009:696) define a research design as the structural framework or blueprint of the study. This framework guides the researcher in the planning and implementation of the study, while achieving optimal control over the factors that could
influence the study. Babbie and Mouton (2001:73) are of the opinion that it is essential for the researcher to formulate the research problem clearly before selecting the design that will best answer the research questions. Mouton (2000:57) refers to the research design as the way in which the research is conceived and executed and how the findings are eventually put together for interpretation. The research design ensures that the researcher strives for objectivity and that the approach to the knowledge is systematic.

In this study, a qualitative, quantitative, contextual, explorative, descriptive and case study research design was utilised to explore and describe

- TOP health care consumers’ information about the TOP programme
- TOP health care consumers’ experiences and feelings of accessing the TOP service at the designated facilities
- the TOP service providers and TOP facility managers’ knowledge about the CTOP Act
- the TOP service providers and TOP facility managers’ experiences and feelings regarding TOP provision

The researcher also reviewed the attendance records for the utilisation of the services.

2.3.1 Qualitative approach

Denzin and Lincoln (2008:4) define qualitative research as “a situated activity that locates the observer in the world”. Research is qualitative if it emphasises processes and meanings that are not rigorously examined or measured in terms of quantity, amount, intensity or frequency, but are interrogated in terms of the quality of information received.

According to Burns and Grove (2009:717), qualitative research refers to inductive, holistic, emic, subjective and process-oriented methods used to understand, interpret, describe and develop a theory on a phenomenon or setting. It is a systematic, subjective approach used when meaningful information on life experiences is required. Qualitative research is mostly associated with words, language, perceptions and experiences rather than measurements, statistics and numerical figures.
Researchers who use qualitative research adopt a person-centred and holistic perspective to understand the human experience, without focusing on specific concepts. The original context of the experience is unique; and rich knowledge and insight can be generated to present the lively picture of the participants’ reality and social context (Holloway 2005:4).

Qualitative researchers set out to investigate phenomena in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people attach to them. This study took place in a real-world setting which is natural and the researcher did not attempt to manipulate the context in which the phenomenon was happening; that is, the study was conducted in the facilities that provide TOP services (Patton 2002:29; De Vos et al 2011:223). The participants presented their experiences in their own words in narratives which described the manner in which TOP services were provided or received.

Qualitative research also seeks an understanding of human thought and behaviour and its interpretation (Parahoo 2006:95). In the present study, the researcher examined the experience from the participants’ point of view and interpreted their words. In order to gain deeper insight, the researcher became involved in the phenomenon by personally collecting the data and making field notes. The researcher’s involvement in data collection helped her to provide dense descriptions from participants’ narratives, to interpret and portray their experiences, and to generate empathetic and experiential understanding.

There are several types of qualitative research (see table 2.1).

Table 2.1  Types of qualitative research

<table>
<thead>
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<tbody>
<tr>
<td>• Ethnography</td>
<td>• phenomenology</td>
</tr>
<tr>
<td>• Case study</td>
<td>• Grounded theory</td>
</tr>
<tr>
<td>• Educational criticism</td>
<td>• Ethnography</td>
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<td></td>
<td>• Historical inquiry</td>
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<td></td>
<td>• Philosophical inquiry</td>
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<td>• Critical social theory</td>
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In the current study, the researcher chose a quantitative and qualitative approach, using a case study design (Glesne & Peshkin 1992:9). The purpose was to understand the TOP health care consumers’ experiences and feelings in accessing the TOP services at the designated facilities and the TOP service providers and TOP facility managers’ knowledge of CTOP Act and their experiences and feelings regarding TOP service provision.

Many authors have written about qualitative research. According to Brink and Wood 1998:246; Burns and Grove 2009:65 and Streubert and Carpenter 2007:20-23), qualitative research:

- takes place in a natural setting where human behaviour and events occur and the researcher is not to manipulate this context.
- regards reality as a phenomenon.
- is ideographic; that is, it aims to understand the meaning that people attach to everyday life.
- requires the researcher to engage with the data to capture and discover meanings.
- presents data in the form of narratives from words, quotes from documents and transcripts.
- analyses data by extracting themes.
- uses holistic units of analysis, concentrating on the relationships between elements and concepts.

Qualitative research design was used to enhance the understanding of the lived experiences of the participants regarding TOP programme in Mpumalanga Province. The participants' accounts of TOP services provided a wealth of information for the understanding of the TOP programme, its operation and management and assisted the researcher in developing and describing practice guidelines to improve the provision of TOP services in the province.

Termination of pregnancy is a very emotional undertaking for both the consumer and the provider as it tackles the morals of individuals. The qualitative approach used in this study provided a platform for catharsis for those experiencing emotional turmoil and
feelings of guilt. Due to the sensitivity of the phenomenon, the researcher personally collected the data in order to understand the participants’ experiences and feelings. The data was collected and analysed simultaneously. The researcher had intended to include all the active facilities in the study, but in the end only five (5) participated as will be described under the sampling section.

2.3.2 Quantitative

Quantitative research is a formal, objective, systematic process in which numerical data are utilised to obtain information about the extent or intensity of a phenomenon (Burns & Grove 2009:37). This research design is used to describe variables, examine relationships between and among variables, and determine cause-and-effect interactions between variables (Burns & Grove 2009:23). Struwig and Stead (2004:4) describe quantitative research as a form of conclusive research involving large representative samples and fairly structured data collection procedures.

According to Struwig and Stead (2004:4-7); Burns and Grove (2009:23-24) and Botma et al (2010:82-83) quantitative research has the following characteristics:

- It produces hard science that is based on rigor, objectivity and control.
- Its focus is usually concise.
- It tests theories.
- Its basis of knowing is cause-effect-relationship.
- Its basic element of analysis is numeric.
- The findings can be generalised.
- The results can be used to describe, explain and predict phenomena.
- It requires the use of questionnaires, numerical observations, scales or physiological instruments that generate numerical data.

In this study, a quantitative research design was necessary to provide quantified scientific demographic information about TOP service providers, TOP facility managers and TOP health care consumers as well as the distribution and utilisation of facilities in terms of access, monthly and annually.
2.3.3 Contextual consideration

Qualitative research does not attempt to control the context of the research, but to capture the context in its entirety within the comprehension of the phenomenon (Brink 2010:151-153). Furthermore, the phenomenon is studied for its intrinsic and immediate contextual significance. Contextual studies focus on specific events in a naturalistic setting, which are not controlled by real-life situations. Research done in a natural setting refers to an inquiry done in a setting free of manipulation (Streubert& Carpenter 2007:459).

The context becomes the framework, the reference point and the map. It is used to provide space and time for activities to take place and as a resource for understanding what people say and do at that time in that space (Patton 2002:62). Therefore, the context was Mpumalanga Province, its districts and facilities where TOP services were provided. The participants were selected according to certain criteria and interviews were conducted with them in the facilities as will be elaborated on under the relevant sections.

2.3.4 Explorative approach

According to Polit and Beck (2012:727), exploratory research focuses on the “what” and facts related to the phenomenon are important. Burns and Grove (2003:313) define exploratory research as that which is conducted to gain new insights, discover new ideas and/or increase the knowledge about a phenomenon. Latimer (2003:80) states that explorative studies are conducted to:

- Satisfy the researcher’s curiosity and for a better understanding of the phenomenon.
- Test the feasibility of undertaking a more extensive study.
- Develop the method to be employed in any subsequent studies.
- Determine the priorities for further research.

This approach was considered suitable as the impact of the TOP programme had not been evaluated before in Mpumalanga Province and nothing was known of the experiences and feelings of TOP service providers and managers as well as those of
TOP health care consumers in Mpumalanga. Exploring the participants’ experiences as expressed in their own words generated new insight in their lived experiences.

2.3.5 Descriptive approach

According to Burns and Grove (2009:237), descriptive studies are “designed to provide a picture of a situation as it naturally happens”. Furthermore, like exploratory studies, descriptive studies provide a detailed encounter with the phenomenon, providing the what, where, how, who, why, when of it. In addition, a descriptive design, therefore, provides a picture of situations as they naturally happen. In a descriptive approach no manipulation of variables is necessary, since the aim is not to establish causality but to describe the phenomenon as it appears (Polit&Hungler 2003:142). The researcher considered this approach appropriate because an accurate and authentic description of the knowledge, experiences and feelings of participants was required to evaluate the impact of the TOP programme from the participants’ point of view.

2.3.6 Case study design

The researcher further selected to use a case study design for the study because the information sourced in this manner would:

- assist in describing the programme and how it functions
- explain the participants’ experiences in real-life and interventions within the TOP programme which are too complex to explain in surveys
- describe the real-life context in which interventions occur

According to McMillan and Schumacher (2010:344) and Burns and Grove (2009:344), a case study design presents an in-depth analysis of a single entity, such as an individual, family, group, programme, event or organisation. A case study investigates a contemporary phenomenon within its real-life context and is especially useful when the boundaries between the phenomenon and its context are not clearly evident. Hence, Henning et al (2004:41), supports the description of how, where, when and why things happen in the case studied. In this study, the case study design was suitable because it incorporates exploratory, descriptive, contextual, qualitative and quantitative approaches in data collection. To further support the suitability of the case study in this
The researcher wishes to outline three other characteristics of the case study design which incorporates qualitative and quantitative approaches. Case studies are particularistic, descriptive and heuristic.

- **Particularistic aspect.** The case study focuses on a particular situation, event, programme or phenomenon and therefore makes it applicable to the investigation of practical problems (contextual, qualitative and quantitative in nature). In this study, the design focused on TOP services provided at the women’s request; to identify the experiences and feelings of the TOP service providers, the managers of the facilities and the TOP health care consumers receiving the service, with the aim of evaluating the impact of the TOP programme in Mpumalanga Province.

- **Descriptive aspect.** The end product in a case study is a rich description of the phenomenon under study as deduced from narratives on experiences and feelings by participants about the phenomenon (qualitative). It includes a complete, literal description of the incident or entity being investigated.

- **Heuristic.** This serves to describe an in-depth (detailed) investigation where unknown variables and relationships can emerge (exploratory) to assist in the rethinking of the phenomenon being studied. The heuristic quality of a case study can explain the reasons for and background of a situation; explain why an innovation is effective or ineffective, and discuss and evaluate alternatives thereby increasing the potential for a better understanding of the phenomenon.

According to Burns and Grove (2009: 244-245) and Parahoo (2006:188) case studies have the following advantages. They:

- provide qualitative information in the form of narratives, verification of which can be done over time as well as by quantitative data,
- provide for the immersion in the data collected as the researcher spends a lot of time transcribing data, collating this with field and observation notes, coding it, reading and re-reading it to develop themes and categories and subjecting it to member checking.
are focused and reflect the reality of the phenomenon to be studied. The researcher, therefore, can explore and describe a specific topic within a specific natural setting and cannot manipulate the situation.

- are flexible, thus the researcher may structure the research in terms of available time, materials, study subjects and money.

- are good for studying a process over a period because, case studies can also be used in narrating history and forecasting the future thereof.

- apply triangulation in that they use multiple methods of data collection to enhance the validity and reliability of the information obtained.

- provide a good source of descriptive data that can be used as evidence for or against theory if well-designed.

- do not provide for generalisation because data is interpreted in the context of a case. Findings can be replicated based on an audit trail

- are better suited to explore people’s beliefs and experiences.

Similarly, the same authors have outlined the disadvantages of the case study design as including:

- Problems with the generalisability of findings, as cases are unique and there is no way for the researcher to know if the study represents the whole population or not.

- The methods for compiling case study data are not rigorously described and can therefore compromise the scientific basis of the study.

- The researcher has no guidelines on how much data is enough and therefore depends on data saturation.

- The researcher collects data for a relatively long period and the close researcher-participant association can lead to the researcher’s bias influencing the findings and conclusion.

In this study, the information gathered through the case study covered the TOP programme’s inception in 1997 and its progress up to the time of investigation. The researcher utilised a case study to contextualise, explore, and describe the participants’ experiences and feelings in order to evaluate the impact of the TOP programme in Mpumalanga. The exploration and description of the case took place through detailed
data-collection methods, involving multiple sources of information from people and records including field notes, minutes, media, diaries and personal journals. Furthermore, the records on the utilisation of the programme were reviewed. The case study therefore explained the reasons for the introduction of the CTOP Act, 92 of 1996, and whether the TOP programme achieved its objectives or not. The discussion was centred around the TOP programme, CTOP Act and its implementation, and the facilities in which top services were rendered. The TOP programme was the case and the unit of analysis was the CTOP Act in relation to the knowledge of its content and its implementation by TOP service providers and TOP facility managers and the utilisation of the services by TOP health care consumers as dictated by the Act.

2.4 RESEARCH METHODOLOGY

Accordingly, the researcher had to implement specific tasks of the research process, such as describing the population, sample and sampling technique, data collection and analysis methods, and ethical considerations. In this study the evaluation of the programme was based on the experiences of providers and consumers of the service.

2.4.1 Research population

All elements which meet the criteria for inclusion in the study are known as the population. Parahoo (2006:471) and Burns and Grove (2007:40) describe a population in research as “the total number of units from which data can be collected”. This includes individuals, groups, artefacts, events or organisations. Groups or individuals are selected for participation when they possess an important characteristic that separates them from others to provide an inclusion criterion. In research, there are two types of populations, the target population which refers to the total population in which the researcher is interested, and the accessible population which is the population within the target population and it is accessible to the researcher (Burns & Grove 2009:724; Polit& Beck 2008:761). As it is not possible to research the whole population for various practical considerations, the accessible population becomes the practical population to work with and from which a sample is selected. In this study, the populations used were:
• the TOP service providers charged with the responsibility of procuring TOPs in the facilities;
• the managers of the facilities offering TOP services,
• the TOP health care consumers utilising the facilities
• attendance records for the utilisation of the TOP facilities including the number of meetings to address the position of the programme.
All these units provided information that assisted in the evaluation of the TOP programme.

2.4.2 Sample and sampling technique

A sample is a representative subset/portion of a population selected from the accessible population for a particular investigation. It is a fraction of a whole selected to participate in the research study and from whom the findings can be generalised (Polit and Beck 2008:758).

A sampling technique is an approach or process through which a sample is selected from the population to represent the entire population. There are two types of sampling, namely, probability and non-probability sampling. In probability sampling every member of the population has an equal chance of being included in the study and the sample is chosen from a population randomly (Burns & Grove 2009:715; De Vos et al 2011:228). Examples of probability sampling include random, cluster and systematic sampling. This sampling technique is used mainly in quantitative research.

In non-probability sampling, the researcher cannot guarantee that each element of the population will be represented in the sample. Members are purposively or conveniently selected to participate in a study based on the contribution they could make to the success of the study (Polit & Beck 2008:758). Therefore, examples of non-probability sampling are purposive or judgemental, convenience, snowball and network sampling.

In this study, non-probability purposive and convenience sampling were used to select the sample which provided the required information:

- purposive sampling was used to select facilities, records of attendance, TOP service providers and TOP facility managers to participate in the study.
convenience sampling was used to select TOP health care consumers who were attending at the facility at the time of investigation to seek TOP services and were willing to participate in the study

Purposive sampling

LoBiondo-Wood and Haber (2002:246) refer to purposive sampling as a method in which the researcher subjectively selects participants aiming at obtaining insight into the phenomenon and not very much concerned about empirical generalisation of findings from a sample to a greater population. Streubert and Carpenter (2007:29) add that in purposive sampling individuals are selected to participate in qualitative research based on their first-hand experience with the culture, social process, or phenomenon of interest. In purposive sampling, individuals or groups of individuals with special knowledge of the topic are chosen. These individuals may also be referred to as useful informants. The choice of participants is done consciously based on the researcher’s judgment (Brink, Van der Walt & Van Rensburg 2006:33, 133; Polit& Beck 2008:355). In this study the researcher used purposive sampling to select:

- **Facilities**: The facilities were selected based on their active participation in the TOP programme and their willingness to participate. Accordingly, in Ehlanzeni District there were four (4) active facilities but only three (3) were willing to participate in the study. In GertSibande District there were two (2) active facilities but only one (1) was included because the other facility although willing to participate, had only provided TOP services for three (3) months. The researcher in her judgement excluded this facility based on its duration of TOP service provision. In Nkangala District the only active facility was included. These provided a natural setting for the study.

- Records of attendance at TOP services and minutes taken in meetings where TOP services were discussed were reviewed.

- **All TOP service providers and managers of facilities** involved in the provision of TOP services and willing to participate were included in the study. To be included, participants had to:
  - have undergone training in TOP
  - have at least two years’ experience in performing abortions
• be working in the service designated to offer TOP service
• be willing to participate in the study

In the researcher’s opinion, those with less than two years experience might not have gained enough experience and would not provide valuable information.

**Convenience sampling**

Convenience sampling refers to accidental sampling whereby people available at the time of the investigation are used as participants for the study provided they are willing to participate (Polit & Beck 2008:341). De Vos et al (2011:232) state that those participants who happen to cross the researcher’s path and have something to do with the phenomenon are included in the study where convenience sampling is used.

Due to the sensitivity of the phenomenon, the TOP health care consumers were most accessible when they attended TOP services (Hess 2006:341). In her report, Engelbrecht (2005:20) also confirmed the difficulty in identifying TOP health care consumers once they return to the community after the termination of pregnancy since they often gave false information to avoid being traced afterwards. To this effect Streubert and Carpenter (2003:25) recommend convenience sampling when it is difficult to reach the target population.

To be included, the TOP health care consumers had to be:

• between 15 and 55 years old;
• at the facility during data collection, after having procured TOP, awaiting discharge; and
• willing to participate in the study

**Sample size**

According to Bassett (2001:66-67), qualitative research does not require a large sample, because such studies seek to describe experiences rather than collect numbers for statistical analysis. Similarly with case studies, in-depth information is
sought from a small sample. According to Holloway and Wheeler (2003:128) sample size does not influence the importance or quality of the study. Moreover, in qualitative research there are no guidelines to determine the sample size, since the size depends on the purpose of inquiry and data saturation. In the current study an attempt was made to include all the active facilities and data saturation in one facility did not influence the process. Data was collected in all five (5) selected active facilities. Only one manager did not wish to participate. Even though data saturation was reached after the fourth interview for the TOP service providers and TOP health care consumers respectively and third interview for the TOP facility managers, interviewing continued until all the available willing participants had been interviewed. Table 2.3 indicates the sample size in relation to facilities, TOP facility managers, TOP service providers and TOP health care consumers.

Table 2.2 Sample size for the study

<table>
<thead>
<tr>
<th>SAMPLE</th>
<th>LOCATION</th>
<th>QUALIFIED</th>
<th>NOT QUALIFIED</th>
<th>SAMPLE SIZE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities 7 (constitutes all active facilities)</td>
<td>Ehlanzeni District</td>
<td>3</td>
<td>1 not willing to participate</td>
<td>5 facilities</td>
</tr>
<tr>
<td></td>
<td>GertSibande District</td>
<td>1</td>
<td>1 only 3 months in the business</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nkangala District</td>
<td>1</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>TOP facility managers 5</td>
<td>Ehlanzeni District</td>
<td>2</td>
<td>1 not willing to participate</td>
<td>4 facility Managers</td>
</tr>
<tr>
<td></td>
<td>GertSibande District</td>
<td>1</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nkangala District</td>
<td>1</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>TOP service providers 8</td>
<td>Ehlanzeni District</td>
<td>4</td>
<td>1 not willing to participate</td>
<td>7 TOP Providers</td>
</tr>
<tr>
<td></td>
<td>GertSibande District</td>
<td>2</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nkangala District</td>
<td>1</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>TOP health care consumers 11</td>
<td>Ehlanzeni District</td>
<td>4</td>
<td>-</td>
<td>9 health Consumers</td>
</tr>
<tr>
<td></td>
<td>GertSibande District</td>
<td>3</td>
<td>1 not willing to participate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nkangala District</td>
<td>2</td>
<td>1 not willing to participate</td>
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</table>

Four TOP facility managers, seven TOP service providers and nine TOP health care consumers in five facilities were included in the study. For consistency, the respondents or informants were referred to as participants.
2.4.3 Data collection

According to Polit and Beck (2004:26) and Burns and Grove (2009:695), data collection refers to a precise and systematic gathering of information relevant to the research problem in an effort to answer research question or questions. Therefore, data collection is the process whereby information is sourced through the use of data collection instruments such as interview schedules and guides, questionnaires, records, observation, field notes, reflective journals, other records such as agendas and minutes, artefacts found in the setting and the researcher her/himself. The research design determines the data-collection methods. When both quantitative and qualitative research approaches are adopted, triangulation of data collection methods is best used (Polit & Beck 2004:27).

Quantitative data-collection methods are used to collect quantifiable data, which is reported in numbers, while qualitative data collection methods provide narratives and are analysed in rich descriptions (Polit & Beck 2004:27). De Vos et al (2011:325) emphasise that data collection and successful fieldwork are determined by the accessibility of the setting and the researcher’s ability to establish rapport and relationships with gatekeepers.

2.4.4 Data-collection instruments

Research instruments are tools used to collect data. These include questionnaires in their various forms including interview schedules and guides, observation sheets, field notes, reflective journals as well as the researcher (Parahoo 2006:325).

- Interview schedule (questionnaire)
In order to collect valuable data, the researcher needs a research instrument that will serve as guidance on how to go about consistently eliciting the type of data necessary to answer presented research questions. A structured interview is based on scheduled questions whereas an unstructured interview usually presents with a grand question that is followed by prompts and probes (Sechrist & Pravikoff (2002) cited in Parahoo 2006:329). Both types of interviews provide the opportunity to change the words but not the meaning of questions should the interviewee ask for clarification or the interviewer
need clarification. The researcher remains in control of the interview process. In the study, the researcher conducted interviews using structured interview schedules with open and closed-ended questions to collect accurate data (Patton 2002:342). Based on the sensitivity of the phenomenon, the interview schedule was most suited for this study as it allowed for an in-depth exploration of the phenomenon with the participant doing much of the talking, and the researcher directing the focus of the discussion.

The interview schedule was divided into sections designed to obtain detailed information from each of the identified populations. Although the questions were stated, these were open-ended and the researcher could pose probing questions:

- **Interview schedule for TOP service providers**

  **Section 1** covered demographic data, including participants’ age and number of years working in the facilities providing TOP.

  **Section 2** explored the participants’ knowledge regarding the content and application of the CTOP Act, 92 of 1996 to the TOP programme.

  **Section 3** explored the participants’ experiences and feelings about their participation in the TOP programme.

  What are your feelings about terminating pregnancies as you do in your job?

  Alternatively:

  What is your experience and feelings about participating in TOP services?

  Probing questions were guided by the information elicited during the interview. The probing questions were thus not prepared in advance. For example:
  - What is the impact of the programme on
    - individuals
    - communities
    - the country?
  - What is the impact of providing this service on you?
• What support do you have from management?
• How many clients do you see in a month?
• Do you think this is a good number?
• If not, what could be the causes of poor utilisation of the service?
• How can this be improved to ensure maximum utilisation?

In your view:
• What are the challenges in the provision of TOP services?

➢ Managers of TOP facilities

Section 1 covered the participants’ demographic data including the participants’ age and number of years managing the facilities providing TOP

Section 2 explored the participants’ knowledge of the content and implementation of CTOP Act.

Section 3 explored the participants’ experience in the management of the TOP programme.

• What is your view or been your experience of the unit and its utilisation?
• How are those procuring TOP service supported to ensure continued service delivery?
• Did you see the report on the M-Net, Carte Blanche programme? (If yes, the participants were asked to give their views on the documentary).
• What has been your experience with the TOP programme?
  - Did it address the need for self determination amongst women?
  - Did it address the issue of morbidity and mortality as a result of backstreet abortions?
  - how is the programme designed?
• From your management point of view what do you consider the impact of the programme to be, on:
  ▪ individuals
  ▪ communities
In your view:

- What are the challenges in the management of TOP services?

➢ **TOP health care consumers**

Section 1 covered the participants’ demographic data, including participants’ age, marital status, employment status as well as the area of residence during the time of investigation.

Section 2 comprised the main research question:

What is your experience regarding TOP service provision and facilities?

Alternatively:

How do you experience TOP service provision and facilities?

Examples of probing questions included:

- How did you know about the legality of abortion in South Africa?
- How do you feel about this? Or how does this make you feel?
- What does this mean to you?
- What support did you have in the unit, at home and community?

The research questions focused on the participants’ lived experiences. Other questions emerged as participants responded to the scheduled research questions and the conversation ensued.

➢ **Records**

The records provided for the:

- number of TOP service providers employed in the hospital
- average number of patients procuring TOPs per month
- average number of clients seen in the TOP unit per month and annually
• agendas and minutes of meetings held to discuss TOP provision and management thereof.
Artefacts were also examined for functionality and aesthetism thereof.

➤ Field notes

Field notes are a written account of what is heard, seen, experienced and thought about in the course of the interview. These include both empirical observation as well as interpretations of what is seen and observed (Babbie 2007:311; De Vos et al 2011:359).

De Vos et al (2011:359) emphasise further that memorising observations made during data collection is sometimes impossible and it is not wise to rely solely on memory to preserve data collected. Consequently, the researcher made field notes to document non-verbal communication and cues and to describe the context and observations made during data collection. During the study the researcher made use of the following types of field notes:

• Observation notes. These are the researcher’s objective description of environmental events, conversations and behaviours that took place in the research setting during investigation (Polit& Beck 2004:382). The researcher therefore noted conversations, participants’ behaviour as well as information pertaining to time, place, activity and dialogue as fully as possible. These notes were taken in order to remind the researcher what had transpired, been seen and done during interviews.

• Theoretical notes. These notes were made to interpret, infer and hypothesise in order to formulate an analytical scheme. Polit and Hungler (2003:369) describe theoretical notes as “interpretive attempts to attach meaning”.

• Methodological notes. These are notes made to direct the researcher on how subsequent observations would be done during the investigation. The notes included instructions or reminders that the researcher wrote for herself to ensure that similar observations across interviews were interpreted in like manner (Polit& Beck 2004:383).
Reflective journal. Neuman (2000:366) maintains that reflection is vital during interviews and the whole research process. Hence it is recommended that the researcher keeps a reflective journal to keep her emotions and perceptions in check throughout the research process.

In the current study, the researcher wrote down her emotions, preconceptions, expectations and prejudices before each interview, so that these could be bracketed in an effort to prevent bias in the final product.

The researcher as a data-collection instrument

In qualitative research, the researcher plays a pivotal role as a data-collection instrument (Creswell 2004:163). This notion is supported by Streubert and Carpenter (2007:22) who point out that in qualitative research, the researcher as an instrument for data collection is the key to the success of the study undertaken. This is primarily founded on the researcher’s roles as someone who has developed the instruments, as a data collector who poses probing questions for clarity or extension of data collected, an observer, interviewer and interpreter of the data collected. Parahoo (2006:65) stresses that the use of the researcher in data collection facilitates responses and enhances prolonged engagement with the data collected. According to Monama (2009:48-49), the positive aspects of the researcher in data collection is that the verification and quality of data happen simultaneously on site as clarifications can be made and positive or negative cues can be observed. The following have been outlined as characteristics which are unique to human beings as human instruments in data collection:

- **Responsiveness.** The researcher as a human instrument can identify and follow up personal (which might be verbal and non verbal cues) and environmental cues that exist thus assisting in guiding the direction interviews can take.
- **Adaptability.** The researcher is capable of collecting data about multiple factors happening at the same time.
- **Holistic emphasis.** Only a human instrument is capable of grasping the phenomenon and its context all in one view.
• **Processual immediacy.** The researcher can process data as soon as they become available on site, faster and with much ease as presence in the scene enhance understanding of the context.

• **Opportunities for clarification and summarising are available.** The researcher as a human instrument can summarise data on the spot and seek clarification of cues from the informants to deduce meanings. This will reduce the data collection period.

• **Opportunity to explore atypical or idiosyncratic responses.** Responses can be explored to test their validity and to reach understanding at the time of data collection.

Streubert and Carpenter (2007:23) argue that the subjectivity inherent in this is not necessarily bad, but could contribute to the richness of the findings of qualitative data. Therefore, it becomes difficult if not impossible to preclude the possibility of the researcher’s bias especially in influencing the way in which the process will flow. The advantage here is that the bias of this nature can be managed. It has been found that even though researchers are ethically bound to ensure objectivity, in qualitative research biases and subjectivity are difficult to exclude as these shape the way researchers view and understand the data collected and the way personal experiences are interpreted. What is required is for the researcher to acknowledge these and bracket them.

Sources of bias include (Manga 1996:50):

• The attitudes and the opinion of the interviewer/researcher.

• A tendency for the interviewer/researcher to see the participant in his/her own view.

• A tendency for the interviewer/researcher to seek the answers that support his/her preconceived notions.

• Misconception by the interviewer/researcher of what the interviewee is saying.

• Misunderstanding by the participant of what is being asked.
To limit bias in the current study, the researcher bracketed her emotions, preconceptions and expectations documented these in the reflective journal as mentioned earlier.

2.4.5 Pre-test of the data collection instrument

The researcher pre-tested the interview schedule with a small sample of informants to determine whether the data-collection instrument was clearly worded and easily understood and could be easily administered within a reasonable time period of an hour (Polit & Hungler 2004:728) and make the necessary preparations physically and psychologically if the time is to be more than an hour. Ethical considerations were adhered to, which amongst others, included obtaining informed consent. The pre-test was conducted with one TOP service provider, one facility manager and two TOP health care consumers, who were not included in the main study. The small pre-test sample size is the indication of the limited size of the target population.

The researcher conducted interviews, using a tape recorder, took field notes and transcribed the interviews verbatim.

The pre-test allowed the researcher to evaluate

• the length of time to be taken in each interview
• the suitability of the interview techniques used to elicit the required information
• the flow of the interview, based on participants' responses and possible comments
• irrelevant or ambiguous aspects that could be removed from the instrument
• competency in using a tape recorder

2.4.6 Data collection process

The data collection process consists of three phases, namely preparatory phase, gaining access to the field, and leaving the field (De Vos et al 2011:333-336).
Preparatory phase

The preparatory phase involves the gathering of adequate information about the study to be undertaken. This includes a literature review to familiarise oneself with the topic under discussion, integration of the research methods, identifying a target population and preparation of interview instruments. The researcher has, amongst others, to determine when and how to gain access to the facilities as well as make the necessary arrangements to inform the authorities of those facilities. In this study, the researcher:

- undertook an extensive literature review on the topic.
- deliberated on the selected research methods
- read around preparing and conducting interviews
- prepared the interview schedule
- identified the target population
- identified settings where the study would be undertaken
- obtained permission to conduct the study from the relevant authorities
- secured venues and made the necessary appointments with participants

Gaining access to the field

It has been established that all settings have gatekeepers. Permission and approval to undertake the study was sought and obtained in writing from the Department of Health Studies, Research and Ethics Committee at the University of South Africa, the Ethics Committee in the MDOH and the authorities of the facilities that participated after intense scrutiny of the research proposal (see annexure B and C).

Individual permission for the participants was sought before any interview could take place. In line with the research ethics, participants were informed that the permission they are granting is not binding and that they are participating on their own free will and could withdraw their participation whenever they feel like doing so and there will be no penalties levelled against them for refusing to grant permission or withdrawal from the study. Where an audio-tape was to be used, permission was also sought with the proviso that this can be halted at any time of the interview when the participant is no longer comfortable with its use.
Leaving the field

The last phase of the data-collection process is leaving the field. This phase marks the conclusion of the field work. De Vos et al (2011:336) state that the field should only be left when the researcher is satisfied with the data collected and there is saturation of data. In some instances, there may be a need to verify data during report writing. In this study, the researcher left the field when she was satisfied that the data collected answered the research questions and highlighted the experiences and feelings of the participants regarding TOP provision. Due to the sensitivity of the phenomenon under investigation, the researcher provided all participants with her contact details so that she could be available to the participants after the interviews should this be necessary.

2.4.7 Data collection methods

Data collection methods are dictated by the research design. In qualitative research where a case study design is preferred, triangulation of data collection methods serves to enhance the quality of the data collected. Triangulation, according to Polit and Beck (2012:603) is referred to as a mixed method of data collection where both qualitative and quantitative approaches are used. The primary goal is to enhance the credibility of data collected and to gain a more complete understanding of the phenomenon under study.

The best way to elicit the various and divergent constructions of reality that exist within the context of a study is to collect information about events and relationships in different ways, using different methods. In this study, the main method was the interview where a tape recorder after permission was sought, was used to capture the discussions. Interviews were supported by the researcher’s field notes and reflective journal, minutes and records of the programme. The interviews provided quantitative data in terms of numbers of TOP service providers, TOP facility managers and TOP health care consumers and TOPs procured and qualitative data in terms of narratives about experiences and feelings about TOP service provision and consumption.

Structured interviews entail the use of an interview schedule with a list of closed and/or open-ended questions to gather the desired information. This type of interview does not exclude probing and the advantage is that similar questions are asked from all
participants, assuring comparability of data. In this study, the researcher used a structured schedule with closed and open-ended questions, and allowed for probing questions depending on the participant's responses.

Unstructured interviews usually use interview guides consisting of one or more core questions followed by probing questions emanating from the information presented. McMillan and Schumacher (2010:206) point out that unstructured interview allow interviewers a great deal of latitude in asking questions in whatever order deemed appropriate. This method was not used as the researcher wanted to be consistent in relation to the questions asked and be able to control the discussion.

In an interview, an open-ended or core question that is directed towards an understanding of the participants' perspectives regarding their lives, experiences, or situations as expressed in their own words may be asked, with other questions being developed from the participants' responses. Patton (2002:296) maintains that a truly open-ended question does not presuppose dimensions of feelings or thoughts that are salient to the interviewer. Thus permitting informants in their response to take whatever direction and use whatever words they choose in order to represent what they have to say.

To add to the interviewing technique, Holloway and Wheeler (2006:97) emphasise that the interviewer should possess the attributes necessary to keep the conversation focused so as to enhance the richness of the information from the interviewee.

According to Burns and Grove (2009:405-406) and De Vos et al (2011:335), interviews have the following advantages:

- Interviews allow for a one-on-one or face-to-face interaction and in this way researchers learn first-hand about the social world of the informants and are thus enabled to understand the definition, concepts and meanings that informants attribute to social situations.
- Interviews allow the researcher to enter another person’s world and in this way understand the person’s perspective in-depth. Both parties explore the meaning of the questions and answers involved and, as such, areas of uncertainty or ambiguity are clarified instantly to avoid misinterpretation.
Interviews are the appropriate method of choice when the evidence sought does not exist and is not directly observable, such as experiences, attitudes and perceptions.

Interviews allow collection of data from informants that are unable to complete or unlikely to complete questionnaires, such as those who’s reading, writing and ability to express themselves is marginal. Intense concentration and rigorous participation in the interview process improves the accuracy, trustworthiness and authenticity of the data.

There is a higher response rate to interviews than to mailed questionnaires, leading to a complete description of the phenomenon under study.

In interviews, interpersonal skills can be used to facilitate co-operation and to elicit more information.

Interviewing allows researchers to explore greater depth of meaning than can be obtained with other data-collection techniques. Participants should be provided with the opportunity to fully explain their experiences of the phenomenon under investigation and should share their own stories, in their own words, rather than be forced into pre-established lines of thinking developed by researchers.

In this study the researcher adopted both the qualitative and quantitative data collecting approaches whereby interviews were conducted and quantitative information completed accordingly in line with what was said in the interview, observed and read in the records. The researcher commenced each interview with a social conversation, introducing herself and the topic for discussion in order to establish rapport with the interviewee.

During the interviews, the researcher consciously avoided leading and evocative questions and constantly asked herself the following salient questions:

- Can I summarise the essential features of this phenomenon from the data received?
- Does the person have anything else to say about the aspect of the phenomenon?
- Are there any other experiences surrounding the phenomenon that the informant has not yet mentioned?
Through these questions the researcher remained centred on the data, listened attentively, avoided interrogating the informants unnecessarily and treated them with respect and interest.

Parahoo (2006:330-331) supports individual face to face interviews for the present study because interviews are deemed:

- Useful for sensitive topics.
- Suited for the exploration of perceptions and experiences
- Best suited for the varied professional, educational and personal history of the informants.

At the same time, interviews can present with challenges in situations where there is:

- Lack of rapport between interviewer and interviewee
- Obtrusiveness in controlling the interview
- Interviewer over-involvement that could bias the research process
- A compromised relationship between the interviewer and interviewee

In order to prevent or cope with these limitations, the researcher applied the following measures:

- *Established and maintained rapport.* TOP service providers, managers in TOP facilities as well as TOP health care consumers in those services were encouraged to talk openly about their experiences, feelings and to display their emotions openly and were assured anonymity and no penalty arising from the information brought forth.
- *Unobtrusive control.* The researcher remained unobtrusive and maintained good interpersonal skills and privacy. The environment was generally relaxed and friendly. The venue for the interview was decided upon based on the interviewees’ choice. For the TOP health care consumers, it was the TOP facility where services were rendered and for the TOP service providers and TOP facility managers it was at their work place.
- **Over-involvement.** The researcher avoided identifying closely with the topic being researched and/or with the participants to maintain balance.
- **Interviewer and interviewee status.** The researcher encouraged and allowed the participants to talk without guiding their responses only providing prompts and positive gestures, such as the nod of the head, to affirm narration or a ‘yes’ or ‘is that so?’ to encourage the participant to continue talking.

### 2.5 ETHICAL CONSIDERATIONS

Ethics is concerned with right and wrong of doing things. Ethics refers to the moral value and code governing behaviour. In research, ethics refer to a system of moral values concerned with the degree to which research procedures adhere to professional, legal and social obligations with special emphasis on respect and appreciation of participants for their participation in research (Polit & Beck 2004:641; Searle et al 2009: 274-275). When scientific study involves human conduct, it is important that the researcher, in searching for the truth should not compromise the integrity of participants (Mouton 2002:238). In this study, the researcher adhered to the following ethical principles

#### 2.5.1 Gaining entry to the setting

In research it is important that researchers treat institutions as a person. Therefore, before the study, the research proposal was submitted to and reviewed by the Department of Health Studies’ Research and Ethics Committee of the University of South Africa to ensure that the required ethical standards were maintained. Ethical clearance was granted before the researcher could continue with the study. Permission to conduct research in the facilities designated to perform TOP by the MDOH was sought and approval given by the authorities in the Department of Health, Mpumalanga. Furthermore, approval to conduct the research in the hospitals that participated was obtained from the Chief Executive Officers of those hospitals after intense scrutiny of the research proposal (see annexure B and C).
2.5.2 Informed consent and voluntary participation

Informed consent is regarded by Brink et al (2006:35) as a mechanism for protecting human rights. Therefore, the informants should be given adequate, understandable and relevant information regarding the research so as to enable them to exercise their right to decide whether or not to participate in the study. Holloway and Wheeler (2006:59) are of the opinion that informed consent is problematic in qualitative research, because the nature of the content changes as probing questions are posed to participants, hence, according to the authors, informed consent should be regarded as a process to be revisited whenever necessary. In the current study, before participants could sign consent to participate, the researcher outlined the purpose of the research as well as its main features including the risks and benefits of participation. Participants were informed that there will be no direct benefits to them; but these would be realised in the future. Participants were also informed about the interview process and that probing questions may be asked to further explore their responses. Of importance was the information that participation was voluntary and even though they would have signed consent, this is not binding, they could withdraw their participation at any time during the study and there would be no penalties levelled against them. Participants could refuse to participate and this would still be acceptable with no negative repercussions on their side. They should not feel pressurised or coerced to participate at any stage of the study (Ritchie & Lewis 2003:67) (see annexure E)

The researcher did not withhold any information, even that of obtaining consent every time she feels that more information different from that which was agreed upon is needed.

2.5.3 Anonymity and confidentiality/privacy

Furthermore, participants were assured of anonymity whereupon their identity would be protected, and confidentiality maintained, in that the information obtained from them would remain between the participants, the researcher and the study promoters. An independent data analyst who was contracted to assist with the coding of data was sworn to secrecy and confidentiality should he have access to privileged information in the data during coding. Their privacy was respected whereupon interviews were conducted in an office away from the busy unit. To further protect their identity, the researcher assured them that their names will not appear or be mentioned in any
discussion verbal or written during the study and in the reports or publications thereafter. In the current study:

- Recordings were edited so that any names mentioned during the interview were deleted
- People not involved in the study were not allowed access to the information without permission from the informants
- Data were analysed such that it pointed to none of the participants
- The participants’ identities were not revealed in the report and would not be revealed in the publications to follow
- Tapes and transcriptions would be erased and destroyed one year after the publication of the research report.

2.5.4 Principle of beneficence

According to Brink et al (2006:32), the researcher needs to adhere to this principle in order to secure the well-being of the informants. In this study, the researcher made sure that no harm was done to the informants. Therefore the following procedure was followed:

- The researcher pre-tested the research instrument before commencing with the study and questions were amended according to the feed-back received.
- The participants were protected from financial harm as TOP health care consumers were met in the facilities when they came for TOP services; TOP service providers and TOP facility managers were also met at the TOP facilities where they worked.
- Process of consenting was done to allow the informants to decide whether to proceed with the study or not.
- Debriefing sessions were arranged for participants should the interview have evoked emotional feelings needing management thereafter (Brink et al 2006:33).
- The researcher maintained non-judgemental attitude throughout her encounter with participants.
- The researcher asked probing questions in an acceptable manner.
- Those who refused to participate in the study were not victimised.
The interviews were not hurried. The researcher spent time with individual participants after the interview giving them opportunity to reflect on the interview and to ensure that they remained in a stable condition.

2.6 TRUSTWORTHINESS OF THE STUDY

A research study is said to be trustworthy when it reflects the reality and ideas of the informants (Streubert & Carpenter 2007:460). In this study, trustworthiness was achieved by observing the following principles:

- Credibility
- Applicability/Transferability
- Dependability/Consistency
- Confirmability/Neutrality

2.6.1 Credibility

Credibility is a quality assessment of whether the data has convincingly described the phenomenon under study. According to De Vos et al (2011:346), credibility “asks whether the researcher has established confidence in the truth of the findings and the context in which the research was undertaken”. Polit and Beck (2008:539) describe credibility in relation to the truth of the data collected and the interpretation thereof. One of the assumptions of qualitative research and also of naturalistic inquiry is that reality is holistic, multidimensional and ever changing. In this study the following measures were undertaken to ensure credibility:

- **Prolonged engagement with data**

  Prolonged engagement with data is one of the best ways to establish credibility. According to Rossouw (2003:181) prolonged engagement with data relates to spending time with participants collecting data, verbatim transcription of audio tapes and member checking to clarify or verify aspects in the data. In this study, this was attained by:

  (i) Development of instruments and in-depth interviews with participants. In this study the researcher regarded herself as a data collection instrument in that
she developed the instruments and conducted the interviews until saturation of data was reached. In that way she engaged with the data from the start.

(ii) The verbatim transcription of data that followed with repeated listening and reading and re-reading of transcripts.

(iii) The intense analysis of data to establish themes and categories.

➢ Multiple investigators

Creswell (2009:191) refers to the use of multiple investigators as investigator triangulation. The researcher enhanced the trustworthiness of the study by engaging the research promoter and joint promoter from the planning phase of the study until the final report was produced. The researcher also allowed the participants to see the drafted version of the data collected so as to ensure credibility.

➢ Multiple sources and methods

The researcher triangulated data collection by combining two fundamentally different data-collection methods, ie, the quantitative and qualitative methods, where the quantities supported the impact of the programme in relation to utilisation and the narratives supported the socio-economic aspect of the program (Burns & Grove 2009:233).

Different but complementary data was also collected from the following sources:

- TOP service providers in TOP facilities
- Managers of TOP facilities
- TOP health care consumers in those facilities
- Records in TOP facilities

The purpose of triangulating data collecting methods was to gain insight from different sources with regard to the understanding of the feelings and experiences of those participating in TOP services based on their knowledge of the stipulations of the CTOP Act. The researcher used a tape recorder to capture information during interviews. Field notes were compiled to supplement tape-recorded interview since the former cannot
portray the physical setting and non-verbal communication nuances picked up during observed interaction.

- **Member checks**

According to Polit and Beck (2010:499) member check is a process whereby data analytical categories, interpretations and conclusions in a study are verified as a true reflection of reality with participants before the report is finalized. This, according to the authors, is a way of enhancing rigour in qualitative research. In this study, the researcher, at the end of each interview, played back the recorded session and invariably misrecordings were corrected immediately. Away from the data collection setting, the researcher first listened to the tapes, made her own transcriptions and deleted names mentioned in the interviews before handing these over to an independent analyst who was engaged specifically to assist with transcriptions with the aim of coding and categorising data for analysis. The results of the analyst were discussed with the researcher who would in turn check these with participants should a need arise.

- **Researcher credibility**

The researcher is the “data collecting instrument as well as the creator of the analytic process” (Polit & Beck 2012:596). In this instance, the researcher holds a Master Curationis degree and is presently facilitating a research module as a lecturer. The researcher remained objective by implementing bracketing and intuition to avoid biases and approached the research with an open mind. She used reflexivity throughout the study. The research promoter and joint promoter were experienced researchers and had been involved in research for many years and their supervision during this process enhanced the credibility of the study.

2.6.2 Applicability/Transferability

Applicability is concerned with how generalisable the outcomes of the study are (De Vos et al 2011:420). According to Babbie and Mouton 2011:278), the researcher can improve applicability of a study by providing an audit trail of rich descriptions of the
research process so that anyone interested in transferability has a base of information. In the current study generalisability of findings was not possible due to the uniqueness of the case under study and the study design selected; but the researcher improved the applicability of the study by providing an in-depth description of the understanding that the TOP service providers and managers of facilities had regarding the content of the CTOP Act and its implementation as well as dense descriptions of the experiences of TOP service providers, managers as well as those of the TOP health care consumers in TOP facilities regarding the service so that anyone interested in transferability could replicate the study based on the information available.

2.6.3 Dependability/Consistency

Dependability or consistency refers to the extent to which the researcher’s outcomes can be replicated with similar outcomes (Babbie & Mouton 2011:278). In dependability, an enquiry must provide its audience with the evidence that, if it were repeated with the same informants in the same context, the findings would be repeated. In this study, dependability was only achieved in section 1 of the research instruments for the TOP service providers and the TOP facility managers. In section 2 of the research instruments for all the participants, it was difficult to achieve dependability as these sections dealt with experiences that might change over time. In this study, the researcher treated such changes as hallmarks of maturing research.

An audit trail or documentation of the process followed, is one way in which a research study may show dependability as opposed to consistency (Silverman 2000:187). The researcher established an audit trail to enable other researchers to scrutinise the research method and the researcher’s interpretation as an aspect of dependability.

2.6.4 Confirmability/Neutrality

Polit and Beck (2008:750) refers to confirmability as a neutral criterion used to measure the trustworthiness of qualitative research. According to de Vos (2000:331), confirmability is “the strategy to ensure neutrality”. To ensure confirmability, the researcher engaged an external analyst. This notion is supported by Holloway and Wheeler (2006:306) who assert that the use of externals in data analysis serve to
confirm the true value of data collected as well as findings from data analysed. To confirm the findings, the researcher used the following auditing criteria:

- Raw data comprised of data from tape recorders and field notes.
- Data was edited to remove names of participants or information that could be linked to participants.
- Themes, codes and categories were examined.
- The conclusions of the findings were supported by literature.

Leininger and McFarland (2002:88) add that documented verbatim statements and direct observational evidence from informants and other people who firmly and knowingly confirm or substantiate the data or findings imply conformability. The researcher sought confirmation from the participants that her interpretations were a true reflection of their experiences and feelings regarding TOP service provision. This was done through sharing the reflections with the participants and asking them to validate the transcripts.

2.7 CONCLUSION

This chapter described the research setting, design and methodological framework used in the study, including the population, sample and sampling technique, data collection, measures to provide trustworthiness, and ethical considerations.

Chapter 3 discusses the data analysis and interpretation.
CHAPTER 3

DATA ANALYSIS AND INTERPRETATION

3.1 INTRODUCTION

Chapter 2 described the research design and methodology, including the data collection. This chapter discusses the data analysis and interpretation according to the emerging themes and categories in the qualitative data.

Data analysis is the separation of data into parts for the purpose of answering research questions and communicating the results. Data analysis involves a dynamic process in which researchers brainstorm on data presented in an effort to arrive at concluding statements, known as findings (Corbin & Strauss 2008:46). McMillan and Schumacher (2010:367) describe data analysis as “an inductive process of selecting, categorising, comparing, synthesising and interpreting data to provide verified explanations about the phenomenon of interest”. During this phase, data is organised into its constituent components to reveal its characteristic elements or structure and to impose order on a large body of unstructured information (raw data) so that general conclusions can be reached and can be communicated in the research report (Polit& Beck 2012:557).

This study was about the evaluation of the impact of the TOP programme in Mpumalanga province, South Africa. Programme evaluation relates to the systematic collection of information about the activities, characteristics and outcomes of a programme so that judgement about the programme can be made. The aim of any programme evaluation is to improve the operation of the programme and/or inform decisions about future programming (De Vos et al 2006:369). The TOP programme aims to enhance individual and social change in providing services which improve the quality of health therefore life of women in society by advancing the acknowledgement of their rights to choose when to have a baby.

In this study, both quantitative and qualitative approaches were used to collect data. Quantitative data was collected mainly from existing records, information of which was confirmed by conducting interviews using structured questions about the demographic
data. Qualitative data was collected by means of interviews with the participants who narrated their experiences about TOP services. In addition, the researcher reviewed minutes of meetings, reports and attendance records for TOP services, in order to evaluate the impact of the TOP programme based on the stipulations of the CTOP Act (92 of 1996) as amended. The data from the TOP service providers and managers indicated their knowledge regarding the content and implementation of the Act as well as experiences and feelings about participating in TOP service provision in line with the Integrated Model of Programme Evaluation (IMPE) (De Vos et al 2006:370) (see chapter 1, figure 1.1). As such, the data collected addressed concerns about community needs (needs assessment), the programme, programme conceptualisation and design (theory), programme implementation (process, progress and monitoring), programme outcomes, and efficiency of the programme (Rossi, Lipsey & Freeman 2004:62).

3.2 DATA ANALYSIS

In this study, as stated earlier, data collected elicited the following:

- Knowledge of the content of the CTOP Act by TOP service providers and TOP facility managers
- Accessibility of the programme by the appropriate target population
- Congruency and consistency of the service provided with the programme objectives
- Service utilisation
- Experiences and feelings in TOP services by TOP health care consumers
- Experiences and feelings in TOP service provision and management of TOP facilities, which included human resources, supplies and attitudes of TOP service providers, managers of TOP facilities and other health professionals not involved in TOP service provision.

3.2.1 Quantitative data analysis

According to Wilson (1989) cited in Monama (2009:83), demographic data in qualitative research can be presented quantitatively to outline the richness of data based on the composition of participants and their various attributes. In this study, the quantitative
data covered aspects such as the participants’ age, gender, and marital status; number of trained TOP service providers and facilities in the districts, and the monthly average of TOPs performed. The following section provides the necessary analysis.

3.2.1.1 Participants’ demographic data

TOP service providers’ demographic data

Although there were eight (8) TOP service providers identified, only seven (7) were willing to participate and share their experiences with the researcher (see table 2.2).

Table 3.1 TOP service providers’ demographic data (n=7)

<table>
<thead>
<tr>
<th>Age in years</th>
<th>Gender</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-45</td>
<td>Male</td>
<td>1</td>
<td>14.29%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2</td>
<td>28.57%</td>
</tr>
<tr>
<td>46-60</td>
<td>Male</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>4</td>
<td>57.14%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>7</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 3.2: Number of years in the programme

<table>
<thead>
<tr>
<th>NUMBER OF YEARS IN THE PROGRAMME</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-5</td>
<td>3</td>
<td>42.86%</td>
</tr>
<tr>
<td>6-10</td>
<td>3</td>
<td>42.86%</td>
</tr>
<tr>
<td>11&gt;</td>
<td>1</td>
<td>14.29%</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>100%</td>
</tr>
</tbody>
</table>

The participants in the study comprised TOP service providers, TOP facility managers and TOP health care consumers. Of the seven (7) TOP service providers participating, 57.0% (n=4) were over 45 years of age and only 14.29% (n=1) had been engaged in the provision of TOP services for more than 10 years. The researcher assumed that informants with more than two years’ experience in TOP service provision would have adequate experience and provide valuable information. Those TOP service providers with less experience would, according to the researcher, have difficulty in answering questions relating to service provision. Hence years of experience in the practice of TOP service formed criteria for inclusion or exclusion. Although gender was not a
priority, in the study only one male participated. This might be due to the fact that there are not as many males in the nursing profession.

**TOP facility managers’ demographic data**

Although five (5) TOP facility managers were identified, only four (4) were willing to participate (see table 2.2)

**Table 3.3: TOP facility managers’ demographic data (n=4)**

<table>
<thead>
<tr>
<th>Age in years</th>
<th>gender</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-45</td>
<td>male</td>
<td>-</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>female</td>
<td>-</td>
<td>0%</td>
</tr>
<tr>
<td>46-60</td>
<td>male</td>
<td>-</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>female</td>
<td>4</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Table 3.4: Number of years managing the programme**

<table>
<thead>
<tr>
<th>NUMBER OF YEARS MANAGING THE PROGRAMME</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-5</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>6-10</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>11&gt;</td>
<td>1</td>
<td>25%</td>
</tr>
</tbody>
</table>

The four TOP facility managers were over the age of 45 and had been managing TOP facilities for over five years. Their participation in the study was viewed as strategic as it would provide the required information to judge the performance of the programme
TOP health care consumers’ demographic data

There were eleven (11) TOP health care consumers approached and requested to participate in the study. Only nine (9) were willing to participate.

Table 3.5: TOP health care consumers’ demographic data (n=9)

<table>
<thead>
<tr>
<th>AGE IN YEARS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-25</td>
<td>5</td>
<td>55.56%</td>
</tr>
<tr>
<td>26-35</td>
<td>1</td>
<td>11.11%</td>
</tr>
<tr>
<td>36-45</td>
<td>1</td>
<td>11.11%</td>
</tr>
<tr>
<td>46-55</td>
<td>2</td>
<td>22.22%</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>7</td>
<td>77.78%</td>
</tr>
<tr>
<td>Married</td>
<td>1</td>
<td>11.11%</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>11.11%</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYMENT STATUS</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>2</td>
<td>22.22%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>7</td>
<td>77.78%</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESIDENTIAL AREA</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>1</td>
<td>11.11%</td>
</tr>
<tr>
<td>Rural</td>
<td>8</td>
<td>88.89%</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>100%</td>
</tr>
</tbody>
</table>

The study found that of the nine (9) TOP health care consumer participants, 77.78% (n=7) were single; 5.56% (n=5) were below the age of 25; 22.22% (n=2) were over 45; while 77.78% (n=7) were unemployed, and 88.89% (n=8) were from rural areas. The high number of rural residents is not surprising because the province is rural in nature. The reasons for wanting TOP varied. Of the nine (9) participants, six (6) were not married and still at school and wanted to pursue their studies. Similar responses were reported by Engelbrecht (2005:158 and 165), whereby pregnant minors opted for TOP because they wanted to complete their studies and also because they were unmarried. Others were concerned about those around them. In a study conducted by Shellenberg and Frohwirth...
(2009:4) some participants indicated that their parents would be disappointed if they can learn of their pregnancy and subsequent abortion. In this study, to support such assertions, TOP health care consumer number 4 stated that:

“I don’t want my mom to have a heart attack because when my sister got pregnant, she did not take it well at all. She became sick.”

3.2.1.2 Number of trained service providers

According to records in the Department of Health in Mpumalanga (DOH 2005:72), a 55% of health care providers (category of health professionals not specified) were trained to provide TOP services. A total of 42% of these were also trained in TOP counselling and 12.5% in manual vacuum aspiration (DOH 2005:72). In this study, at the time of investigation, only eleven (11) TOP service providers were found to be actively involved in the provision of TOP services in the three districts (see table 3.6). According to the participants, not all trained TOP service providers are allocated in TOP units because of the general shortage of staff in the general wards. This situation is similar to the findings in the study by Varkey-Sanjani et al (2000:104) whereby not all midwives trained to provide TOP services were allocated in TOP facilities. In addition, TOP units in Mpumalanga tend not to be busy and therefore if there is a staff shortage elsewhere, those in the TOP units are deployed to the general wards. This is contrary to the stipulations of MTOPIP whereby the minimum requirement for staff in TOP units is 3 professional nurses and 1 enrolled nurse (MDOH 2009:12) (see annexure D).

Table 3.6 Total number of active trained TOP service providers per district found at the time of investigation

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>TOTAL NUMBER OF ACTIVE TRAINED TOP SERVICE PROVIDERS PER DISTRICT</th>
<th>TOP SERVICE PROVIDERS INVOLVED IN TOP PRACTICE PER DISTRICT</th>
<th>NUMBER OF TRAINED TOP SERVICE PROVIDERS NOT INVOLVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ehlanzeni District</td>
<td>6</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Nkangala District</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>GertSibande District</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>11</td>
<td>8</td>
<td>3</td>
</tr>
</tbody>
</table>
3.2.1.3 Average number of TOPS performed per month

The data collected showed that between 40 and 218 TOPs were performed per month per facility (see table 3.7). The researcher is of the opinion that the limited number of TOPs performed might be influenced by the infrastructural challenges, lack of equipment for the provision of TOP services, and the shortage of TOP service providers in Mpumalanga as will be highlighted later in the text. This is based on some of the comments made by participants to support the quantitative data:

TOP service provider 1: “We are put in one corner in one room having to do everything there.” (infrastructural challenge)

TOP service provider 5: “We have six packs. We end up doing only six TOPs because of the number of packs. If we had many packs we would do as many as we could.” (material/supplies)

TOP service provider 1: “I am the only one providing this service in this hospital. If we were more than one I think the number of TOPs performed will be increased as I send some of them back because of being fully booked. If these clients have money, they will then go to the doctors’ private practice, they don’t come back.” (human resource challenge)

According to the MDOH (2009:1), the numbers of TOPs performed in the facilities are declining (see chapter 1, table 1.7). Sibuyi (2004:77) commented that lack of knowledge within the community regarding the stipulations of CTOP Act and the rights of women may contribute to the low number of TOPs performed as some women present after twelve weeks when TOP can no longer be procured by a nurse.

Table 3.7 indicates the average number of TOPs performed monthly per facility in the districts.
Table 3.7  Monthly averages of TOPs performed per facility and district and the number of packs supplied daily

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>FACILITY</th>
<th>TOPs PERFORMED</th>
<th>Number of packs supplied daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ehlanzeni District</td>
<td>01</td>
<td>50</td>
<td>0-6</td>
</tr>
<tr>
<td></td>
<td>02</td>
<td>218</td>
<td>0-12</td>
</tr>
<tr>
<td></td>
<td>03</td>
<td>40</td>
<td>0-6</td>
</tr>
<tr>
<td>Nkangala District</td>
<td>01</td>
<td>65</td>
<td>0-6</td>
</tr>
<tr>
<td>GertSibande District</td>
<td>01</td>
<td>70</td>
<td>0-8</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>443</strong></td>
<td></td>
</tr>
</tbody>
</table>

Conclusion

From the quantitative data presented above it is shown that the service is utilised mainly (88.89%) by those residing in rural areas. It is also shown that authorities in the Department of Health in Mpumalanga Province are not supportive of the TOP programme. The data shows gross shortages for human resources for health as only nurses work in the units. Although the province claims to have trained over half (55 %) of the health care providers in TOP provision, only 11 nurses were said to be practicing TOP in the three districts and at the time of investigation only 8 were actively involved in the provision of the service (see table3.6). Managers could only assume that the other three were deployed to the general wards. The supply of packs is also not supportive of the activities of units. All units investigated reported non delivery of packs as a common problem. The largest number of packs that was reported to have been delivered was twelve (12). This number was also not regular. The lack of packs resulted in the cancellation of cases, some of whom were lost to the system forever. But from the average number of TOPs performed per month (table 3.7), there is proof that the utilisation is improving, especially when compared to the 2006 figures (see table 1.7 and 1.4) when a total of eleven (11) facilities were in operation.

3.2.2 Qualitative data analysis

In qualitative research, data analysis is an on-going, emerging and interactive or linear process (Henning et al 2004:127). Therefore, in this study, apart from the quantitative data from records, and interviews, qualitative data analysis commenced and continued simultaneously with data collection. Participants narrated their experiences and feelings
resulting in large volumes of raw data which had to be creatively reduced and transformed to findings. Directed research questions were asked to the different categories of participants. The questions were as follows:

3.2.2.1 TOP service providers’ and TOP facility managers’ knowledge of the content of the CTOP Act and their experiences and feelings in the provision of TOP services

The TOP service providers and TOP facility managers’ responses to the following questions indicated their knowledge of the content of the CTOP Act and the implementation thereof:

- In what circumstances and under what conditions may a pregnancy be terminated?
- What should happen before and after termination of pregnancy?
- In the case of a pregnant minor, who should give consent for termination of pregnancy?
- What are the stipulations in the Mpumalanga policy document for the implementation of the CTOP Act which support the provision of TOP services

These were considered pertinent to everyday functioning of TOP service providers and TOP facility managers

Additional questions were to explore and describe the participants’ experiences and feelings and about the services and therefore the impact of the TOP programme. These included:

- In your view, what is the impact of the TOP programme on individuals, communities and the country?
- How does providing this service affect you physically, socially, emotionally and psychologically?
In addition, TOP service providers were asked:

- What are your feelings about terminating pregnancies as you do in your job?
- What support do you have?
- In your view, what are the challenges you experience in the provision of TOP services?

In the case of the TOP facility managers, additional questions included:

- What has been your experience about the unit and its utilisation?
- How are those procuring TOP service supported to ensure continued service delivery?
- Did you see the documentary on the M-Net, Carte Blanche programme about the TOP service provision in the province (SABC, M Net, 2002)?

If yes, the participants were asked their views on the documentary.

- In your view, what are the challenges in the management of TOP services?

3.2.2.2 TOP health care consumers’ knowledge of the stipulations of the CTOP Act and the experiences and feelings about TOP service provision

Inherent in this question was the question on how TOP health care consumers knew about the legalisation of abortion. The TOP health care consumers were asked the following core questions:

- What was your experience regarding TOP service provision and the facility you are in?

Or alternatively,

- How did you know about the facility and what was your experience about the TOP service provision and the facility which provided the services?
Examples of the probing questions included:

- Who informed you about abortion being legal?
- How did you feel about the service you received?
- How would you describe the support you received in the facility you are in?

### 3.2.2.3 SUPPORTING DATA FROM RECORDS

From the records including minutes of meetings, the researcher obtained:

- The number of trained TOP service providers employed in the hospitals (see table 3.6).
- The average number of clients seen in the TOP unit per month (see table 3.7)

The data from the records was used to validate the quantitative data previously analysed and to evaluate the utilisation of the services provided in terms of attendance as indicated in the register, human resources, space and accessibility.

Responses to the questions above resulted in massive data sets, some of which were similar while others were different. The researcher utilised Tesch’s eight-step approach to analyse the data collected. Tesch (1992:113) defines qualitative data analysis as “a process, which entails an effort to formally identify themes and to construct hypotheses (ideas) as they are suggested by data and an attempt to demonstrate support for those themes and hypotheses”. Therefore qualitative data analysis is a mechanism of reducing and organising data to produce findings that require interpretation by the researcher (Burns & Grove 2009:695). Tesch (1992:95-97) provides principles for data analysis and asserts that:

- Analysis in qualitative research is not the last phase in the research process; it is concurrent with data collection.
- The analysis process, although systematic and comprehensive, is not rigid.
• Attending to data includes a reflective activity that results in a set of analytical
notes that guide the process.
• Data are segmented, that is, divided into relevant and meaningful units.
• The data segments are categorised according to an organising system derived
predominantly from the data themselves known as themes and categories.
• Categories for sorting segments are tentative and preliminary, and remain
flexible.
• Manipulation of qualitative data during analysis is an eclectic activity which has
no single correct mode.

To ensure adherence to the above-mentioned principles of qualitative data analysis, the
researcher used multiple methods of data analysis. The results of the quantitative data
analysis, were presented in tables to reflect frequencies and percentages while that of
qualitative data analysis are presented in themes, categories and subcategories (Brink

To analyse the qualitative data:

• The researcher replayed the tapes after each interview to listen to the voice, its
tone, pauses and responses as well as the entire content. The interviews were
transcribed verbatim, and pauses, exclamations, crying or laughter were marked
as such. After transcription, the researcher replayed the tape to correlate the
information for accuracy. The transcriptions were read and reread carefully. Field
notes were reviewed as additional data. This exercise contributed to the
researcher’s engagement with and immersion in the data collected.
• The researcher used reflexivity, bracketing and intuition to exclude preconceived
ideas or biases about the phenomenon under study; and integrated this
understanding into the data analysis (Burns & Grove 2009: 718). The researcher
constantly referred to her reflective journal.
• Then the researcher picked the most interesting transcript and highlighted
recurring words and phrases, identifying differences and interrelationships in the
text to extend meaning and enhance understanding of the participants’ narration.
• Thoughts that occurred during the transcription were written in the margin.
• The researcher made a list of all the topics that emerged.
• Common meanings among topics were used to form themes. The themes were reduced through a process of eliminating redundancies (see figure 3.1).
• The topics that related to a theme were grouped together to show interrelationship and formed categories.
• The spoken words and sentences from which the topics were derived formed "meaning units".

Figure 3.1 represents a model of the coding process in qualitative data analysis.

In an effort to enhance data credibility, an independent analyst was further engaged for data analysis. The analyst assisted in the coding of the data and in confirming or disputing themes identified from the data. Upon completion of data analysis, the researcher further had a meeting with the analyst to compare findings. Although
findings were the same, these were, in some instances worded differently. After discussion, the appropriate wording was agreed upon and this is the wording that is used in the formulation of themes and categories. According to Creswell 2008:254) themes reflect an in-depth understanding which is central to the phenomenon.

In the data analysed, five (5) themes and twenty categories emerged, namely:

**Theme 1: Knowledge of the legislation that regulates the practice of TOP**
- Category 1.1 Acts that regulate the practice of TOP
- Category 1.2 Knowledge of the content of the CTOP Act (92 of 1996) as amended

**Theme 2: Health considerations**
- Category 2.1 Emotional including psychosocial health considerations
- Category 2.2 Physical health considerations
- Category 2.3 Spiritual health considerations

**Theme 3: Support system**
- Category 3.1 Managers’ support for TOP service providers
- Category 3.2 TOP service providers’ support for TOP health care consumers
- Category 3.3 Support from other personnel not involved in the provision of TOP services for TOP health care consumers
- Category 3.4 Community members’ support of TOP services

**Theme 4: Challenges in TOP service provision**
- Category 4.1 Human resources
- Category 4.2 Material resources
- Category 4.3 Financial resources
- Category 4.4 Decentralisation of services
- Category 4.5 Attitudes of other personnel not involved in the provision of TOP services
- Category 4.6 Attitude of the community towards TOP services
Theme 5: Benefits of the TOP programme

Category 5.1 Residual
Category 5.2 Health
Category 5.3 Educational
Category 5.4 Socio-economic
Category 5.5 Respect for constitutional human rights

From these, a further forty two (42) subcategories emerged. All these served to provide a better understanding of the participants’ experiences and feelings as TOP service providers, managers of TOP facilities and TOP health care consumers of the TOP services. The identified themes, categories and sub-categories also provided a yardstick with which to evaluate the impact of the TOP programme

Conclusion

In this chapter, the analysis, interpretation and findings of the quantitative data were concluded. The qualitative data was analysed and themes and categories outlined. In the following chapter the findings of the qualitative data are discussed and sub-categories may emerge to further extend the understanding of the themes. The meaning units will be used to support the findings and discussions thereof.
4.1 INTRODUCTION

Chapter 3 discussed the data analysis and interpretation thereof. In chapter 3, quantitative data was presented to support the qualitative approach to the study. This chapter presents the research findings as deduced from interviews. These are supported by literature reviewed. The purpose of the literature review (LoBiondo-Wood & Haber 2002:79) was to

- verify whether the identified themes had been documented, which would establish the credibility of the findings
- formulate a scientific body of knowledge on which to base the findings of the study
- agree or disagree with previous research on the identified themes
- establish whether the study would add to the scientific body of knowledge

4.2 FINDINGS

In qualitative research, findings are reported by providing rich descriptions of themes and categories which may be extended by sub-categories and supported by meaning units. Table 4.1 summarises the qualitative data analysis, indicating themes, categories and sub-categories which will be discussed. Subsequent tables will be presented to extend each theme with its categories, sub-categories and meaning units. The meaning units have been edited.
Table 4.1: Summary of qualitative data analysis

<table>
<thead>
<tr>
<th>THEMES</th>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Knowledge of the legislation that regulates the practice of TOP</td>
<td>1.1 Acts that regulate the practice of TOP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1.1 CTOP Act 92 of 1996, as amended.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1.2 Other related Acts such as the Nursing Act, 33 of 2005 and the Health Act, 61 of 2003</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2 Knowledge of the content of the CTOP Act (Act No 92 of 1996), as amended</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2.1 Circumstances or conditions under which pregnancy may be terminated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2.2 Procedure before TOP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2.3 Procedure after TOP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2.4 Consent by minor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2.5 Conscientious objection</td>
</tr>
<tr>
<td>2</td>
<td>Health considerations</td>
<td>2.1 Emotional factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.1.1 Feelings about procuring TOP by TOP service provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.1.2 Difficulties in making decisions from TOP health care consumers’ perspective</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.2 Physical factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.2.1 TOP service providers’ exhaustion experienced</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.2.2 TOP health care consumers’ pain experienced during TOP procedure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.3 Spiritual factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.3.1 Guilt feelings from TOP service provider’s perspective</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.3.2 Guilt feelings from health care consumer’s perspective</td>
</tr>
<tr>
<td>3</td>
<td>Support system</td>
<td>3.1 Managers’ support to TOP service providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.1.1 Lack of support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.1.2 Support indifferent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.1.3 Support available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.2 TOP service providers’ support to TOP health care consumers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.2.1 Lack of support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.2.2 Support indifferent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.2.3 Support available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3 Support by other personnel in the facilities not</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3.1 Lack of support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3.2 Support indifferent</td>
</tr>
<tr>
<td>THEMES</td>
<td>CATEGORIES</td>
<td>SUB-CATEGORIES</td>
</tr>
<tr>
<td>--------</td>
<td>------------</td>
<td>---------------</td>
</tr>
<tr>
<td>involved in the provision of TOP services to TOP health care consumers</td>
<td>3.3.3 Support available</td>
<td></td>
</tr>
</tbody>
</table>
| 3.4 Support of TOP services by community members | 3.4.1 Lack of support  
| | 3.4.2 Support indifferent  
| | 3.4.3 Support available |
| 4 Challenges in the provision of TOP services | 4.1 Human resources  
| | 4.1.1 Retention of staff  
| | 4.1.2 Distribution of staff |
| | 4.2 Material resources  
| | 4.2.1 Infrastructural challenge  
| | 4.2.2 Equipment and supplies |
| | 4.3 Financial resources  
| | 4.3.1 Budgetary constraints |
| | 4.4 Decentralisation of TOP services  
| | 4.4.1 Distribution of designated facilities |
| | 4.5 Attitudes of personnel in the facilities not involved in the provision of TOP services  
| | 4.5.1 Negative attitudes of personnel |
| | 4.6 Attitude of the community towards TOP services  
| | 4.6.1 Negative attitudes of community members |
| 5. Benefits of the TOP programme | 5.1 Residual benefits  
| | 5.1.1 Government savings |
| | 5.2 Health benefits  
| | 5.2.1 Improved quality of life as indicated in reduced morbidity and mortality |
| | 5.3 Educational benefits  
| | 5.3.1 Career pathing for TOP health care consumers |
| | 5.4 Socio-economic benefits  
| | 5.4.1 Contribution to controlling population explosion  
| | 5.4.2 Reduction in child abandonment  
| | 5.4.3 Reduction in crime  
| | 5.4.4 Preservation of marriage  
| | 5.4.5 Prevention of unwanted pregnancies |
| | 5.5 Respect for constitutional human rights  
| | 5.5.1 Restoration of fundamental human rights |
4.3 DISCUSSION OF FINDINGS

4.3.1 Theme 1: Knowledge of legislation that regulates the practice of TOP

The study examined the TOP service providers and TOP facility managers’ knowledge of legislation that regulates the practice of TOP (MDOH 2009:7-8). In South Africa the CTOP Act, 92 of 1996 as amended, provides for the legal termination of pregnancy within the health system, to ensure a holistic approach to health care of the individual. Thus medical and nursing personnel in implementing this act have to practice within the parameters of the Nursing Act, 33 of 2005, the Health Act, 61 of 2003, Medical and Dental and Supplementary Health Service Professions Act, 56 of 1974; Medicine and Related Substances Act, 101 of 1965, as amended, The Constitution of the Republic of South Africa Act, 108 of 1996; South African Nursing Council (SANC) Regulation 2598 of 1984 as amended, on the Scope of Practice of Persons who are registered and enrolled under the Nursing Act; SANC Regulation 888 of 1987 as amended, on the Acts and Omissions in respect of which the South African Nursing Council may take disciplinary steps, SANC Regulation 2488 of 1990, on the Regulation relating to the conditions under which registered midwives and enrolled midwives may carry out their profession, SANC Regulation 2418 of 1984 as amended, on Keeping, Supply, Administering or Prescribing Medicines by Registered Nurses.

Two categories and seven sub-categories emerged from this theme (see table 4.1). Category 1.1 reflected on the knowledge of the Acts that regulate the practice of TOP indicated by TOP service providers and managers of facilities while Category 1.2 reflected on the knowledge of the content of the CTOP Act 92 of 1996 as amended. Table 4.2 depicts the categories, sub-categories and related meaning units of theme 1.
Table 4.2: Summary of categories, sub-categories and meaning units for theme 1

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
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TOP service provider 4: “Choice on Termination of Pregnancy Act No 92 of 1996 as amended”  
TOP service provider 6 “CTOP Act No 92 of 1996 as amended in 2008”  
TOP service provider 2 “Act No 65 of 1996”  
TOP service provider 7 “Act No --- of 1963”  
TOP facility manager 1,2,3,4: Choice on Termination of Pregnancy Act, 92 of 1996                                                                 |
| 1.1.2 Other related Acts                       |                                                     | TOP service provider 5: “And other Acts that are guiding us in the service, although I don’t remember their numbers, like the Child Care Act, Human Tissue Act and the Domestic Violence Act, the Constitution of the Country and Batho Pele Principles”  
“CTOP Act”                                                                 | |
| 1.2 Knowledge of the content of the CTOP Act   | 1.2.1 Circumstances or conditions under which pregnancy may be terminated | TOP service provider 5; TOP facility manager 2: “TOP is performed during the first 12 weeks by a registered midwife who has undergone training in TOP. TOP is done if requested by the woman. From there on (13 weeks) till the 20th week it is done if the doctor after discussing with the woman is of the opinion that the pregnancy is of danger to the health of the woman or if the pregnancy was as a result of rape or incest or if the foetus is having malformations and/or the socio-economic status of the woman does not allow the pregnancy to continue”  
TOP facility manager 3: “...,After the 20th week the doctor might discuss with another doctor and agree to induce abortion if continuation of pregnancy might...”  
...                                                                                                                                 |
<p>| (92 of 1996) as amended                        |                                                     |                                                                                                                                                                                                             |</p>
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|            |               | affect the woman’s life, in such a way that she may suffer physical or psychological trauma, or if the foetus is malformed”
|            |               | TOP service provider 1: and TOP facility manager 4: “Any woman can just come and request for termination of pregnancy.”
|            |               | TOP service provider 3: “…, the facility must be designated for such services…” |
| 1.2.2      | Procedure before TOP | TOP facility manager 2: “Non-mandatory and non-directive counselling.”
|            |               | TOP service provider 5: “Tell them about the options that are available other than TOP, like adoption, foster care and child grants. But we don’t dictate to the woman what should be done. Also the use of contraceptives”.
|            |               | TOP service providers 1, 2, 4, 6, 7: “The consent form is completed.”
|            |               | TOP service provider 7: “Counselling. I discuss with the woman about the reasons for termination of pregnancy. The woman may tell you that the husband does not want the pregnancy. I also discuss what the woman should expect…, like pain…, because we don’t give pain injections.”
|            |               | TOP service provider 1: “I make her aware that the pregnancy might be the last one as nobody can predict what will happen in the future. Only God knows”.
|            |               | TOP service provider 5: “Ask about prevention and the use of assisted methods, we talk about condoms because they are cheap and not expensive as gels.
|            |               | TOP service providers 1, 3, 4: “Take the specimen of blood for Haemoglobin (Hb) level because the woman may bleed too much when we do TOP and Rapid Plasma Reagin (RPR) to exclude syphilis.”

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| 1.2.3      | Procedure after TOP | TOP service provider 5: “Post-counselling includes contraception. Proper post-counselling will ensure that the woman does not come back for repeat TOP and also does not suffer post-TOP depression.”  
TOP service provider 6: “Whilst evacuating the client, we are preparing the woman for prevention. The woman is given 14 days’ review date. We are basically going to do post-counselling, because sometimes even if the woman requested it, after it is done she feels guilty and … some will even tell you that ‘I see my baby’ or ‘I can’t sleep because my baby is crying every night’. Then we try to reassure the woman and even send her for further counselling to the psychologist” |
| 1.2.4      | Consent by a minor | TOP service provider 7: “The minor can consent but she should be advised to inform the parents. If she chooses not to, it’s okay.”  
TOP service provider 5: “The minor consents but you inform her to consult the parents or a friend above 18 yrs of age… but this is with the understanding that if she chooses not to consult these people… the termination will still continue” |
| 1.2.5      | Conscientious objection | TOP service provider 4: “This is a voluntary practice for TOP service providers. The legislation does not compel anybody.”  
TOP service provider 3 “A TOP service provider can conscientiously object to participate in the termination of pregnancy.”  
TOP facility manager 2: “You cannot force them…, (health workers)…, if they don’t want to participate...,” |
Category 1.1: Legislative Acts that regulate the practice of TOP

The TOP programme is part of sexual and reproductive health service (MDOH 2009:7). As a government initiative and commitment, the programme aims to reduce the morbidity and mortality due to unsafe abortion practices. Therefore, to meet this aim, health care providers should know all the Acts that relate to TOP and those that govern their practice, especially as nurses, as this will assist in quality service provision.

Sub-category 1.1.1: Title of the Act: CTOP Act 92 of 1996, as amended

TOP service providers and managers of the facilities are expected to know the titles of the Acts that guide their practice so that, they, at least, know which acts to look for should a need arise. The responses were most worrying, as only three of the TOP service providers were able to state the correct title of the act with the fourth citing an incomplete title. None of them mentioned that the act was amended to replace terms such as the ‘midwife’ with ‘registered nurse’ an aspect which can make a contribution in the production of human resources in this regard. Some of the responses on the title of the Act included:

TOP service provider 1: *Termination of pregnancy Act, No.92 of 1996*

This could still be acceptable seeing that the lead words, number and year of the act are correct.

The following are some of the titles which were given which were totally wrong

TOP service provider 6: “Act No 65 of 1996”

and

TOP service provider 2: “Act No--- of 1963”

The finding above is confirmed by Ratlabala, Makofane and Jali’s (2007:28) assertion that participants were not familiar with the title of the Act with some of the participants in this study indicating that the Act was not taught in class while others claimed never to have seen the document. This did not only reflect negatively on the institution but also
on the individual nurse managers who are expected to keep a professional file with all the legislative documents for reference in conducting their caring business.

**Sub-category 1.1.2: Other related Acts**

Only one participant made an attempt to mention other legislation other than the CTOP Act:

TOP service provider 5: “Acts that are guiding us in the service, although I don’t remember their numbers are Child Care Act, Human Tissue Act and the Domestic Violence Act, the Constitution of the Country and Batho Pele Principles.”

The poor response to the question on ‘related Acts that support the CTOP Act’ discredited the TOP service providers and the TOP facility managers because, although the knowledge of the content of the CTOP Act (92 of 1996) was good as will be indicated further on in the text, service provision may be seriously compromised by the providers’ lack of integration of acts such as the National Health Act, 61 of 2003 and the Nursing Act, 33 of 2005 which are fundamental to the practice of nursing.

None of the participants mentioned the Mpumalanga Termination of Pregnancy Implementation Policy (MTOPIP) (MDOH 2009:7). This then indicated that TOP service providers and TOP facility managers have no knowledge of the policy stipulations and therefore no direction in their everyday function, hence, the reported lack of support from management. The policy is an extension of the national mandates which has been adapted and focused on Mpumalanga Province and it provides direction to the implementation of the CTOP Act in Mpumalanga Province and if applied, would strengthen the issues of TOP management, human resources, supplies, equipment and advocacy by key stakeholders.

**Category 1.2: Knowledge of the content of the CTOP Act, 92 of 1996, as amended**

Although the TOP service providers and their managers had a good knowledge of the content of the CTOP Act (92 of 1996), none of them highlighted the aspect of including registered nurses in the training for TOP provision which is an addition on those who
can be trained to increase human resources. This is important because it widens the criteria on who can perform TOP.

**Sub-category 1.2.1: Circumstances or conditions under which pregnancy may be terminated**

The conditions under which a pregnancy may be terminated are stipulated in the CTOP Act, 92 of 1996, as amended (South Africa [Republic] 1996a:4). In the context of this study, although not all the TOP service providers and TOP facility managers knew the title of the Act that regulates the practice of TOP service and all of them not knowledgeable of the MTOPIP, it was encouraging to learn that all of them knew the circumstances and conditions under which a pregnancy may be terminated:

**TOP service provider 5:** “TOP is performed during the first 12 weeks, by a registered midwife who has undergone training in TOP...., TOP is done if requested by the woman. ....,From thirteen weeks (13 weeks) till the 20th week it is done if the doctor...., after discussing with the woman...., if of the opinion that the pregnancy is of danger to the health of the woman... or... or ... if the pregnancy was as a result of rape or incest.... or..., if the foetus is having malformations..., or....,the socio-economic status of the woman does not allow the pregnancy to continue..., “

**TOP facility manager 3:** “...After the 20th week..., the doctor might discuss with another doctor and agree to induce abortion if continuation of pregnancy might affect the woman’s life..., In such a way that she may suffer physical or psychological trauma, or if the foetus is malformed.”

Based on their not being knowledgeable about the amendments of the act, participants stated that people allowed to participate in the provision of TOP services were trained midwives and designated doctors, yet in its amendment the Act states that it should be registered nurses not only midwives as stated above. In this way more professionals can do terminations of pregnancy. In Zambia, although the abortion law has undergone some liberal reforms, it still requires that three doctors certify that the woman meets all of the requirements as mentioned above (Ngwena 2004:714). Complicated procedural requirements limit the number of abortions performed in Zambia. According to Ngwena
South Africa is the only country in the Southern African Developing countries (SADC) to institute radical reform on abortion.

Nevertheless it was of concern that the participants were not aware of the amendments that included the wording “registered nurse”. They were still referring to a registered midwife only. The researcher is of the opinion that whenever an Act is amended, management should bring the new information to the attention of staff so as to keep them abreast of new developments. At the same time, TOP service providers and their managers have the responsibility to keep abreast of developments so that they function within the law. The above scenario is supported by Ratlabala et al (2007:28) who found that participants in their study were not conversant with the conditions of the CTOP Act and that the participants were not taught about the Act and its contents in class. The fact that managers were not aware of the amendments also raised questions in relation to those already trained in terms of in-service training, because the amendments should have been brought to the attention of staff through in-service

The CTOP Act (92 of 1996), as amended, stipulates that the termination of pregnancy may take place only in a designated facility (South Africa [Republic] 1996a:4). In Mpumalanga, all the 28 hospitals were designated as facilities where TOP can be performed; but only 7 (25%) were active at the time of investigation. This figure represents a quarter of all the hospitals in the province.

In this study, all the participants, ie, TOP service providers, TOP facility managers and TOP health care consumers knew that TOP is performed in designated facilities.

TOP service provider 3: “the facility must be designate for such services”

TOP facility manager 4: “Of course... the facility must be legally designate...even in the hospital the unit must be designated as such...”

TOP health care consumer 6: “I know that I need to go to a special hospital to have an abortion... to me a special hospital is the one like this one where I am at”
The response from the consumer indicated willingness to have a termination of pregnancy procured in a place other than the illegal unhealthy backstreets. The above citation concurs with what Kumar, Hessini and Mitchell (2009:1) found in their study, that abortion done in good hygienic settings carry fewer health risks.

According to WHO (1997a) as cited by Engelbrecht (2005:26) backstreet abortions constitute unsafe termination of pregnancy “which takes place in an environment that lacks minimum medical standards”. However, every year, approximately 20 million women risk their health and lives by undergoing unsafe termination of pregnancies (Sedgh, Henshaw, Sigh, Ahman& Shaw 2007:1340). According to WHO (2007:13), twenty-five percent of these women face a risk of permanent sequelae, such as infertility and emotional distress.

Sub-category 1.2.2: Procedure before TOP

According to the CTOP Act (92 of 1996), as amended, the state shall promote non-mandatory and non-directive counselling before termination of pregnancy (South Africa [Republic] 1996a:4). Brookman-Amissah(2004a:39) found that the provision of high quality counselling services helps the woman clarify her feelings and emotions, identify her needs, and is assisted to make well-informed decisions without the imposition of the counsellor’s personal opinions. Engelbrecht (2005:84) is of opinion that, counselling should be offered and not imposed or made a requirement to access TOP service. The MDOH (2009:8) stipulates that counselling must be available following the principle of informed choice. This will prepare a woman for healthy coping after TOP (Upadhyay, Cockrill&Freedman 2010:416).

In this study, all the participants knew about pre-counselling:

TOP facility manager 1: “clients must be counselled before TOP is performed....Pre-counselling...., using the technique that supports free and informed choice..., I am sure you know about the..., ‘braided’ technique..., It means that counselling that is provided should explain the benefits and risks of the procedure, the alternatives that may be considered, inquiries, decision to change, explanation and documentation..., it is the whole package of counselling”
TOP service provider 5 “You tell them about the options that are available other than TOP, like adoption, foster care, child grant ... but we don’t dictate to the woman about what should be done..., Also the use of contraceptives..., The consent form is completed.”

This was in contrast with the study by Littman et al (2009:421), where misinformation and exaggeration of the risks and sequelae of abortion was prevalent. The report claimed that misinformation included factors such as, ‘TOP predisposes women to have severe psychological distress similar to post traumatic stress disorder, increased risk of cancer and subsequent impaired fertility’.

The researcher found it encouraging that the TOP service providers were conversant with the procedure to be followed before terminating pregnancies, even though there was one TOP service provider who expressed concern.

TOP service provider 4: “yes we know about counselling, but most of the time we do not do it.... I, for one, always think that this person has already made up her mind..., I am busy.... let me get on with the job”

TOP service provider 4 (continuing) “I do not think there is anything anybody can say or do to dissuade these people....it is either they come or they don’t”

Some of the information from the TOP service providers reflected dissuasion;

TOP service Provider 1: “..., I make her aware that the pregnancy might be the last one as no one can predict ......what will happen in future. Only God knows”

Sub-category 1.2.3: Procedure after TOP

The CTOP Act (92 of 1996), as amended further stipulates that a non-mandatory and non-directive counselling session shall be conducted after termination of pregnancy (South Africa [Republic] 1996a:4). In this study, all the participants referred to post-counselling and what should be done after the procedure.
According to one participant:
TOP service provider 5: “We try...and...tell the women how to handle themselves after the procedure and tell them about the complications such as bleeding, offensive discharge if the products of conception are not completely expelled and...reiterate ‘contraception’. We discuss about fertility...and...eh...infertility after abortion and where to report if such complications occur. We try to find out about the support system they have at home, because most of the women came here because of lack of support, we tell them that we are here to provide such.”
(also see meaning units in table 4.1, sub-category 1.2.3)

In line with Engelbrecht (2005:85), TOP health care consumers were also informed of the risks associated with termination of pregnancy. Brookman-Amissah (2004:39) added that contraceptive counselling and services are essential immediately post abortion to prevent revisit to the facility.

Sub-category 1.2.4: Consent by a minor

In terms of the CTOP Act (92 of 1996), as amended (South Africa [Republic] 1996a:5), “in the case of a pregnant minor, a medical practitioner or registered midwife, as the case may be, shall advise such minor to consult her parents, guardian, family members or friends before the pregnancy is terminated; provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.” The stipulation above does not prohibit anyone from accessing TOP services, it is merely encouraging free access and disclosure to the significant others.

The participants knew about this section and it was reported that in many instances pregnant minors chose not to inform their parents and according to legislation could not be denied the TOP services. According to a participant:

TOP service provider 4 and TOP facility manager 4: “It is the minor that gives the consent because she is the pregnant lady.”
TOP service Provider 4 (continues): “on many occasions I do not even worry about asking them to go to their parents for consent...I just give them the forms and they sign...you see when women report to the unit...it...it...is with one intention....to terminate the pregnancy....and the sooner this is done,...the better.”

In the United States, this is different, minor pregnant women seeking an abortion have to obtain parental consent and/or delay their abortion for a period of 24 hours after receiving information intended to discourage abortion. Furthermore, Engelbrecht (2005:41) confirms that in the United States a pregnant minor who does not want to go to her parents for consent has to go to court and present her intent to terminate pregnancy. This poses a risk of a breach in confidentiality. According to Gerber Fried (2000:176), a pregnant minor had to travel 1000 miles away from her home state to obtain abortion after permission was granted by the Supreme Court, in an effort to maintain anonymity.

McQuoid-Mason (2010:213) contends that there is a need to clarify the position concerning consent by minors to certain procedures inherent in the termination of pregnancy. According to the author, the provisions in the CTOP Act (92 of 1996), as amended, in relation to consent to a termination of pregnancy by girls of any age are not affected by the Child Care Act. As long as the pregnant girl is mature enough and is capable of giving consent, this should be allowed. Failure to do so, will be undermining the stipulations of the South African Constitution in terms of human rights and self determination.

**Sub-category 1.2.5: Conscientious objection**

Another stipulation by the Act is that health professionals are free to refuse to participate in the TOP programme and/or performance of the termination. A nurse seeking employment is free to, on assumption of duty, state that he or she will not be participating in the performance of TOP and this should not be held against the individual. A registered nurse/midwife has the right to freedom of conscience; and may, thus, not be denied employment, dismissed or victimised for either the choice to participate or not in the termination of pregnancy. Such an action would constitute unfair labour practice. Thus nurses may also not be coerced to participate in direct termination
of pregnancy (DENOSA 1997:6). This stipulation though, does not exonerate them from providing basic nursing care to patients who are or have undergone termination of pregnancy.

In this study, the participants were aware that nobody is forced to participate in the programme. They were also aware that they are not exempted from providing basic nursing care to the TOP health care consumers before and/or after TOP. Brookman-Amissah (2004a:41) is of the opinion that policies must be formulated to address the barriers identified to deny women access to TOP services including conscientious objection by providers. This concurs with the study by Castle (1990) as cited in the International Reproductive and Sexual Health Law Programme (2008:4) whereby conscientious objection was cited as a barrier for women to access abortion services in Zambia. Furthermore, doctors were reported to have refused referring clients to abortion service providers because of their conscience or personal beliefs (International Reproductive and Sexual Health Law Programme 2008:15).

According to one participant:

TOP service provider 5: “We know that we are involved voluntarily. My understanding is that if you don’t want to be actively involved you are not forced..., but with basic nursing care activities like insertion of a drip, observations, giving medicine, or giving food and cleaning the patient and the ward where patients who had abortions are housed..., you have an obligation to provide that service. You can’t say I will not provide the service because this one had an abortion. The scope of practice forces you to provide for basic nursing activities..., otherwise you are in the wrong profession....It is only the actual procedure that you may choose not to participate in.”
Conclusions on knowledge of the legislation that regulates the practice of TOP

Although participants were fairly knowledgeable of the operational content of the Act, CTOP Act, 92 of 1996 as amended, aspects not known were critical to their functioning in the unit. They:

➢ Did not know that the amended Act required registered nurses (not only midwives) to be trained to procure abortions. Knowledge of this could have strengthened advocacy in the request for human resources

➢ Did not know the title of the Act. This poses a problem and it reflects on their functioning in the units and increases the assumption that they have no professional files in the units where they practice. They therefore are much more likely to practice out of their scope, an action that would expose them to litigation and disciplinary action by the profession

➢ Did not know other legislation including the MTOPIP which support the TOP provision. It is a great concern that none of the TOP service providers and TOP facility managers mentioned the Nursing Act, 33 of 2005 and the National Health Act, 61 of 2003 which are the pinnacles of nursing practice and it is imperative for every nurse to uphold the principles thereof.

From the meaning units in the area of counselling some statements could be said to ethically influence the decision of the woman,

“...we make her aware that the pregnancy might be the last one as no one can predict ...what will happen in the future. Only God knows”

Recommendations

There is a need for in-service training to interrogate the content of the CTOP Act as participants were not aware of amendments as well as the MTOPIP. Participants were also not aware of the interrelatedness of the other acts in the implementation of the stipulations of the CTOP act in the TOP programme.
Theme 2: Health considerations

This theme reflected on the experiences and feelings of the participants, ie TOP service providers, TOP facility managers and TOP health care consumers in either providing or receiving TOP services and the impact of these experiences on the health of the participants. *Blackwell’s Nursing Dictionary* (2005:269) in line with WHO, defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity”. The impact of participating in the TOP services is discussed under three categories, emotional, physical and spiritual factors. Table 4.3 depicts the categories, sub-categories and related meaning units of theme 2 (meaning units are edited).


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| 2.1 Emotional factors             | 2.1.1 TOP service providers’ emotional feelings about procuring TOP | 2.1 TOP service provider 3: “...You get that stigma as if you don’t care about cultural and religious beliefs, you just care about killing. It really affects me psychologically...,”
2.1.2 Emotional feelings of TOP health care consumers
2.1.1 TOP service providers’ emotional feelings about procuring TOP
2.1.2 Emotional feelings of TOP health care consumers |

|                          |                                                      | TOP service provider 5: “It’s hard and exhausting, physically and emotionally. I have psychological trauma. I am helping them to..., kill ..., innocent souls, I am actually assisting with..., killing...(swallowing)..., It’s painful and at times you feel reluctant to help..., But in the end you just do it...,”

“TOP service provider 4: “I have developed a thick skin. Criticisms do not penetrate.”

TOP service provider 7: “...,It’s not nice, especially because at times you don’t sleep, especially if during the TOP procedure ... you see foetal parts, it’s hurting...,”

2.1.2 Emotional feelings of TOP health care consumers

|                          |                                                      | TOP health care consumer 9: “ it is difficult to make a decision to abort... you just do not feel comfortable and the community out there .....if they come to know do not want to associate with you.... you become sore inside....you feel unwanted by society”

TOP health care consumer 7: “ you become quite sore inside...I cannot explain the feeling well enough for you to understand....you are guilty, angry with yourself....oh...you are miserable and this feeling lingers on.... for me ...I feel as if this will stay with me for the rest of my life...I regret...,”

TOP health care consumer 4: “ I feel lonely...,”

|                          |                                                      | 2.1.2 Emotional feelings of TOP health care consumers |

2.1.1 TOP service providers’ emotional feelings about procuring TOP

2.1.2 Emotional feelings of TOP health care consumers

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TOP health care consumer 4: “ I feel lonely...,”

2.1.2 Emotional feelings of TOP health care consumers
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|            |                | TOP health care consumer 8: “you know...no one seem to know that you can have an abortion done nicely here in the hospital..., so ..., no one believes ...you are seen as this monster...”.
<p>|            |                | 2.1.3 Difficulties in making decisions |
|            |                | TOP service provider: “I remember when I had to come to this unit, I had doubts because people will know the type of work I am doing ... and what about my reputation?” |
|            |                | TOP health care consumer 3: “It’s not an easy decision...., It was not easy to decide ... I still blamed myself for being so negligent...,” |
|            |                | TOP health care consumer 4: “I regret about the whole thing, including the decision to fall pregnant and to terminate this pregnancy......” |
|            |                | TOP health care consumer 6: “When I made a decision, I felt very much embarrassed....when I first saw her, I nearly turned back, but I feel good about it now.” |
|            | 2.2 | TOP service providers’ exhaustion experienced |
|            | 2.2.1 | TOP service provider 5: “...,I am physically exhausted because here in our facility there is staff shortage.” |
|            | 2.2.1 | TOP service provider 1: “...,I am always tired because here I am the only provider of TOP service.” |
|            | 2.2.1 | TOP service provider 4: “It is tiring, you become exhausted; but who cares?...” |
|            | 2.2 | TOP health care consumers’ pain experienced during TOP procedure |
|            | 2.2.2 | TOP health care consumer 7: “The procedure is painful... It is painful. For 5 minutes when they do it, it is like you are having labour pains, but after that it’s fine.” |
|            | 2.2.2 | TOP health care consumer 3: “It was a bit painful ... bleeding was severe.” |</p>
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<td>TOP health care consumer 1 &quot;It was sore for about 15 minutes, and 15 minutes for me were like the whole 24 hours.&quot;</td>
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| 2.3 Spiritual factors | 2.3.1 Guilt feelings from TOP service providers' perspective | TOP service provider 2: "Like myself, at church they used to say a lot of bad things about this programme. I went to the elders, explained the importance of the service rendered. Now they even ask me to address the youth in church."
TOP service provider 7: "If I am sinning, God will forgive me. But I don’t think I am because God does not want His children to suffer."
TOP service provider 5: "I once told my pastor about what I am doing in my work and he did not have any problem. He said as long as I am not doing it for personal gain, God will give me wisdom and strength to overpower those that are saying bad things about me."
| | 2.3.2 Guilt feelings from the TOP health care consumers' perspective | TOP health care consumer 1: "And every time when I pray, I ask God to forgive me."
TOP health care consumer 6: "My church does not approve it but I had to do it. I will ask God for forgiveness for that. I know He will forgive me for that even if I did it knowing very well that I am committing a sin."
TOP health care consumer 4: "I will also ask that even those nurses who helped me..., let them be forgiven. .....They are compromising themselves for our sake." |
Category 2.1: Emotional factors

This category describes the participants', ie, TOP service providers, TOP facility managers and TOP health care consumers', emotional experiences regarding the provision and reception of TOP services, respectively. Potgieter and Andrews (2004:24) refer to the provision of TOP services as a public health discourse and in the current study, TOP service providers, TOP facility managers and TOP health care consumers explained termination of pregnancy as a very emotional and exhausting exercise. From the narratives participants did not enjoy the work they were doing. They perceived that they were stigmatised and therefore suffered emotional trauma. The TOP health care consumers expressed long-lasting regret.

Sub-category 2.1.1: TOP service providers’ emotional feelings about procuring TOP

The TOP service providers reported mixed feelings regarding the provision of TOP services. Some reported that they felt great as they were providing a necessary service to desperate people, but even as they said so, the tone of their voices indicated otherwise, showing that the action affected them emotionally. Some of them had feelings of regret, self-blame, guilt and anger. According to the participants:

TOP service provider 5: “Eish, I am having mixed feelings, I... for one cannot terminate my pregnancy because I take it as an irresponsible act.”

TOP service provider 5 (continued): “…I am helping them to..., hh.. kill..., innocent souls, I am actually assisting with.... killing...[swallowing], it’s painful and at times you feel reluctant to help, but..., in the end..., you just do it... because you are at work and anyway if the woman requests termination of pregnancy....if you do not do it she will go to the .....to those backstreet abortionists.”

TOP service provider 1: “It gives me fulfilment to say at least I have touched somebody’s life.”

TOP service provider 2: “Sometimes I feel depressed, you know, it’s all about that.”
The feeling of providing a needed service was supported by Potgieter and Andrews (2004:24) who also found that TOP service providers only participated in the services because they wanted to help those in need.

Furthermore, emotionally the participants felt that they were stigmatised and this affected them. According to one of the participants:

**TOP service provider 3:** “You get that stigma as if you don’t care about cultural and religious beliefs ..., you just care about ......, killing. It really affects me psychologically....Uyangizwa (do you hear what I am saying)”

**TOP service provider 5:** “It’s hard and exhausting, physically and emotionally. I have psychological trauma.”

In line with how Shellenberg and Frohwirth (2009:1) defined and conceptualised abortion stigma, the informants experienced perceived stigma whereby they had a negative perception of what other people felt and thought about them as human beings. Some of the TOP service providers found that some clients came repeatedly for TOP. This made them feel bad as though the service provided encourages TOP:

**TOP service provider 3:** “Some days I feel that the service we provide is not good enough...especially if clients come repeatedly for termination. The counselling we give is supposed to assist them avoid unwanted pregnancies...but with some people this is not the case. Even though we want people to use the TOP services, we are not comfortable when one person comes back now and again......, you see what I mean?”

This finding suggested that although pre- and post-procedure counselling put emphasis on contraception, repeated requests for TOP might be an indication that contraception was not used or advice and counselling were not heeded.

A concerning comment came from TOP service Provider 7:

“..., it is not nice, especially because at times you don’t sleep, especially if during the TOP procedure..., you have seen foetal parts...,”
On exploring this comment, clarity was provided that, (although this does not happen often), on occasion, because of lack of equipment, TOP service providers are not able to confirm the gestation period through physical examination. In those instances, they rely on the history as given by the TOP health care consumers who may sometimes miss a month or two. It is at these times that a well formed foetus is aborted. This is most upsetting to the TOP service providers

**Sub-category 2.1.2: Emotional feelings of TOP health care consumers**

TOP health care consumers expressed deep emotional feelings of regret, guilt and self-blame. This is captured in this:

TOP health care consumer 9: “..., it is difficult to make a decision to abort... you just do not feel comfortable and the community out there...if they come to know..., they do not want to associate with you... you become sore inside...you feel unwanted by society”

This respondent is supporting the stigmatisation by the community as indicated by ostracism

**Sub-category 2.1.3: Difficulties in making decisions**

In this study, the TOP health care consumers reported feelings of blame, anger, regret and guilt while TOP service providers cited difficulty in making a decision to work in TOP facilities. This, concurred with the findings of Poggenpoel and Myburgh (2006a:5); Lehana and Van Rhyn (2003:32), and Mpshe, Gmeiner and Van Wyk (2002:32) who reported TOP service providers and TOP service recipients (TOP health care consumers) as presenting with depression based on the work or decision made about TOP. According to the participants:

TOP service provider 1: “I remember when I had to come to this unit, I had doubts that people will know the type of work I am doing...and what about my reputation?”

TOP health care consumer 3: “It’s not an easy decision... It was not easy to decide ... I still blamed myself for being so negligent.”
TOP health care consumer 4: “I regret about the whole thing.... including the decision to fall pregnant...and..., to terminate this pregnancy. This is a big lesson for me.”

The above feelings are reported by Shellenberg and Frohwirth (2009:1) as internalised or perceived stigma manifesting as feelings of guilt, shame, anxiety or other negative feelings about self.

Some of the participants developed defence mechanisms. For example:

TOP health care consumer 9: “I boldly said ‘yes’ because I did not want anybody to think that I am taking chances ... I wanted the nurses and all the people in hospital to know that I had been informed of the service...,”

The response from this participant supported Major, Richards, Cooper, Cozzarelli and Zubek (1998) as cited by Littman et al (2009:420) findings which reinforced a perception that says women with more resilient personalities have positive defence and coping mechanisms after abortion.

Category 2.2: Physical factors

This category describes the TOP service providers’ and TOP health care consumers’ physical experiences regarding provision and receiving of TOP services.

Sub-category 2.2.1: TOP service providers’ physical exhaustion experienced

In this study, the TOP service providers reported physical exhaustion due to heavy workloads as it was rare to find a full complement of personnel in a unit. On occasions where the general wards experienced staff shortages, managers would deplete TOP units to make up for the shortages in the general wards. According to the participants:

TOP service provider 1: “I am always tired because here I am the only provider of TOP services.”

TOP service provider 4: “It is tiring, you become exhausted; but who cares?”
This last comment, also indicates lack of support from management and illustrates a sign of despair “but who cares”

In their study, Poggenpoel and Myburgh (2006b:5) and Mayers, Parkes, Green and Turner (2005:20) found that midwives charged with the task of termination of pregnancies for a large number of women often reported physical and emotional exhaustion while the International Reproductive and Sexual Health Law Programme (2008:15) is of opinion that exhaustion in TOP units is due to staff shortage. Internationally, it is reported that lack of trained TOP service providers as a result of fear of harassment from the pro-life groups, leaves the few trained TOP service providers with heavy loads of work that make them physically exhausted.

Sub-category 2.2.2: TOP health care consumers’ pain experienced during the TOP procedure

In this study, the participants reported pain and discomfort during TOP service provision. This was to be expected because the TOP service providers reported that their protocols do not cater for pain management. This is an omission, because the MTOPIP mandates TOP service providers to particularly provide for comfort and pain relief to clients after termination of pregnancy. Failure to control pain when it is mandatorily provided for in the policy is a constitutional infringement of the TOP health care consumers’ rights to access medication when needed.

TOP health care consumer 7: “The procedure is painful.... It is painful. The 5 minutes they do it, is like you are having labour pains, but after that it’s fine.”

TOP health care consumer 3: “It was a bit painful ... bleeding was severe.”

TOP health care consumer 1: “It was sore for about 15 minutes, and 15 minutes for me was like the whole 24 hours.”

Poggenpoel and Myburgh (2006a:734) also reported pain that was experienced during TOP as stated by participants. Stevens (2010:36) adds that the severity of the pain is
also dependent on the duration of the pregnancy. Therefore TOP service providers should make adequate analgesia readily available to all women who undergo TOP without waiting for the women to request such analgesia. The latter statement concurs with Brookman-Amissah (2004a:39), who stated that appropriate use of pain management should form part of clinical care during TOP service provision. In this study, TOP service providers were not aware of the existence of MTOPIP, and it is in this policy document that pain management is indicated as mandatory, hence there was no analgesia given during the procedure.

**Category 2.3: Spiritual factors**

This category describes the participants’ spiritual experiences.

**Sub-category 2.3.1: Guilt feelings from the TOP service providers’ perspective**

The participants reported guilt feelings as follows:

TOP service provider 2: “... at church they used to say a lot of bad things about this programme. I went to the elders, explained the importance of the service rendered. Now they even ask me to address the youth in church.”

TOP service provider 7: “If I am sinning, God will forgive me. But I don’t think I am because God does not want His children to suffer.”

Rakhudu et al (2006:58) and Nandipha (2008:14) have confirmed in their reports that religious stigma is attached to those terminating pregnancies and that people are vocal about their disapproval.

**Sub-category 2.3.2: Guilt feelings from the TOP health care consumers’ perspectives**

In this study, the participants reported guilt feelings as follows:

TOP health care consumer 1: “And every time when I pray, I ask God to forgive me...,”
TOP health care consumer 4: “My church does not approve; but I unfortunately have to do it. I will ask God for forgiveness for that. I know He will forgive...mh...”
TOP health care consumer 4 (continued): “I will also ask that even those nurses who helped me, let them be forgiven..., They are compromising themselves for our sake...,“

Shellenberg and Frohwirth (2009:1) reported that internalised stigma manifests itself with feelings of guilt, shame, anxiety and other negative feelings about self.

Conclusions on health considerations: theme 2

The findings confirm that:

- Participants had mixed feelings about either providing or receiving TOP services. This generated a lot of guilt, self-blame, regret and anger in all the parties concerned
- Those providing and receiving TOP services experienced religious and spiritual challenges as they found themselves in a situation where they had to render a service they considered morally wrong and those requesting the service make a decision to “kill” and make others be associated with their decision to ‘kill’
- TOP service providers experienced emotional and physical exhaustion due to the nature of the work done and strain as a result of staff shortage.
- The TOP health care consumers experienced pain and discomfort during the TOP procedure because protocols used by TOP service providers did not have any pain management schedules. This is a direct result from lack of knowledge of legislation, in particular the MTOPIP, which mandates TOP service providers to provide for comfort and pain control measures.

Recommendations

TOP services are priority within the reproductive health services and management of the emotional trauma experienced by providers and consumers is paramount if health care provision is to be at a high standard and holistic in nature. It is therefore recommended that:
TOP service providers and TOP facility managers should periodically attend
debriefing sessions as stipulated in the MTOPIP
TOP health care consumers must undergo pre and post TOP counselling
Physical factors such as pain should be managed and basic nursing care
rendered to enhance comfort
Involvement of the family should be paramount with a view to provide support

Theme 3: Support system

This theme explored the support experienced by all the participants regarding providing
and receiving TOP services. The TOP service providers experienced lack of support
from their managers while the managers experienced a lack of funds to provide for
human resources, supplies and equipment. According to TOP facility managers it
seemed as though the TOP programme was secondary to contraception. Authorities
emphasised prevention much more and so was spending.

In this theme there were four (4) categories and twelve (12) sub-categories which
emerged. These reflected the type of support available or not available to participants.
Category 3.1 and related sub-categories reflected the managers’ support for TOP
service providers. Category 3.2 and related sub-categories reflected the TOP service
providers’ support to TOP health care consumers. Category 3.3 and its related sub-
categories reflected the support or none thereof by other personnel in the facilities not
involved in the provision of TOP services to both TOP service providers and TOP health
care consumers, while category 3.4 and related sub-categories reflected the support or
none thereof of TOP services by community members. Table 4.4 presents the
categories, sub-categories and related meaning units in support. (Meaning units are
edited)
Table 4.4 Summary of categories, sub-categories and meaning units of theme 3

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<tr>
<th>CATEGORY</th>
<th>SUB-CATEGORY</th>
<th>MEANING UNITS</th>
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| 3.1 Managers’ support for TOP service providers | 3.1.1 Lack of support by management | TOP service provider 2: “So management is not supportive from head office.... Because they should also think of us. They just started this programme because they did not want to be seen as not complying....,”
TOP service provider 4: “Mmm ... Management is not supportive. They just initiated this programme because it is a requirement for service delivery ... apart from the initial training..., there are no refresher courses..., not even debriefing sessions...,“
TOP service provider 7: “...If that lady from Head Office does not arrange debriefing sessions for us, our management does not care. That’s bad ... where is advocacy?. The TOP facility managers do not talk for us”.
TOP service provider 5: “There is no recognition even if you are doing good for the clients. It is very rare that you will see our managers here. They are in other wards. I understand we have our operational manager but the poor woman has to feel what we feel. She is not regarded as a manager because she always works with us.”
TOP service provider 3 “It’s painful to talk about support. (Pause) (Crying) We are to work in these circumstances...,“
TOP service provider 6: “the manager, just does one site visit which is not really adequate support”.
<p>| 3.1.2 Support indifferent | | TOP service provider 4: “And with budget, you can see that TOP has no budget allocation; managers use money left over from other votes.” |
| 3.1.3 Support available | | TOP service provider 1: “Management is supportive. Unlike when we started when the programme was labelled ‘your programme’ and they did not want to |</p>
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<td>know what is happening ... The department is giving debriefing sessions for us ... I really feel better after that.”</td>
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<td>TOP facility manager 3: “If they feel tired or rather exhausted and depressed, we take them to the occupational nurse then she will give them occupational leave.”</td>
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<td>TOP service provider:5: “But in essence they are supportive ... The province gives debriefing sessions though it’s not enough. We had it in April and ... that’s it, for the whole year.”</td>
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<td>TOP facility manager 1: “The provincial coordinator of the programme is really trying her best. She involves departmental psychologists and social workers.”</td>
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<td>TOP service provider 1: “Management is supportive even if you can see that they are not for it, but they will come and visit the unit at times to see what is happening..., and ...,we have equipment ... It’s just that some issues are beyond them because one of them said if it was for them to decide, we could get extra remuneration and all that stuff ... you see...,Unlike when I compare with other institutions where they will tell you that management does not know what is happening in their units ... one would feel that here we are lucky...,“</td>
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<td>3.2</td>
<td>TOP service providers’ support to TOP health care consumers</td>
<td>3.2.1 Lack of support</td>
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<td>3.2.2 Support indifferent</td>
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|          |             | TOP health care consumer 8: “..., she (TOP service provider) kept asking me
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<td>how did I know about the service..., as if I was not supposed to be there to seek TOP services...&quot;</td>
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| 3.2.3 Support available | TOP health care consumer1: “She really assured me that I made a correct decision and that whatever happened in this unit remains within the walls of the unit: “(Kekoma, dikhupamarama re hwanao’... meaning it is confidential)..., The nurse had respect for me because throughout she was calling me ‘mama’. She did not judge or criticise me.”  
TOP health care consumer 3:“..., And the way she talked to me, I don’t have ill feelings about my decision. I think the respect and assurance she gave me strengthened me.”  
TOP health care consumer 9: “I feel the sisters here are good to us because even if you misbehave they just help you.”  
TOP health care consumer 6:“I found the sister who welcomed me with a smile..., she gave me a lot of information...,”  
TOP health care consumer 4:“The support she gave me was excellent to rate it. She is a good sister and dedicated to do her work. But that reflect the image of the family she comes from.”  
TOP health care consumer 1 (continued): “...,But this time it is like you are treated like a VIP. Nobody shouts at you, they politely talk to you. When you express that you are feeling pain, they say sorry ... The service here is good such that if abortion was a good thing to do, I would prefer to do it rather than getting ill and having to face the rude maternity nurses.”  
TOP health care consumer 9 (continued): “But then the nurse in this ward made everything easy for me..., It was painful and she kept on saying, ‘It’s ok ... it’s ok ...'” |
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<td>3.3.1 Lack of support</td>
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<td>Support by other personnel in the facility not involved in the provision of TOP services to TOP health care consumers</td>
<td>3.3.2 Support indifferent</td>
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<td>3.3</td>
<td>Support by other personnel in the facility not involved in the provision of TOP services to TOP health care consumers</td>
<td>3.3.3 Support available</td>
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<td>3.4</td>
<td>Community members' support for TOP services</td>
<td>3.4.1 Lack of support</td>
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<td>Community members' support for TOP services</td>
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<td>3.4</td>
<td>Community members' support for TOP services</td>
<td>3.4.3 Support available</td>
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Category 3.1: Managers’ support of TOP service providers

This category describes the support from TOP facility managers to TOP service providers in the provision of TOP services. It is a feeling of all TOP service providers that management initiated the TOP programme so that the province is seen to comply with national expectations. This assertion is based on the lack of support as perceived by TOP facility managers and TOP service providers.

Sub-category 3.1.1: Lack of support by management

TOP service providers felt that management including the TOP facility managers were not providing the support to the TOP programme as they should. The location of all the units was always not easily accessible, supplies were limited and human resources were inadequate and as a result service provision was always an undertaking. Much has been said to indicate lack of support by management (see table 4.4: item 3.1.1). This assertion was supported by Sibuyi (2004:77) who also found that lack of support by management impacted negatively on the provision of TOP services. According to the participants:

TOP service provider 2: “...So... management is not supportive from head office..., because..., They should also think of us. They just started this programme because they did not want to be seen as not complying...,”

TOP service provider 4: “Mmmm..., Management is not supportive. They just initiated this programme... because it is a requirement for service delivery..., apart from the initial training..., there are no refresher courses..., not even debriefing sessions”

TOP service provider 7: “....as you know, this is a controversial issue. Here in the hospital it is not given a number one priority... as most of the managers ...are not for it....If that lady from Head Office does not arrange debriefing sessions for us, our management does not care. That’s bad. Where is advocacy? The TOP facility managers do not talk for us”
TOP service provider 3: “It’s painful to talk about support. (Pause) (Crying) We are to work in these circumstances..., (gesturing to the small room)....”

Mayers et al (2005:23) found that lack of support from managers in the workplace was an issue. Support from the managers would provide the context in which the providers would feel cared for and would also encourage them to continue providing the services. Gmeiner et al (2001:77) found that support would assist midwives to deal with the issues of value conflict and utilisation of defence mechanisms as a way of coping. In this study, although MDOH (2009a:12) and the MTOPIP state that regular debriefing sessions shall be provided, the report from the participants stated different.

**Sub-category 3.1.2: Support indifferent**

TOP service providers in this study reported indifferent support from the managers, as the managers allowed themselves to run units with no cost centres and therefore no budget allocation. The following statement was said in support of the above:

TOP service provider 4: “And with budget you can see that TOP has no budget allocation, managers use money left over from other votes.”

This TOP service provider went on to marvel at how the Mpumalanga Provincial government can continue to assist non-nationals when there are no resources even to serve the nationals:

TOP service provider 4: “more and more people are from outside the country, Swaziland, Mozambique and Zimbabwe. They are flocking here in big numbers. But what can we do, we just help them?”

In Mpumalanga, the budget for TOP programme is estimated at R750 000.00 but still the managers in the facilities do not utilise the budget as planned (MDOH 2009b:3).
Sub-category 3.1.3: Support available

From the data collected there were some positive responses where participants had experienced support (see table 4.4: item 3.1.3). This, although not much, encouraged them to continue giving the best TOP services to the TOP health care consumers. The following meaning units support the above statement:

TOP service provider 1: “Management is supportive. Unlike when we started when the programme was labelled ‘your programme’ and they did not want to know what is happening....”

TOP service provider 5: “But in essence they are supportive ... The province gives debriefing sessions though it’s not enough. We had it in April..., and ... that’s it, for the whole year.”

TOP facility manager 1: “The provincial coordinator of the programme is really trying her best. She involves departmental psychologists and social workers.”

TOP service provider 1 (again): “Management is supportive even if you can see that they are not for it, but they will come and visit the unit at times to see what is happening and we have equipment ... It’s just that some issues are beyond them because one of them said if it was for them to decide, we could get extra remuneration and all that stuff ... you see.”

TOP service provider 1 (again): “...,Unlike when I compare with other institutions where they will tell you that management does not know what is happening in their units ... one would feel that here we are lucky.”

Category 3.2: TOP service providers’ support to TOP health care consumers

This category describes the support or none thereof experienced by TOP health care consumers from TOP service providers. In the current study, the following sub-categories were discussed:
Sub-category 3.2.1: Lack of support

There was an expression of discontent from one participant who experienced lack of support from the TOP service provider and cited that she would not easily recommend others in the same situation to the services. According to the participant:

TOP health care consumer 6: “She was just rough...like... she was doing it so that I don’t come back here again... you know. She was just pressurising me, not making me calm you know ... She knows how to do it.... but has no patience.”

The above comment supported the MNet TV programme ‘Carte Blanche’ (23 June 2002 at 12:00) which featured a documentary entitled “DIY Abortions” in which TOP health care consumers were harassed in TOP units and left to care for themselves during the termination of pregnancy process (SABC, MNet 2002). In that documentary the nurse was shown uninterested in looking after the patients in the units, she was not responding to any of their calls and instead was telling the patients in the unit to get out of bed to dispose their products of conception. This was not in line with the stipulations of the CTOP Act, which makes provision for the nurse to refuse to do the procedure but mandates the nurse to provide for basic nursing care before and after procurement of TOP. Mokgethi, Ehlers and Van der Merwe (2006:37) also reported a lack of support from TOP service providers in the North-West Province. Here, patients were said to be left alone to care for themselves thus not receiving adequate care before and after the TOP procedure. Another report of lack of support came from South Asia, where abortion providers routinely refused to perform abortions in a number of circumstances especially if the woman was nulliparous or presented unaccompanied in the unit (The International Reproductive and Sexual Health Law Programme 2008:16).

Sub-category 3.2.2 Support indifferent

One TOP service provider referred to the negative impact of the foreigners who came across the borders requesting TOP services. The TOP service provider was of the opinion that these foreigners crowd the services and utilised the scarce resources which are not enough even for South Africans. This, according to her, contributed to provider exhaustion, shortage of packs, and the irritation of staff.
According to the participant:

TOP service provider 4: “... more and more people are from outside the country, Swaziland, Mozambique and Zimbabwe. They are flocking here in big numbers. But what can we do, we just help them?”

In her report, Engelbrecht (2005:50) has confirmed the cross border issue of women seeking TOP services. To this effect she states that women from Lesotho access services in the Free State, because in Lesotho the law regarding abortion has not developed with times.

Furthermore some TOP service providers were not impressed with the numbers of TOP seekers. To this effect one of the TOP service providers wanted to know how a TOP health care consumer came to know about the facility

TOP health care consumer 8: “..., she (TOP service provider)..., kept asking me ..., how did I know about the TOP services..., in this hospital..., I told her I heard from my friends..., because i could not remember reading anywhere about the TOP..., she did not look happy..., i do not know why...”

According to Morroni, Myer and Tibazarwa (2006:1-5), there was only 32% of women reported to know that abortion is currently legal; but very few among these knew of the time restrictions and the designated facilities. In their study researchers were informed that women often missed the cut-off period of three months while still searching for designated facilities. This is quite possible in Mpumalanga with only seven (7) active facilities for the whole province.

**Sub-category 3.2.3: Support available**

Most of the TOP health care consumers expressed satisfaction with the support they received from the TOP service providers. The experience corroborated with that reported by Varkey-Sanjani et al (2000:106) whereby TOP service providers were friendly, helpful and made TOP health care consumers to feel relaxed. These positive
responses are outlined in the meaning units in table 4.3: item 3.2.3. According to the participants:

TOP health care consumer 1: “She really assured me that I made a correct decision and that whatever happened in this unit remains within the walls of the unit: ‘kekoma, dikhuparamama... re hwanao’ (Meaning: here in this unit, your diagnosis is confidential and nobody will ever know about it)”

TOP health care consumer 2: “They gave me a lot of information here.”

TOP health care consumer 1 (continued): “But this time... is like ...you are treated like a VIP... nobody shouts at you......, they politely talk to you... When you express that you are feeling pain, they say sorry ..., as if you are not to feel it... The service here is good such that if abortion was a good thing to do I would prefer to do it rather than getting ill and having to face the rude maternity nurses.”

TOP health care consumer 4: “The support she gave me was excellent. To rate it... she is a good sister..., and dedicated to doing her work. But that reflects the image of the family she comes from...,”

Category 3.3: Support by other personnel in the facilities not involved in the provision of TOP services to TOP health care consumers

This category describes the TOP health care consumers’ and TOP service providers’ experiences of support or non-support thereof from other personnel in the facilities not involved in the provision of TOP services.

Sub-category 3.3.1: Lack of support

Some participants felt that other personnel who are not in the TOP team did not provide the support required.

TOP health care consumer 2: “I felt very much embarrassed when the clerk at the reception, after I asked where I could go to have the service, said to me, ‘You are still
young and you got involved in sex, now you want to terminate that pregnancy.’ ... I nearly turned back because I had whispered to him and he just said it loud, not considering that other people are listening.”

TOP service provider 3: “the other nursing staff tend to ostracise you...they do not want to be seen with you”

Varkey-Sanjani et al (2000:105) reported judgemental attitudes experienced by women who came for TOP as ascribed by those personnel not involved in TOP service provision. The authors further reported that women were also denied pregnancy results or referral letters so as to make sure that the pregnancy was not terminated. They were told that abortion was immoral and sinful, or even given misleading information on their eligibility for abortion.

The researcher is of the opinion that such lack of support might hamper the effective use of TOP services, especially if confidentiality is violated thus compromising the TOP programme.

Sub-category 3.3.2: Support indifferent

Some of the TOP health care consumers also experienced indifferent support. According to one participant:

TOP health care consumer 9: “She asked me if I am the one who also wants to kill. I said to her ‘Please show me the way.’ It was like she didn’t want to show me the way; she just pointed in the direction with her finger...,”

TOP health care consumers have the right to information, including information about TOP service and where to access the services (Morroni, Buga& Myer 2006:38). The researcher is of opinion that failure to freely provide the information to TOP health care consumers has a negative influence on the accessibility of TOP services and the TOP programme.
Sub-category 3.3.3: Support available

It was encouraging to learn that some of the participants experienced support from personnel not involved in TOP service provision because this will broaden access. According to Littman et al (2009:419) non-judgemental actions and positive attitudes by the general hospital community could help, not only in the utilisation of TOP services, but in the utilisation of all services provided in the hospital. One participant stated

TOP health care consumer 8: “...,As I did not know where the TOP ward was, I asked one of the workers for directions. She (health worker) accompanied me to the ward and wished me luck..., I felt good..., encouraged...,”

Category 3.4: Community members’ support of TOP services

This category describes the nature of the support received from community members by participants.

Sub-category 3.4.1: Lack of support

The participants reported a lack of support for TOP services from the community members. This was said to be so bad that the TOP service providers are ostracised by the community and TOP health care consumers can even be excommunicated from the church. For example:

TOP service provider 1: “Community members started to isolate me because, according to them, I was doing an evil action...,”

TOP service provider 7: “The thing is we meet a lot of criticism in the community. Some call us names like murderers, witches ... but that does not touch me.”

TOP health care consumer 8: “this is so bad... The other day in church... the catechism leader made an announcement...eh... to say ...eh...'there is an increase in the number of people visiting the wellness clinics....should it transpire that a church member has done an abortion...that member will be excommunicated immediately. Oh..., I was sitting
there thinking... may be... I should cancel my appointment which was set for the following week... but then... I also knew that I did not want this pregnancy...,"

In line with Sibuyi (2004:77), the community members manifested their lack of support by harassing, name-calling and intimidating TOP service providers and TOP health care consumers alike. Furthermore, Potgieter (2004:6) reported that TOP service providers were labelled as “serial killers” or “baby killers”. A study by Gerber Fried (2000:176) found that, in Arizona, pro-life forces followed a 14 year old pregnant girl who had received a court permission to procure abortion, for 1000 miles to Kansas city and lined the side walk outside the clinic where she had come to perform an abortion, in an effort to persuade her not to have an abortion. Weitz (2010:161) also stated lack of support from community members regarding provision of abortion whereby she reported the assassination of a TOP service provider by pro-life forces. The report further stated that TOP health care consumers and TOP facilities became the direct targets of large scale anti-abortion demonstrations at which anti-abortion activists blockaded clinics to prevent women from obtaining abortions. International Reproductive and Sexual Health Law Programme (2008:15) also reported that some anti-choice organisations, presented as pregnancy crisis centres, purposely discouraged, misinformed and coerced women into not exercising their right to do abortion. Failure of the community to provide support might hamper access to TOP services by the TOP health care consumers who fear retributions from community members.

**Sub-category 3.4.2 Support indifferent**

There were incidents where the support received required participants to apply their minds and take a principled decision. The following quote illustrates that sentiment:

TOP health care consumer 3: “*Although my partner told me that he is not in favour of abortion, he supported me throughout ... This is because we were having financial problems and he would not be able to take care of the coming baby.*”

In this instance the reason for TOP was socio-economic. According to Littman et al (2009:424), every woman deserves non-judgemental support regarding her choice on abortion. Furthermore, women have abortions because they need to care for children
they already have and that abortion put them in a better position to raise the existing children properly providing them with a future (Littman et al 2009:423).

Sub-category 3.4.3: Support available

Some of the participants experienced support from other stakeholders. For example:

TOP service provider 5: “I am lucky because my family supports me. My husband knows that this is the work I am doing and nothing more. He is not in the health sector but in finance ... But he supports me and sometimes he has even referred his colleagues that needed TOP services. My mother is an old woman and also supports me.”

To this effect, Sibuyi (2004:78) commented that value clarification workshops are necessary to promote acceptance of TOP services by the stakeholders. Thus when stakeholders have positive attitude towards TOP; services will be utilised, more health professionals will undergo training and provide the service with no problems

Conclusions on support system: Theme 3

Based on the findings, the researcher drew the following conclusions on the support systems. That:

- The perception of TOP service providers and TOP facility managers was that the TOP programme was not supported by provincial government authorities. According to them there was no budget allocated to the programme. The programme was run under other programmes which often took precedence
- TOP facility managers did not advocate on behalf of the TOP service providers, hence the chronic shortage, poor supplies, lack of recognition and no career advancement
- Other members of staff and community members did not support TOP services and thus discouraged participation in the programme. Comments and attitude displayed towards those participating in the programme were such that these were labelled as murderers.
The programme was not marketed well by health authorities; hence information about the services was mainly as a result of hearsay in the community. The TOP health care consumers could not recollect any campaign to introduce the programme. From this it seemed as though it is only the desperate who go out to look for these services.

**Recommendations**

Based on the findings in this theme, it is recommended that:

- The provincial government revisits its commitment to prioritise reproductive health delivery and allocate a budget to the TOP programme. The budget will give meaning to human resources, supplies and equipment
- TOP facility managers to ensure that there are adequate resources (human and material) for the provision of TOP services
- The TOP programme to be adequately marketed at appropriate platforms to ensure that the community is well informed and for it to propose implementation strategies that are acceptable to it.

**Theme 4: Challenges in the provision of TOP services**

This theme deals with the challenges experienced by the participants in the provision as well as in the receiving of TOP services.

In this theme six (6) categories and eight (8) sub-categories emerged. The first three categories and their sub-categories reflected on the challenges related to human resources, material resources and financial resources. Category 4.4 as well as its related sub-category reflected on issues in the decentralisation of TOP services. Category 4.5 and related sub-category reflected on attitudes of other personnel not involved in the TOP programme as a challenge, while category 4.6 and related sub-category reflected on issues related to community attitudes towards TOP services as a challenge (see table 4.5). (Meaning units were edited)
### Table 4.5: Summary of categories, sub-categories and meaning units of theme 4

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>SUB-CATEGORY</th>
<th>MEANING UNITS</th>
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</thead>
</table>
| 4.1 Human resources challenges  | 4.1.1 Recruitment and retention of staff  | TOP facility manager 2: “it has been very difficult to recruit staff to come and work in the TOP unit.... even the trained personnel are not keen...I can just say it has been impossible to get nurses... as a result we have a chronic shortage...As it is, I now and then have to serve as a relief when one of the TOP service providers are not at work”  
TOP facility manager 1: “If the government would consider this as a scarce skill and pay people, I think many professionals would be attracted to it.”  
TOP service provider 4: “There are no incentives for providing the service. I mean this is a scarce skill like the others, but it is sidelined.”                                                                                                                                                                                                                       |
| 4.1 Human resources challenges  | 4.1.2 Distribution of staff               | TOP service provider 4: “Here in our facility, if there is a shortage somewhere the first unit they take somebody out of is this one ...Then you will remain with a lot of clients that were booked for 2 even less providers. They don’t even consider that...”  
TOP service provider 1: “But maybe the fact that I provide the service alone may be taken as a bad experience.”  
TOP facility manager 1: “Two, sometimes only one because of our staff situation. If there is staff shortage somewhere in the wards, we take them to those wards because there lies priority for patient care.”                                                                                                                                                                                  |
| 4.2 Material resources          | 4.2.1 Infrastructural challenge           | TOP service provider 1: “We are put in a corner in one room and have to do everything there.”  
TOP service provider 7 “The other thing that bothers me is the limited space where I have to provide the service. I do counselling here, TOP here, eat here, do a lot of things here.”  
TOP service provider 3 "We don’t have a place for counselling and even doing the procedure.”  
TOP service provider 4 “The only problem still facing my unit is that of limited
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<th>CATEGORY</th>
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|          | 4.2.2 Equipment and supplies | TOP service provider 5: “We have six packs. We end up doing only six TOPs because of the number of packs. If we had more packs, we would do as many as we could. Sometimes a client who is 11 weeks of gestation is sent away because of those constraints and to come back at a later date. In many instances we lose that client.”  
TOP service provider 4: “The only problem still facing my unit is that of ... equipment. But I am sure before long the equipment will be bought because there was a representative of a company that came and I was told to select what I want....”  
TOP service provider 6: “A number of qualifying clients were sent away because of no supplies and as such we could not help them”  
TOP service provider 1: “This couch I took from the stores and requested that they paint it for me. This lamp I took from ICU. Work is going on.”  
TOP service provider 3: “Sometimes we misdiagnose patients because we don’t have equipment, such as the ultrasound, sonar machine, so we diagnose through experience”. |
|          | 4.3 Financial resources | 4.3.1 Budgetary constraints | TOP facility manager 2: “The budget also for us is limited..., so it is difficult...,”  
TOP service provider 4: “And with budget you can see that with TOP they just use the remaining money.”  
TOP facility manager 1: “Even if you submit the estimates for the budget in time, it is considered last.....” |
|          | 4.4 Decentralisation of TOP services | 4.4.1 Distribution of designated facilities | Top service provider 7: “If TOP services could be provided by all the hospitals and clinics, I think that would help.”  
Top service provider 5: “Decentralising the services to certain clinics might also help. Not to centralise it to one institution because it thus increases the workload in that facility. You see ...” |
<p>|          | 4.5 Attitudes of other personnel in the facilities not involved in the provision of TOP services | 4.5.1 Negative attitudes of personnel | TOP health care consumer 2:: “I felt very much embarrassed when the clerk at the reception, after I asked where I could go to have the service, said to me, ‘You are still young and you got involved in sex, now you want to terminate that pregnancy.’ ... I nearly turned back because I had whispered to him and he just ...” |</p>
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|           |             | said it loud, not considering that other people are listening."
|           |             | TOP health care consumer 2 (continued):“The attitude of health providers should change from top management to the general assistant.”
|           |             | TOP health care consumer 9:“She asked me if I am the one who also wants to kill. I said to her ‘Please show me the way.’ It was like she didn’t want to show me the way, she just pointed in the direction with her finger.”
|           |             | TOP service provider 3: “Like here in the hospital they know exactly who is an abortion sister. If you come here wanting an abortion they will refer you to me. When I pass by, you will hear them saying, ‘There is the abortion sister.’ I am very much known here. You get that stigma.”
|           |             | TOP service provider 1:“The thing is the stigma is still attached to the providers because at times you will hear some colleagues asking me if I think I am doing the correct thing.”
|           |             | TOP service provider 3: “Sometimes you can perforate the uterus as it has happened before, and to get the doctor to come and help or look... it is as if you did it deliberately... You don’t have the doctor to stand behind you and support you”
|           |             | TOP facility manager 2: “They withhold information from the patients. I think some are turned back before they reach the unit. The place is stigmatised...The attitude of other health workers who impose their perceptions....., you know...., that TOP is not good, it’s an evil action. Health workers withholding information from the patients. The attitude as a whole ...is ...”
|           |             | TOP facility manager 1:“She used to come to my office and complain that colleagues were calling her Satan.”

4.6 Community attitude towards TOP services

4.6.1 Negative attitudes of community members

|               |             | TOP service provider 1: “She (TOP health care consumer) told me that...Community members started to isolate her because....., according to them she is doing an evil action.”
|               |             | TOP service provider 7“In the area where I stay people labelled me a serial killer...”
|               |             | TOP service provider 5: The thing is we meet a lot of criticism in the community. Some call us names like murderers, witches ... but that does not touch me.”
Category 4.1: Human resources challenges

Since the introduction of the TOP programme in the province the TOP services have faced personnel challenges. Human resources form the cornerstone for the successful provision of services. Without adequate staff, quality service provision is compromised. In this study, the human resources for health challenges related to recruitment, distribution and retention.

Sub-category 4.1.1: Recruitment and retention of staff in TOP units

Human resources challenge is based on the ability of the facility to recruit registered nurses including midwives trained in TOP service provision. In the current study TOP facility managers reported difficulty in sourcing any nurse (trained in TOP provision or not) and in retaining these in the service, hence the gross shortage in the units. Providing TOP services was viewed as an emotionally-charged task and retention of staff should be priority to ensure continuity of quality service and confidentiality as clients are assured of privacy if staff is stable. According to the participants, nothing has been done to retain staff in the TOP services and attrition is high. According to participants:

TOP facility manager 1: “If the government would consider this as a scarce skill and pay people, I think many more professionals would be attracted to it.”

TOP service provider 4: “There are no incentives for providing the service. I mean this is a scarce skill like the others, but it is sidelined.”

TOP service provider 7: “And you are not compensated. The government does not even consider it a scarce skill.”

TOP service provider 3: “One of the sisters asked management to motivate for an incentive and the request was not received in good faith. They told the sister that she is the one who chose to be an abortion provider; and it was not agreed that she would get extra money for that ...”
The incentive issue is serious in Mpumalanga Province. To this effect, this is what one of the participants had to say:

**TOP facility manager 2:** “This has a negative impact on the provision of services as some staff members are unwilling to work in those units because of lack of incentives. Based on unattractive remuneratory factors, doctors in Mpumalanga do not participate in the TOP service provision in the public sector (because there is no incentive for that). The doctors offer TOP services in their private practices because they charge money for it...”

**Sub-category 4.1.2: Distribution of staff**

The participants indicated an uneven distribution of staff members in TOP units because people do not want to work in the units. In Mpumalanga, TOP services are provided by nurses in the seven (7) active facilities. According to the participants:

**TOP service provider 1:** “But..., maybe the fact that I provide the service alone... may be taken as a bad experience.”

**TOP service provider 4:** “Here in our facility, if there is a shortage somewhere, the first unit they take somebody out of is this one ... Then you will remain with a lot of clients who were booked for two providers. They don’t even consider that... you work yourself to death because you have to do all the work by yourself. You become exhausted ... but who cares?”

These findings indicate non-adherence to the stipulated minimum requirements for staffing in TOP units, namely 3 professional nurses and 1 enrolled nurse (MDOH 2009:12). According to Brookman-Amissah (2004a:40) the uneven distribution of TOP service providers is especially pronounced in rural settings and it compromises women’s access to reproductive health services.
**Category 4.2: Material resources challenges**

The participants were asked to indicate the challenges they faced regarding material resources for TOP services provision. The challenges were divided into the sub-categories below.

**Sub-category 4.2.1: Infrastructure**

All the participants indicated lack of space as a great concern. In their opinion, this factor compromised privacy, confidentiality and quality of services in the provision of TOP services. According to participants the work environment was not user friendly, space was limited with no privacy for counselling (see table 4.4: item 4.2.1 for supporting meaning units).

This is contrary to the stipulations of the CTOP Act and the MTOPIP that an enabling environment for the provision of TOP services should be created. According to MTOPIP, there must be adequate space for privacy during assessment and counselling. The records should be stored safely where access by other personnel is impossible. This situation is not unique to Mpumalanga. A similar phenomenon was reported in the Free State by Engelbrecht (2005:147) whereby lack of space for the provision of TOP services was a great concern.

**Sub-category 4.2.2: Equipment and supplies**

Most of the participants complained of limited equipment and supplies. According to the participants, just as the units did not have a dedicated budget, so was the situation with supplies. For meaning units see table 4.5: item 4.2.2):

TOP service provider 5: “We have six packs... so we end up doing only six TOPs because of the number of packs. If we had adequate packs we would do as many as we could. Sometimes a client who is 11 weeks of gestation is sent away because of those constraints, to come back at a later date and in many instances we lose that client.”
TOP service provider 4: “..., because of this (no equipment)..., we..., sometimes..., we misdiagnose patients because we don’t have equipment, such as the ultrasound, sonar machine,... so ...we diagnose through experience...and in some instance rely on the history given by the patient....,”

The lack of supplies impacts negatively on the services as the bookings are done according to the availability of equipment. At the same time it infringes on the clients’ right to receive services in a safe, hygienic and well equipped environment. Due to the poor resourcing of units, Brookman-Amissah (2004a:41) has warned facilities, stating the “no product, no programme” phenomenon which is an outcome of frequent stock outs and if this was to continue not only would the services but the programme also would be compromised. Engelbrecht (2005:147) also reported a challenge in the number of beds in TOP facilities which may result in some TOP health care consumers resorting to unsafe abortion services which will mitigate against the objective of the TOP programme.

The impact of misdiagnosis is also highlighted in table 4.3, item 2.1.1, where TOP service provider 7, is referring to emotional feelings where she states that “...it is not nice, especially because at times you do not sleep, especially if during the TOP procedure ... you see foetal parts” this happens where pregnancy dates could not be confirmed and an abortion is procured on a much older pregnancy than the allowed twelve weeks

Category 4.3: Financial resources

At its inception in 1997 the TOP programme was prioritised by the national government as an extension of the human rights initiative to women. An amount of R750 000, 00 was set aside annually to implement the programme. Presently, because of negative attitudes towards the programme the money is diverted to other projects in the Department, with the TOP programme being secondary, hence the challenges on resources.
**Sub-category 4.3.1: Budgetary constraints**

The participants stated that the budget is not enough for the service. This influenced the service provision negatively, especially in relation to equipment and supplies. In many instances funds are used for other more acceptable programmes in the Primary Health Care system. According to the participants:

TOP facility manager 1: “Even if you submit the estimates for the budget in time, it is considered last and no allocation is ever made.”

TOP service provider 4: “And with the budget you can see that with TOP they just use the remaining money.”

The above is contrary to the specifications in the 5 year review in the International Conference on Population and Development (ICDP) as cited by Brookman-Amissah (2004a:41) whereby measures to overcome challenges in the provision of TOP services includes advocacy at the national level to ensure that abortion care resources receive adequate priority and separate budgetary allocations are seen as an integral part of safe motherhood and other reproductive health programmes. The aforementioned fact will ensure that the budget for TOP service provision is utilised adequately to ensure sustainability of the programme.

**Category 4.4: Decentralisation of TOP services**

This category describes the participants’ views on centralisation of TOP facilities. The participants maintained that TOP services should be decentralised to improve access and alleviate the strain on the units and on service providers. Decentralisation of TOP services is supported by Engelbrecht (2005:151-152). She has cited one of the factors impacting negatively on access as distance. In this study, women seeking TOP services had to travel a long distance to access the service. She further explains that this has a negative effect on accessibility as only those who can afford paying for transport to reach those TOP service points can access the service. If the TOP programme is about redress, then access should be equitable across provinces. To this, Brookman-Amissah (2004a:41) adds that “universal access” guarantees that all reproductive health services
a woman might need (including TOP services) are accessible geographically and financially.

**Sub-category 4.4.1: Distribution of designated facilities**

In Mpumalanga there are only 7 active designated facilities, and these are in the form of district and regional hospitals. The services are not available in community health clinics. Lack of services in community clinics compromises accessibility. Decentralising services would increase availability and accessibility of TOP services. Hord and Xaba (2002) as cited by Engelbrecht (2005:132) were of the opinion that by permitting trained midwives to perform a TOP of less than twelve weeks gestation, the CTOP Act aimed at increasing accessibility of TOP services to the most inaccessible parts of the country. Despite that effort, little progress has been made in moving TOP services out of hospitals (Althaus 2000:85).

The following sentiments by the participants confirm the difficulties experienced:

TOP service provider 7: “*If TOP services could be provided by all the hospitals and clinics, I think that would help.*”

TOP service provider 5: “*By decentralising the services to certain clinics also might help. Not to centralise these services in one institution because it thus increases the workload in that facility, you see...,*”

The latter concurs with the study by Engelbrecht (2005:109), who cited that refusal of some hospitals to provide TOP services leave those providing the services being overloaded and struggling to cope with high numbers of clients seeking TOP.

**Category 4.5: Attitudes of personnel not involved in the provision of TOP services**

This category describes the participants’ experiences of the attitudes of personnel in the facility not involved in the provision of TOP services.
Sub-category 4.5.1: Negative attitudes of personnel

The TOP services providers, managers and TOP health care consumers experienced negative attitudes towards TOP service provision from staff not working in TOP services. Shellenberg and Frohwirth (2009:4) also found that abortion was stigmatised. The authors defined and conceptualised abortion stigma into a three domain framework ie 1st domain refers to the perception of how people feel about abortion or women who have abortion; 2nd domain includes rejection by spouse, family members or being mistreated in the community or health setting; and 3rd domain refers to internalised stigma that manifests itself as a feeling of guilt, shame and anxiety about self. The three domains could be deduced in the narratives of participants:

TOP health care consumer 9: “…, She said to me am I the one who also wants to kill… I said to her…, ‘please show me the way’…, It was like she didn’t want to show me the way…; she just pointed in the direction with her finger…, and the second one I asked…, directed me without any questions.”

TOP health care consumer 2: “The attitude of health care providers should change from the top management to the general assistants.”

TOP service provider 3: “…, like here in the hospital they know exactly who is an abortion sister. If you come here wanting an abortion they will refer you to me. When I pass by, you will hear them saying, ‘There is the abortion sister.’ I am very much known here. You get that stigma.”

TOP facility manager 2: “The attitude of other health workers who impose their perceptions, you know, that TOP is not good, it’s an evil action. Some health care workers withhold information from the patients. The attitude as a whole… is ....”

This is in line with the Carte Blanche documentary on “DIY Abortions” on 23 June 2002 at 12:00 (SABC, MNet 2002), which displayed health care providers’ reluctance to assist in TOP service provision. Women who came for TOP services were not treated professionally and with dignity. Walker (1995:819) found that Primary Health Care Nurses considered women who had TOP to be irresponsible. According to Walker
TOP conflicted with their expectations of women as mothers, as TOP was regarded not only as the termination of life, but also the termination of motherhood, which is seen to be an irresponsible act.

**Category 4.6: Attitude of the community towards TOP services**

This category describes the attitude of the community towards TOP services as experienced by TOP health care consumers and TOP service providers, respectively.

**Sub-category 4.6.1: Community members’ negative attitudes**

In this study, TOP service providers and TOP health care consumers reported isolation by community members. Informants cited:

TOP service provider 1: “... she (TOP health care consumer) told me that ... community members started to isolate her ... because according to them she is doing an evil action.”

TOP service provider 6: “People started calling me terrible names ... serial killer.”

TOP service provider 7: “The thing is we meet a lot of criticism in the community. Some call us names like murderers, witches ... but that does not touch me.”

Nandipha (2008:14) found that stigma is attached to those terminating pregnancies and people are vocal about their disapproval. Harrison et al (2000:426) found that communities considered TOP an immoral action which should, therefore, not be supported.

As stated earlier, Weitz (2010:161) also stated lack of support from community members regarding provision of abortion whereby she reported the assassination of a TOP service provider by pro-life forces. The report further stated that TOP health care consumers and TOP facilities became the direct target of large scale anti-abortion demonstrations at which anti-abortion activists blockaded clinics to prevent women from obtaining abortions. In line with Shellenberg and Frohwirth (2009:1), the above is described as a second domain stigma.
Conclusions on challenges in the provision of TOP services: theme 4

The narration in this theme provided a variety of challenges faced by TOP service providers, TOP facility managers and TOP health care consumers while providing or receiving TOP services in Mpumalanga Province. These included:

- A shortage of the human resources for health to provide services. It was not easy to recruit or retain TOP trained practitioners. The government did not provide the necessary incentives to enhance retention. The lack of incentives resulted in the doctors not participating in the TOP programme but referring clients to their consulting rooms where they would be charged handsomely for services rendered. The distribution of the few available nurses was also not even, whereupon in other facilities there was only one TOP service provider in a TOP unit.

- Financial constraints were also experienced as there was no dedicated budget for the TOP programme, as a result units did not have adequate supplies and equipment. This compromised service provision and resulted in poor utilisation of services. Some TOP health care consumers had to be sent back at a crucial stage of their pregnancy (11 weeks) with the risk of losing them from the service.

- Financial constraints also meant that the units did not have adequate space, a factor that compromised the quality of the service given as there was no privacy that could be maintained in the space available, cleanliness was also an issue. The units sometimes ran out of sterile packs, limiting the number of TOPs that could be performed.

- The location of designated facilities was also a challenge in that these were centralised in hospitals and nothing was available in clinics. Hospitals by their very nature are usually in urban areas with community clinics in the rural outskirts. In this case women from rural areas had to travel long distances, inter and intra districts first to access services and secondly to secure privacy from their communities. This resulted in some units being over utilised while others grossly underutilized (see table 3.7).

- It was the perception of participants that the TOP programme is not supported by the Mpumalanga Provincial government based on challenges relating to funding, human resources and provision of positive work environment. The TOP programme was also generally not accepted in the community and by other...
facility personnel not involved in the TOP services. This was evidenced by the isolation of TOP service providers and ostracism of women who have done TOP including disparaging remarks as outlined in the meaning units.

**Recommendations**

It is recommended that:

- Government needs to revisit its commitment to the TOP programme and dedicate a budget that will enable facilities to have proper space, human resources, equipment and supplies to achieve the outlined objectives of the programme.
- Government to strengthen community education and lobby support for the TOP programme.

**Theme 5: Benefits of the TOP programme**

Much as there are challenges in the provision of TOP services, participants are also aware of benefits associated with the TOP programme. It is not clear whether the cited benefits are generic or apply to Mpumalanga. The theme therefore covers the participants’ perceptions of the benefits of the TOP programme. The benefits are residual, health related, educational, socio-economic and constitutional in nature. These are presented in five (5) categories and eleven (11) sub-categories (see table 4.6). Meaning units are edited.
### Table 4.6 Summary of categories, sub-categories and meaning units of theme 5

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<th>CATEGORY</th>
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<tr>
<td>5.1 Residual benefits</td>
<td>5.1.1 Government savings</td>
<td>TOP facility manager 1: “The government used to treat septic abortions spending a lot of money. But now this expense is reduced, the money used to treat septic abortions is channelled to other health projects.”                                                                                      TOP facility manager 2: “The programme is cost effective because TOP is done within a day. The economy is positively affected.”</td>
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<td>TOP facility manager 4: “The government also is no longer keeping patients for a long time like when they... (aborting patients) ..., had to be on aggressive antibiotics for septic abortion. This has a positive impact on the government budget....”</td>
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<tr>
<td>5.2 Health benefits</td>
<td>5.2.1 Improve quality of life</td>
<td>TOP service provider 2: “Things like the retained products of conception are a risk and you may bleed a lot as a result.”</td>
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<td>as indicated in the reduced morbidity and mortality</td>
<td>TOP service provider 3 “Sometimes you find that the woman is frustrated and then tries to induce abortion herself..., and..., may die. Then who is to look after her other children? If the women don’t die..., they end up in hospital with sepsis. This makes them to suffer a lot.....”</td>
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<td>TOP service provider 1: “...I think in 1988 ... 1990 ... I saw young women dying due to backstreet abortions..., and that thing..., keep coming back to me time and again....”</td>
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<td>5.3 Educational benefits</td>
<td>5.3.1 Career pathing</td>
<td>TOP facility manager 2: “Even schoolchildren pursue their careers after TOP.”</td>
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<td>TOP service provider 3: “It impacts positively on them (school children) because they benefit from the programme, like, if she is a school child and terminates her pregnancy , she can go on with her schooling with no interruptions..., and..., or.. continue with her profession....”</td>
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<td>5.4 Socio-economic benefits</td>
<td>5.4.1 Contribution to the control of population explosion</td>
<td>Top service provider 2:“There won’t be any overpopulation and overcrowding.”</td>
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<td>Top service provider 5:“Informal settlements will be reduced.”</td>
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<td>5.4.2 Reduction in child</td>
<td>Top service provider 1:“Those poor kids from unwanted pregnancies may be...”</td>
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<td>CATEGORY</td>
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<td></td>
<td>abandonment</td>
<td>dumped. I am actually preventing street kids and unwanted kids. In our villages there are no orphanages ...</td>
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<td>TOP facility manager 1: “Putting a live baby in the pit toilet or leaving the baby in a plastic bag on the road to be crushed by cars ...unimaginable....., that's cruelty.”</td>
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<td>Top service provider 4: “You know, I feel great because I am stopping a lot of things, like making children suffer.”</td>
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<td>Top service provider 7: “The thing of putting babies in the pit toilet has been reduced also.”</td>
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<td>TOP facility manager 4: “... There are no more bad things like throwing kids away. Because we had children dumped in the bushes, toilets and so on, but now with this..., that is history.”</td>
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<td>TOP facility manager 3: “In the past, in some instances terrible things would be reported..., like..., you would read about dogs found pulling the remains of foetuses in the streets of informal settlements ....or....., a baby’s body found at the dumping site..., So I feel in a way that TOP services prevent these shocking things.”</td>
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<td>TOP facility manager 2: “Mostly it has reduced abandonment of children.”</td>
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<td>5.4.3</td>
<td>Reduction of crime</td>
<td>TOP service provider 3: “Crime will be reduced ... and I can say a healthy community with no street kids, drug abuse and also abuse of alcohol will finally happen.”</td>
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<td>TOP facility manager 1: “The courts can now handle only serious crime, thus it has reduced the number of cases in courts hence the magistrate or those people have less work to do....”</td>
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<td>TOP service provider 4: “And children will receive the love that they deserve and there won’t be street kids and juvenile delinquents....”</td>
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<td>5.4.4</td>
<td>Preservation of marriage</td>
<td>TOP facility manager 1: “People are thanking me for saving their lives and marriages....”</td>
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<td>TOP service provider 4: “It’s painful to see a woman crying, stating that her spouse does not want the pregnancy.”</td>
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|          |             | TOP facility manager 1: “The rate of divorce is reduced as some of the families were destroyed by the fact that women had unwanted pregnancies.... And from
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<th>CATEGORY</th>
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<td>a health perspective, the community will be healthy and intact because there won’t be so many divorces.”</td>
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<td>TOP service provider 3: “When this woman cries, you find that you also cry with her because you feel that the marriage for this woman is over.”</td>
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<td>TOP facility manager 4: “It has contained many families..., It preserved their lives and fertility because the person who comes for the treatment of septic abortion may be infertile at the end... and..., not having children might .., spell an end of a marriage.”</td>
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<td>5.4.5</td>
<td>Prevention of unwanted pregnancies</td>
<td>TOP service provider 6: “The rate of unwanted pregnancies will drop.”</td>
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<td>TOP service provider 5: “Women will carry to term only the pregnancies that they wanted or planned.”</td>
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<td>5.5</td>
<td>Respect for constitutional human rights</td>
<td>TOP service provider 1: “I feel these women have the choice to do as they wish and, as such, their choices need to be respected.”</td>
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Category 5.1: Residual benefits

From the data collected, the participants were of the opinion that the government benefits from the TOP programme, because even though they did not know the benefit in monetary terms, from records the government had spent approximately R18 million prior to the inception of the CTOP Act to treat complications associated with unsafe termination of pregnancies (MDOH 2009:6; DOH 2005:19). Apart from self determination for women and the reduction of indecent unnecessary deaths due to unsafe TOPS, the programme was also therefore, introduced to reduce government expenditure on health care in this regard (MDOH 2009:6; DOH 2005:19). If this incidental saving was actually realised, then there was a residual benefit for the government.

Sub-category 5.1.1: Government savings

According to the participants, since the inception of the TOP programme the government is saving a lot of money as the number of septic abortions was reduced:

TOP facility manager 1: “The government used to treat septic abortions spending a lot of money. But now this expense is reduced, the money used to treat septic abortions is channelled to other health projects..., which is a good thing... I suppose”

TOP facility manager 4: “The government also is no longer keeping patients for a long time like when they .... (aborting patients).....,had to be on aggressive antibiotics for septic abortions. This has a positive impact on the government’s budget..., patient stay is reduced”

Category 5.2: Health benefits

According to the participants, women who terminate pregnancy in the TOP programme would benefit health wise. The likelihood of trauma, haemorrhage and infection is limited as termination of pregnancy is performed under clean conditions using appropriate equipment and supplies; and the psychological effects of abortion are attended to free of charge by a professional. Ratlabala et al (2007:29) found that
women desiring to terminate pregnancies benefit from the programme in that their health needs are promptly and adequately attend to in a TOP unit.

Sub-category 5.2.1: Improved quality of life as indicated in the reduced morbidity

The participants stated that the TOP programme benefitted families, communities and the country because backstreet abortions had detrimental effects on the women’s quality of life and health. The availability of the service has, according to the participants, freed the woman to exercise her choice in accessing the reproductive health services. One of the older TOP service providers stated that:

TOP service provider 1: “I think in 1988 ... 1990 ... I saw young women dying due to backstreet abortions..., and that.... keeps coming back to me time and again.”

TOP service provider 3: “Sometimes you find that the woman is frustrated and then tries to induce abortion for herself and may die..., then..., who is to look after her other kids?... If the women don’t die..., they end up in hospital with sepsis. This makes them suffer a lot..., following infection there may be a problem of secondary infertility...,”

Van der Post (2007:1) reported in the Mail and Guardian that backstreet abortions were still killing African women because they were unsafe and performed by untrained people and/or under unhygienic conditions. In these cases some of the complications included excessive bleeding, trauma to reproductive organs, sepsis, infertility and death.

Ratlabala et al (2007:29) found that backstreet abortions had debilitating effects on the physical, social and mental health of women. As these services are also not for free, there is some monetary loss as well. Potgieter and Andrews (2004:24) maintain that facilitating access to safe terminations would reduce the number of backstreet abortions which contribute to high mortality and morbidity rates among women.

Category 5.3: Educational benefits

The participants stressed that the TOP programme has educational benefits for young women because termination of unwanted and unplanned pregnancies assisted these women in continuing with their education and/or careers.
Sub-category 5.3.1: Career pathing

According to the participants, the TOP programme allows for career pathing.
TOP service provider 3: “It impacts positively on them because they benefit from the programme, like, if she is a school child and terminates her pregnancy..., she can go on with her schooling ..., and ...or..., continue with her profession.”

Category 5.4: Socio-economic benefits

Many of the participants maintained that the TOP programme impacted positively on the socio-economic status of the country and that of individuals. The issue of the government savings on reduced septic abortions is indicated in category 5.1, families could decide on the number of kids they will raise in line with affordability, the phenomenon of ‘street children’ may, in the long term be addressed and individuals may be able to advance their education and careers.

Sub-category 5.4.1: Contribution to control of population explosion

Population growth is a worldwide concern with advances in medical science resulting in increased fertility and longevity. According to Van Oosten (1997:63), the motive for legalising the termination of pregnancy was not to curb population growth, but to allow women to have a choice in procreation and control of population growth would be an indirect benefit thereof. According to the participants, the TOP programme would in the future contribute to the curbing of population growth.
TOP service provider 2: “There won’t be any overpopulation and overcrowding.”
TOP service provider 5: “Informal settlements will be reduced.”

Sub-category 5.4.2: Reduction in child abandonment

Although no figures were presented, child abandonment was a serious problem prior to the inception of the TOP programme. This notion is confirmed by Nandipha (2008:14)
who asserts that the programme allowed women to bare children they could afford to raise. In this study, most of the participants stated that the programme, even though not confirmed, has contributed in the reduction of child abandonment:

TOP facility manager 1: “Putting a live baby in the pit toilet or leaving the baby in a plastic bag on the road to be crushed by cars ...unimaginable...., that’s cruelty....,”

TOP facility manager 3: “In the past, in some instances terrible things would be reported...,like..., you would read about dogs found pulling the remains of foetuses in the streets of informal settlements ..or.....,a baby’s body found at the dumping site..., So I feel in a way that TOP services prevent these shocking things.”

Sub-category 5.4.3: Reduction in crime

The participants felt that crime would be reduced if women accessed the TOP programme as they would be able to take care of their children and only have children they could afford to raise. According to the participants:

TOP service provider 3: “Crime will be reduced ... and I can say a healthy community, with no street kids, drug abuse and also abuse of alcohol, will finally happen.”

TOP service provider 4: “And children will receive the love they deserve and there won’t be street kids and juvenile delinquents.”

Sub-category 5.4.4: Preservation of marriage

A pregnancy brings about a huge change in the lives of couples as they have to plan the costs for providing supplies for the baby and how income generation will be maintained during maternity leave if both parents are employed. In some instances it may also mean creating more space for the additional person to come. Unplanned pregnancies may create tensions in families. According to the participants:

TOP facility manager 1: “The rate of divorce is reduced as some of the families were destroyed by the fact that women had unwanted pregnancies.”
TOP service provider 1: “One woman came to me to say, ‘Sister, you really protected my marriage because of the … TOP..., my husband did not want me to fall pregnant....”

TOP facility manager 4: “It preserved their lives and fertility because the person who comes for the treatment of septic abortion may be infertile at the end and not having children..., and this..., might ..., spell an end of a marriage.”

Sub-category 5.4.5: Prevention of unwanted pregnancies

South African women had a right to obtain a legal abortion since 1975. However, by its rigidity, the Abortion and Sterilization Act, 2 of 1975 tended to prohibit the TOP regardless of reasons (Morroni et al 2006:1-5; Ratlabala et al 2007:26). The said process further made it impossible for most women, especially black women, to get permission for the abortion to be effected within the recommended period (Engelbrecht, Pelser, Ngwena& Van Rensburg 2000:5). In this study, the participants indicated that the TOP programme reduces the rate of unwanted pregnancies:

TOP service provider 5: “Women will carry to term only the pregnancies that they want or planned.”

Category 5.5: Respect for Constitutional rights of TOP health care consumers

Potgieter and Andrews (2004:25) and Mhlanga (2005:39) maintain that assisting women with TOP is one of the fundamental human rights of women to express their choice in procreation.

Sub-category 5.5.1: Restoration of fundamental human rights of reproduction

The participants maintained that not only were they assisting patients to exercise their right to choose, they were also providing support in the realisation of the constitution of the country. Even though procuring abortions was not one of the best tasks that people can do for a living, TOP service providers and TOP facility managers were excited by the fact that they are contributing to the transformation of the country by implementing this controversial piece of legislation.
TOP service provider 7: “Their reproductive health is controlled by them,... This is self-determination.”

TOP service provider 2: “It’s a choice that one has to consider.”

TOP service provider 3: “Our women are self-empowered because they know their rights.”

TOP service provider 4: “And more and more people are from outside the country, Swaziland, Mozambique and Zimbabwe. They are flocking here in big numbers. But what can we do, we just help them, as they have the right to access health services?”

TOP service provider 5: “It has empowered women. They can now decide what is suitable for them regarding child bearing.”

Section 12 (2)(a) of the Constitution supports the right to make decisions concerning reproduction (South Africa [Republic] 1996b:5-7). DENOSA (1997:6, 26) stipulates that nurses have to respect the pregnant woman’s right to freedom of choice and maintenance of dignity; for example not to judge the woman in terms of her choice to terminate the pregnancy, and not to unduly influence her to change her mind. Because of the liberal law of TOP in South Africa, people from neighbouring countries like Swaziland, Mozambique and Zimbabwe come to South Africa to procure abortion (Ngwena 2004:711). The fact that TOP services is rendered free of charge and with the privacy it requires, contributes to the people from across the borders flocking in for the service.

Furthermore, the right to freedom of conscientious objection allows health workers to also express a choice and as such these may not be coerced to participate in the termination of pregnancies (DENOSA 1997:6, 26). This is expressed in the following statements:

TOP facility manager 2: “You cannot force them (health workers) if they don’t want to participate..., It is also their choice..., they (health workers) are just exercising their right to conscientious objection without infringing on other people’s rights.”
Therefore in Mpumalanga, where the study was undertaken, health care workers were not compelled to participate in the actual procurement of TOPs, an aspect that compromised the human resources in the TOP units.

**Conclusions on benefits of TOP programme: Theme 5**

In this theme, the participants speculated on the benefits without attributing these to the programme under discussion. There were:

- **Financial benefits to the government and to individuals.** In the case of the government, participants stated that before the inception of the programme the government spent an estimated amount of R18 million towards treating backstreet abortion cases; but they could not say if the government was now paying less. Similarly there was a feeling among participants that the population growth may with time be reduced, street children may also decrease thus saving the government money for the provision of other services to a large number of people. For individuals, there was a feeling that the numbers of children born to a family will be determined by affordability and mothers can only proceed with a pregnancy to term if they so choose.

- **Even though there was no proof, psychosocial benefits were stated as improved relationships including a decrease in the divorce rates as unplanned and unwanted pregnancies can be dealt with in a professional manner.** The counselling that is provided ensures that any psychological effect of the termination of pregnancy is attended to promptly and professionally.

- **Health benefits were cited as availability of a professional services where the women’s reproductive health is maintained because the complications of abortion, such as haemorrhage, sepsis, infertility and death were eliminated** (participants were not able to provide figures to support this claim). In the TOP programme services are free of charge and the holistic approach extends these to other related services such as contraception and counselling making these affordable and accessible to every woman in the country.
Self determination in the TOP programme is supported constitutionally thus instilling confidence in women who choose to terminate a pregnancy. They therefore are not at risk of being indecently treated as murderers as they do not have to dump babies in toilets, die from complications of abortion such as haemorrhage and sepsis and their human rights are respect unconditionally when they access professional TOP services.

Recommendations

Based on the narratives presented by participants, it is recommended that:

- Campaigns about the TOP programme should be intensified, where women and the community should be informed about the benefits of the programme to increase participation.
- Further research be conducted to support the claims made above.

4.4 CONCLUSION

This chapter presented and discussed the research findings supported by the literature reviewed. The findings were divided into themes, categories, sub-categories which were supported by meaning units. Conclusions and recommendations were provided on each theme. Records on utilisation of the units based on attendance were reviewed. Order books were also reviewed as part of the records to determine the number of packs supplied daily in each unit, and this provided an indication of the number of TOPs which could be performed each day. An evaluation of the TOP programme could be made based on the findings deduced from participants’ narration. From the study findings, the TOP service providers and TOP facility managers were found to have a good understanding of the content of the Act. The findings indicate further that the TOP service providers and TOP facility managers were not integrating all the applicable legislation in the implementation of the CTOP Act. For example, TOP service providers and TOP facility managers did not know about the MTOPIP framework and they also did not know how the Nursing Act, 33...
of 2005; the Health Act, 61 of 2003; the Medical and Dental and Supplementary Health Service Professions Act, 56 of 1974; the Medicines and Related Substances Act, 101 of 1965, as amended, and others applied in their functioning as nurses. Neither did they know how Regulation 2598 of 1984, as amended on the Scope of Practice of Persons who registered and enrolled under the Nursing Act; Regulation 888 of 1987, as amended on the Acts and Omissions in respect of which the South African Nursing Council may take disciplinary steps; Regulation 2488 of 1990 on the Regulation relating to the conditions under which registered midwives and enrolled midwives may carry out their profession, and Regulation 2418 of 1984 relating to the Keeping, Supply, Administering or Prescribing of Medicines by Registered Nurses impacted on the implementation of the CTOP Act in the TOP programme.

The implementation of the CTOP Act requires the integration of all legislation that impacts on TOP service delivery. The lack of knowledge that was displayed compromised the nursing practice thereof as observed in the provision for pain control in procuring abortions. The TOP service providers did not administer pain medications.

From the experiences of participants, the TOP programme provided an important service which, of importance, allowed women to exercise their human right to choose whether to have a baby or not, should they find themselves pregnant. In that way, the programme, within the IMPE, addressed a social need which was identified by the government in relation to legally restrictive measures which did not allow for free access in the termination of pregnancy. The programme aimed at empowering women, by enhancing their self-determination in the expression of their human right to choose whether to carry a pregnancy to term or not based on their socio economic status. The implementation of the programme was also aimed at curbing government expenditure which was estimated at R18million incurred in the treatment of unsafe termination of pregnancies (DOH 2005:19; MDOH 2009:19). To address the identified need, the programme was designed such that it provided not only for the termination of pregnancies but for all the other supporting services such as information sharing, physical assessment, counselling and family planning.
In the study, information sourced from participants indicated lack of support from authorities, whereupon there were very few nurses to offer the services and doctors did not participate because there was no recognition attributed to service providers. This resulted in gross staff shortages. The resources in terms of supplies and instruments were lacking and participants reported having to use experience to make diagnoses because there were no scans and monitors, an aspect that often caused them to suffer emotionally when an abortion was performed on an older pregnancy because foetal parts could be identified. The lack of supplies also resulted in the low TOP statistics in the province as only a few terminations could be performed in accordance with available TOP packs.

In line with the participants’ narratives, the TOP programme was important and necessary. The programme was making a difference, albeit small; but it was difficult to quantitatively report on this as record keeping in the province was poor. For example, there was a report that stated that 15% of the health professionals were trained in TOP, but there was no records of who, when and where were these trained and located. Only eleven (11) trained TOP service providers were said to be in the seven (7) active facilities (see tables 1.4, 3.6 and 3.7) and only eight (8) of these were active at the time of investigation. No further detail could be provided about these TOP service providers.

This then concluded phase 1 of the study, which focused on the evaluation of the impact of the TOP programme in Mpumalanga.

Phase 2 focused on the development of guidelines to assist in the translation of the CTOP Act to action at service level. The conceptualisation of the TOP programme is based on the understanding of the content of the CTOP Act (92 of 1996), as amended. Chapter 5 discusses the guidelines developed to assist in the translation of the CTOP Act to action at service level.
Chapter 4 discussed the findings of the study with reference to the literature reviewed. This then concluded phase 1 of the study, which focused on the evaluation of the impact of the TOP programme in Mpumalanga. This chapter discusses phase 2 of the study, which focused on developing guidelines to assist in the interpretation of the content of the CTOP Act (92 of 1996) as amended and its implementation. The findings formed the basis for the development of the guidelines. These guidelines were developed not only for consideration by the MDOH authorities but also for the National Department of Health (NDOH). The reason for this is that table 1.1, although projecting 2005 data, indicates slow implementation of the programme nationally (see chapter 1).

5.2 GUIDELINES FOR THE INTERPRETATION AND IMPLEMENTATION OF THE CTOP ACT (92 of 1996), AS AMENDED

Guidelines are “systematically developed statements to assist practitioners and clients to adopt appropriate healthcare practices for specific clinical circumstances” (Monama 2009:127). In this study the researcher regarded guidelines as protocols that guide TOP service providers in the interpretation and implementation of the CTOP Act (92 of 1996) as amended and its implementation. The protocols are referred to as practice guidelines. Stanhope and Lancaster (2000:533-535) describe practice guidelines as “a set of patient care strategies developed to assist in clinical health care disciplines”. The guidelines vary and are framed such that they consider the clinical speciality and the uniqueness of the circumstances thereof. Therefore, the practice guidelines developed in this study are not intended to replace existing standards and protocols in health care services. Rather, they are intended to support TOP service providers and TOP facility
managers as well as TOP health care consumers to ensure maximum provision and use of services, respectively.

5.2.1 Strengths of guidelines
Thompson and Dowding (2002), Todd, Biskupik and Weingarten (1998) as well as Sidumo (2005) as cited in Monama (2009:128) state that guidelines in healthcare setting have a number of strengths when applied properly. For example, guidelines
- lead to the improvement in both the structure, process and outcomes of care
- synthesise evidence into clear recommendations for practice and thereby help to overcome some practical difficulties faced by practitioners in clinical areas
- attempt to improve the quality of clinical decision making and implementation of those decisions in health services
- have the power to reduce inappropriate variability in decision making and implementation of care plans
- describe appropriate practice-based scientific evidence and broad consensus
- reduce inappropriate variation in practice
- provide a focus for continuing nursing education
- promote the efficient use of health care resources
- act as a focus for quality control, including audits (Monama 2009:128).

5.2.2 Purpose of guidelines
Guidelines serve as a quality-improving strategy to support decision making within organisations. Guidelines provide for good planning as they outline what is to be done, how, by whom, when and why (Mkhonta 2008:153).
In this study, the purpose of the guidelines was to
- provide a framework for TOP service providers in TOP facilities in the interpretation and implementation of the CTOP Act, 92 of 1996
- provide the framework for the support of TOP service providers by TOP TOP facility managers
• improve quality of patient care by providing protocols for continuous value-clarification workshops to assist nurses with a negative attitude to TOP service provision
• create a positive practice environment for TOP service provision in designated settings
• provide direction to TOP facility managers in their supervision and guidance of TOP service providers to ensure service sustainability.

5.3 DEVELOPMENT OF GUIDELINES

The process followed in this study for the development of the guidelines included logical reasoning.

Logical reasoning is the “processing and organisation of ideas to reach a logical conclusion” (Mkhonta 2008:152). Polit and Beck (2008:13) add that logical reasoning combines experiences, intellectual faculties and formal systems of thought in solving prevailing problems. It includes two systems of reasoning, namely inductive and deductive reasoning. These were used in the formulation of the guidelines.

Inductive reasoning is a process that starts with the details of the experience and moves to the general picture of the phenomenon to provide a highly probable conclusion (Polit & Beck 2008:13). The researcher used inductive reasoning to draw conclusions from the findings of phase 1 and then summarised and combined these conclusions to form one concluding statement under each theme.

Brink et al (2006:6) point out that the deductive reasoning process starts from a general premise to a more specific situation. In the context of this study, as guidelines were developed from the conclusions, recommendations were developed from the concluding statements and enriched with relevant literature.

Furthermore, the conceptual framework on IMPE as presented by De Vos et al (2006:369) was used as the basis for the development of guidelines. The researcher
believed that in order to support TOP health care consumers to effectively utilise TOP services, TOP service providers needed to provide quality TOP services in well managed facilities. Th guidelines need to address the stages of the IMPE which are:

**Needs assessment:** This phase, as indicated earlier in chapter 1, indicated that the TOP programme was aimed at providing professional services in the termination of pregnancies in order to curb the morbidity and mortality related to unsafe termination of pregnancies. The study also set out to assess the need for the knowledge of the content of the CTOP Act as well as other legislation including MTOPIP which would support the TOP programme.

**Conceptualisation and design of the programme** followed the understanding of the needs and how these will be met. These include the way the TOP programme is designed in South Africa as informed by the CTOP Act. The TOP programme is designed such that it provides for information session regarding termination of pregnancy, Counselling before and after procurement of TOP, basic nursing care before and after TOP and pregnancy prevention and family planning services.

**Implementation of the programme** was guided by the objectives and expected outcomes as outlined in the CTOP Act. Thus, in the current study, the researcher identified the activities to be undertaken to translate the Act into action, the challenges related to the implementation of the programme such as human and material resources challenges, infrastructural challenges, stigmatisation of TOP services, uneven distribution of TOP services, insufficient knowledge of legislation supporting CTOP Act, insufficient knowledge of CTOP Act by the community, lack of managerial support to TOP service providers as well as lack of support of TOP services by health workers not involved with TOP provision and community members. Insufficient funding of TOP programme was also identified as a challenge in the implementation of the programme.

**Impact and efficiency assessment.** The study evaluated the effectiveness and the efficiency of TOP programme. This was done based on the TOP health care
consumers’ lived experiences and feelings regarding TOP services received. TOP service providers and TOP facility managers reflected their knowledge of the content of CTOP Act as well as the experiences in the provision of TOP services. Furthermore, the records indicated the utilisation of the TOP services. The guidelines were developed based on data elicited from the above aspects, to make the implementation possible.

5.4 PRESENTATION OF THE GUIDELINES

The guidelines presented here are a synthesis of conclusions drawn from the findings in chapter 4 and are not necessarily in line with the stages of the IMPE. Applicable conclusion statements were identified and summarised from various categories and sub-categories to support the recommended activities in the guidelines.

5.4.1 Theme 1: Knowledge of the legislation that regulates TOP practice

Two guidelines were developed from this theme. The first was to build capacity amongst TOP service providers and TOP facility managers on legislation relating to TOP. The purpose of this guideline is to address the gaps identified in the TOP service providers’ and TOP facility managers’ knowledge of legislation that regulates the provision of TOP services. The second was to promote community understanding of the CTOP Act, 92 of 1996, as amended.

Box 5.1: Summary of conclusions on the knowledge of the Acts that regulate TOP practice

- All the participants were fairly knowledgeable of the operational content of the Act, CTOP Act, 92 of 1996 as amended, but aspects not known were critical to their functioning in the unit. Thus:
  - some did not know the title of the Act.
  - all did not know that the amended Act required registered nurses (not only midwives) to be trained to procure abortions.
- They did not know other legislation such as the Nursing Act, 33 of 2005, the National Health Act, 61 of 2003 and the MTOPIP which support the TOP provision.
Guideline 1: Maximise the knowledge of legislation that regulates the provision of TOP services

It is envisaged that this guideline will improve TOP service providers’ and TOP facility managers’ knowledge of legislation that regulates the provision of TOP services.

Recommended activities and procedures for the implementation of the guideline

- Lobby for the integration of TOP training into the existing health care programmes to increase the human resource capacity in that area of practice.
- Provide continuing TOP education to TOP service providers and other health care workers.
- Provide information on the CTOP Act (92 of 1996) and its amendments to ensure up-to-date application and implementation of the Act.
- Conduct workshops on other related legislation, such as the National Health Act, 61 of 2003; the Nursing Act, 33 of 2005; nursing regulations, particularly R2488 of 1990 relating to the Practice of a Midwife, R2418 of 1973 relating to keeping, supplying, administering or prescribing of medicines by registered nurses, R2598 of 1984 as amended relating to the Scope of Practice of Nurses and Midwives, and other legislation such as the South African Constitution Act, 108 of 1996, the Children's Act No.38 of 2005 and the Human Tissue Act.
- Provide scenarios on how the legislation integrates with the CTOP Act and how the integrated whole impacts on TOP practice and service provision.
- The Mpumalanga Termination of Pregnancy Implementation Policy (MTOPIP) should be introduced and integrated into the interpretation of CTOP Act, 92 of 1996, as amended and the provisions of this policy to be inherent in the provision of TOP services.

Guideline 2: Promote community understanding of the CTOP Act and its implementation

This guideline explains the purpose of the CTOP Act to community members to promote utilisation of TOP units to realise the impact of the TOP Programme.
Recommended activities and procedures for the implementation of the guideline

- Design and promote roadshows and campaigns about gender issues, human rights, self-determination and women’s health.

5.4.2 Theme 2: Health considerations

This guideline provides mechanisms to address physical pain during the TOP process and promote emotional and spiritual stability for both TOP service providers and TOP health care consumers.

Box 5.2: Summary of conclusions related to health considerations

- TOP service providers experienced emotional and physical exhaustion during the execution of their duties,
- TOP health care consumers experienced pain and discomfort during the TOP procedure.
- Both TOP service providers and TOP health care consumers felt regret, self-blame, guilt, and anger about the decision to terminate pregnancy.
- Both TOP service providers and TOP health care consumers experienced emotional and religious challenges related to the provision and procuring of TOP services, respectively.

Guideline 3: Promote emotional, physical and spiritual comfort in the provision of TOP services

This guideline addresses the gaps identified in the maintenance of quality of life during TOP services provision. It is envisaged that this guideline will improve the quality of life for both TOP service providers and TOP health care consumers.
Recommended activities and procedures for the implementation of the guideline

➢ To control TOP health care consumers’ pain:

- Encourage TOP health care consumers to come for TOP in the early stages of pregnancy.
- Provide professional psychological support to TOP health care consumers when they present for TOP services.
- Use appropriate instruments for TOP.
- Develop protocols that include appropriate drugs for pain relief; for example,
- Administer non-steroidal anti-inflammatory drugs (NSAIDs) like Ibuprofen 200mg and where necessary with codeine 30-40mg (Stevens 2010:36; MTOPIP) as recommended in the MTOPIP

➢ To prevent TOP service providers’ physical exhaustion:

- Decentralise TOP service provision to PHC level for better distribution of clients in the facilities.
- Increase the number of trained and motivated TOP service providers to maintain a good provider:client: ratio. This will reduce TOP service providers’ fatigue.
- Develop a retention strategy for TOP service providers to keep them in the service to address human resources shortages and reduce fatigue and burnout.
- Conduct regular debriefing sessions for TOP service providers.
- Draw up the duty roster so that it takes into consideration the emotional strain and provides enough rest (rest days and holidays) for TOP service providers.
- Rotate TOP service providers to other departments so that they can feel part of the general stream and keep in touch with the care of other patients.
- Classify TOP service provision as a speciality and scarce skill and remunerate providers accordingly. This will motivate staff to participate in the TOP programme and would promote retention thereof.
To relieve TOP health care consumers’ guilt feelings:

- Empower women with knowledge of their reproductive health rights to reduce the feeling of blame and guilt for their actions.
- Provide value-clarification workshops to communities and religious groups to lessen the spiritual feeling of guilt in TOP services.

To relieve TOP service providers’ guilt feelings:

- Provide value-clarification workshops to TOP service providers to reduce the spiritual feeling of guilt.
- Provide regular debriefing sessions by professional psychologists.
- Acknowledge good work done by TOP service providers by means of incentives, such as good reports, positive performance appraisals and promotions.
- Lobby for awards for the best TOP service provider of the year at institutional and provincial level.

5.4.3 Theme 3: Support systems for TOP service providers and TOP health care consumers

This guideline provides mechanisms to strengthen support systems for TOP service providers and TOP health care consumers.

Box 5.3 Summary of conclusions on support systems

- Clients using TOP services experienced that some of the TOP service providers had a positive attitude towards the provision of TOP services.
- TOP service providers reported a limited support from staff members who are not involved in TOP service provision.
- There was also a feeling that the public does not support TOP services.
- TOP service providers experienced lack of support from management and provincial government authorities.
- TOP facility managers did not advocate on behalf of the TOP service providers.
- The programme was not marketed well by health authorities.
Guideline 4: Provide support to TOP service providers and TOP health care consumers in the provision and reception of TOP service respectively

The purpose of this guideline is to strengthen the support to TOP service providers and to TOP health care consumers in providing and receiving the TOP service respectively.

Recommended activities and procedures for the implementation of the guideline

- **Measures to promote managerial support for TOP service providers**
  - Managers should do on-site supervision of TOP service providers on a regular basis.
  - Support and encourage initiatives that support TOP service providers to optimise the service.
  - Conduct value-clarification workshops to address existing negative attitudes, dispel myths about TOP, and separate personal and professional values that health care providers should have.
  - Acknowledge and reward good TOP service provision at institutional level.
  - Deal assertively with negative behaviour which impacts negatively on the quality of TOP service provision in the institution.
  - Provide for continued and inservice training and education for capacity building for TOP service providers in the form of refresher and certificate courses.
  - Create a mentoring programme to support TOP service providers.
  - Provide adequate equipment, supplies and space for TOP service provision.
  - Provide enough budget for TOP services to support the implementation of the TOP Programme.
  - Provide enough rest (rest days and holidays) for TOP service providers.
Measures to promote TOP service providers’ support to TOP health care consumers

Recommended activities and procedures for the implementation of the guideline

- Deal assertively with negative behaviour which impacts negatively on the quality of TOP service provision in the institution.
- Conduct value-clarification workshops on a regular basis until most health care workers accept the service. This will thus enhance support to the TOP health care consumers.
- Educate health care workers regarding the provisions of the CTOP Act.
- All health care workers should support TOP service provision, understand human rights and self-determination.
- Provide for continued and inservice training and education on the rights of individuals on a regular basis.
- Encourage health care workers to approach TOP in a non-judgemental manner.
- Encourage health care workers to treat women seeking TOP with respect and dignity.
- Introduce protocols that indicate referral pathways to facilitate utilisation of services.

Measures to promote support for TOP services by the public

Recommended activities and procedures for the implementation of the guideline

- Design and promote roadshows and campaigns about gender issues, human rights, self-determination and women’s health.
5.4.4 Theme 4: Challenges in the provision of TOP services

This theme deals with the TOP service providers, TOP facility managers and TOP health care consumers’ challenges regarding TOP services.

Box 5.4 Summary of conclusions related to challenges in the provision of TOP services

- Lack of support for TOP programme by the Mpumalanga Provincial government based on challenge mentioned below:
  - There is shortage of staff to provide TOP services.
  - Designated facilities are few and centralised in hospitals and TOP services are not provided for at community clinic level.
  - Staff in TOP units is often deployed to the general wards.
  - There are no strategies in place to retain TOP service providers.
  - There is lack of incentives to providers of TOP services.
  - The infrastructure for TOP services is inadequate.
  - There is a lack of equipment to enhance quality TOP service provision.
  - The budget for TOP programme is limited.

- Personnel not working in TOP units have a negative attitude towards TOP service providers and services.

- TOP service providers feel that they are stigmatised.

- The public does not support TOP services.

Guideline 5: Address the challenges in the provision of TOP services

This guideline provides measures to put in place to address challenges in the provision of TOP services.

- Maximise staff distribution in TOP services

The following measures should enhance effective provision and utilisation of staff in TOP units.
Recommended activities and procedures for the implementation of the guideline

- Create and maintain a database of trained and practising TOP service providers so that these can be distributed fairly in the active TOP units to comply with the staffing stipulations as outlined in the MTOPIP.
- Increase the number of trained TOP personnel in the province.
- Investigate the reasons why trained TOP service providers are not practising in TOP units and tackle issues that impact on their practice.
- Provide emotional, spiritual and physical support to TOP service providers.
- Provide relevant equipment, supplies and space for effective and efficient service provision.
- Introduce protocols and orientate TOP service providers to protocols to maximise service provision.
- Indicate referral pathways and orientate staff on this to facilitate access to TOP services.
- Management should consider the TOP programme as one of the priority programmes in reproductive health and provide the necessary budget to support it.
- Educate practitioners on the benefits of TOP and emphasise its integration.

➢ Develop a staff retention strategy
The implementation of this strategy should enhance the retention of TOP service providers.

Recommended activities for the retention of TOP service providers

- TOP service providers should be debriefed monthly and whenever indicated.
- TOP facility managers should do on-site supervision in TOP facilities on a regular basis.
- Good work done by TOP service providers should be acknowledged by means of incentives. These could include positive written reports, positive performance appraisals that would lead to monetary gains and promotions to senior levels within the practice. Monetary gains could assist in addressing the human
resources shortages as it was reported that doctors are not participating in TOP services provision in the hospital because there is no specific dispensation for TOPs

- The provincial government should recognise TOP service and provide relevant remuneration allowances for those trained in the practice.
- TOP service providers should be rotated to other departments to give them a break from the stressful practice.
- Periodic inservice training should be done on newer and more efficient procedures as well as legislation that impacts on TOP service provision.
- Develop facility-specific interventions to support TOP service providers.
- Create a mentoring programme to support TOP service providers.
- Establish TOP service provider care groups.
- Increase the human resources capacity in TOP units.
- TOP facilities should be well equipped with necessary equipment to enable TOP service providers to make the necessary correct diagnoses and perform the expected activities with relevant ease.
- Stress management workshops should be held on a regular basis for TOP service providers, to enable them to cope with stressful situations.
- Staff support meetings should be held bimonthly while provincial staff support meetings could be held monthly.

➢ Provide financial and material resources for TOP services

An adequate budget is key to the successful provision of TOP service.

Recommended activities for provision of finance and material resources

- Ensure that the budget allocation is adequate for planned activities.
- Develop a business plan which details activities and funds anticipated for those activities.
- Do secondary research to include TOP service costing into the findings.
- It is important to put financial tracking mechanisms to ensure proper utilisation of funds and avoid over- or underspending.
- Develop an advocacy strategy involving key role players, including the trade unions to support the budget increment.
- Lobby with relevant policy makers to support the funding of TOP services.
- Form partnerships with pro-choice non-governmental organisations to support budget advocacy.

➢ **Promote decentralisation of TOP services**

According to Guttmacher, Kapadia, Te Water Naude and De Pinho (1998:940) decentralisation of TOP services would enhance the accessibility and provision of TOP services to all.

**Recommendations on how TOP services can be decentralised**

- TOP services should form an integral part of reproductive health service and as such all clinics offering 24-hour services should provide TOP services because at present these services (TOP services) are only in hospitals.
- Provide a well-defined referral system for TOP services and other related services, eg, psychological services.

➢ **Promote utilisation of TOP services**

Utilisation of services can only be measured by the number and rate of attendees and attendances at the units respectively. As TOP service is central to reproductive health, patronising these facilities is also a measure of self-determination for women in the province.

**Recommendations for the promotion of utilisation of TOP services**

- Empower women and the community with knowledge on reproductive choice as a fundamental human right.
- Integrate the TOP information in all health promotion events; eg, contraception use, child birth and care, and other youth services.
- Increase community understanding of legislation, including the Constitution of South Africa and the CTOP Act, and how health professionals function.
• Utilise the media, including television, the radio and newspapers, to disseminate information on TOP services and where these can be accessed.
• Influence positive reporting on TOP services and reproductive choice issues, such as positive steps by government to save women’s lives.
• Arrange value-clarification workshops for the community periodically to assist in a change of perceptions.
• Involve key figures in the community to advocate for TOP services.
• Decentralise TOP services to clinic level to increase and enhance accessibility.
• Increase measures to ensure confidentiality during TOP service.
• Encourage ongoing capacity building for health professionals in relation to TOP services and how these are to be offered, such as the realisation of individuals’ Constitutional right to reproductive choice and health information, respect for clients and confidentiality.
• All health facilities designated to offer TOP services should display the programme as part of the services provided to the community in that facility.
• Promote TOP advocacy among professional groups.

5.5 CONCLUSION

This chapter discussed the development of guidelines to support the implementation of TOP services based on legislation. The guidelines were developed, described under themes identified from the findings in chapter 4. Recommendations for the implementation of the guidelines were also outlined. The guidelines addressed yet another need, that of supporting TOP service providers to provide quality professional TOP services

Chapter 6 concludes the study. It briefly discusses its limitations, and makes recommendations for future research.
6.1 INTRODUCTION

The purpose of the study was to evaluate the impact of the TOP programme in South Africa, using Mpumalanga Province as the focal area, and to develop guidelines to assist service providers in the implementation of the CTOP Act, 92 of 1996. The study was conducted in two phases. Phase 1 focused on the evaluation of the impact of the TOP programme in Mpumalanga. The objectives were to

- explore and describe the experiences and feelings of TOP health care consumers in accessing the TOP service at the designated facilities
- explore and describe the knowledge of TOP service providers and TOP facility managers regarding the CTOP Act (92 of 1996) as amended
- explore and describe the experiences and feelings of TOP service providers and TOP facility managers regarding TOP service provision
- review records of attendance to determine utilisation of the TOP services

Phase 2 focused on the development of guidelines to assist in the translation of the CTOP Act to action at service level. The objective was to

- develop guidelines to assist in the interpretation of the CTOP Act (92 of 1996) and its implementation

The data collected in phase 1 was used to develop guidelines envisaged to translate policies and legislation into action.
A qualitative, quantitative, contextual, explorative, descriptive and case study research design was used to
• describe the knowledge TOP service providers and TOP facility managers had about the CTOP Act and other supporting legislation in the provision of TOP services
• explore and describe the experiences and feelings of TOP service providers and TOP facility managers in providing TOP services as well as the experiences and feelings of TOP health care consumers in receiving TOP services, in Mpumalanga Province.

The IMPE (De Vos et al 2006:370) was used as the conceptual framework for the study (see chapter 1, figure 1.1). Increased morbidity and mortality due to unsafe termination of pregnancies were identified as social problems necessitating the introduction of the TOP programme. The programme is designed based on the CTOP Act, 92 of 1996, which was promulgated to facilitate the women’s right to choice on reproduction and whether to have a child or not. Where the choice is not to have a child, abortion, according to CTOP Act, can be conducted legally in a safe and controlled environment. Accordingly, the TOP programme was initiated in 1996. The programme specifies the nature of services to be provided to whom, by who, when, where, how and with what.

The impact of the programme was assessed:
• Quantitatively, in terms of utilisation of services as outlined in the numbers of those providing the service and those receiving the service, availability of equipment and the organizational structure.
• Qualitatively, in terms of experiences, feelings and attitudes of those providing and receiving TOP services

The implementation has been slow and the current study provides the first evaluation of the programme in Mpumalanga Province since its inception.

6.2 CONCLUSIONS OF THE STUDY
The discussions that took place in Addis Ababa regarding reproductive health revealed that effective action to end the scourge of unsafe abortion requires an integrated
approach and an involvement of all sectors of society (Brookman-Amissah 2004b:12). It is concerning that newspaper, The *Daily Sun* (2008:13), still carry reports on backstreet abortions performed in places such as the “hospital of horror”. The newspaper reported on abortions performed in squalor using dangerous instruments such as wires, glass and tins with no running water. The newspaper reported the place as horrifying and although the people who kept this place were arrested and the place demolished as indicated in the newspaper, it had taken very long for the community to react. From the blood stains on the floor, walls and bed it was obvious that the termination of pregnancies undertaken in this place were not provided in a dignified manner. The processes followed infringed on the rights of the individuals who received the service. It is imperative that in the termination of pregnancies, dignity and respect of person are maintained.

The study found that although TOP service providers and TOP facility managers were familiar with the content of the CTOP Act and the services were rendered in a professional manner, the impact of the programme was minimal, because:

- There is stigma attached to those participating in the programme in terms of providing and receiving the service.
- Minimal utilisation was due mainly to:
  - Few service providers. Although the report from the Department of health indicated Mpumalanga Province having trained 15% of its health personnel for TOP provision, at the time of investigation only eleven (11) TOP service providers could be identified and only eight (8) were active in the three districts.

The findings also indicated that nurses were the only category providing TOP services because the services were not incentivised. Doctors referred clients to their consulting rooms where they charged a fee, thus reducing numbers which come to the designated facilities.

The distribution of the few TOP service providers in line with the distribution of active designated facilities also impacted negatively on the TOP programme because the referral system was not consistent and women had to travel long distances to access TOP services.
- Lack of equipment and supplies. This resulted in only a few TOP health care consumers being attended to at a time. The findings indicated six TOP packs supplied for a day and this resulted in TOP health care consumers being sent away. It is the notion of TOP service providers that the clients sent back often did not come back and were lost to the facility.

- Lack of TOP facility managers’ support of TOP service providers was also expressed. The participants were of the opinion that the work they did went unrecognised as there were no obvious incentives; no effort was made to ensure adequate human resources and equipment to support their function, and no counselling programmes or debriefing sessions were organised for TOP service providers at service level. Furthermore, other personnel not involved in TOP service rendering viewed the TOP service providers as evil. Finally, the lack of space was a factor that to them indicated lack of support.

- The lack of knowledge about the Act in the community and therefore the lack of understanding of the existence of such stipulations of choice and self determination resulted in the community not supporting TOP services. Community members labelled those who procured Termination of pregnancies or received TOP services as murderers. Community members stigmatised both TOP service providers and TOP health care consumers.

The few positive responses were overshadowed by the many negative responses. From head office a few debriefing and counselling sessions were reported. Some of the TOP health care consumers applauded the TOP service providers because they were respectful, gentle, non-judgemental and assuring.

Furthermore, the participants applauded the TOP programme as contributing positively to improving the reproductive health of women, lowering the morbidity and maternal death rate, reducing child abandonment, and greatly preserving marriages even though they could not provide scientific proof about this.
6.3 LIMITATIONS OF THE STUDY

The researcher encountered problems in accessing relevant literature. Literature found tended to be old and this delayed the process of conducting the study. The record keeping in the province left much to be desired. Where available, this was inconsistent. The researcher found that the statistics available for TOP services at both provincial and national level were old. Moreover, no statistics on septic abortions were kept and the format of reporting TOP did not classify the abortions, thus acquiring categorised information was a limitation.

The researcher encountered problems in obtaining permission to conduct the research in the province. It took approximately eight months to obtain a written permission from the Provincial Ethical Committee. Thus data collection was delayed and this impacted negatively on the data-collection duration.

As the study was qualitative in nature, the sample size was small and in accordance with the qualitative research approach stipulations, the results cannot be generalised to the whole country, but the research process has a rich audit trail to allow for replication in similar situations.

6.4 RECOMMENDATIONS

Based on the findings, the researcher made the following recommendations to the nursing practice, education and research.

6.4.1 Nursing practice

It is recommended that a positive practice environment be established by:

- Providing an adequate number of trained TOP service providers distributed equitably in the districts and facilities in line with the staffing norms as indicated in the MTOPIP.
• Providing adequate and functioning equipment in all service points to enable TOP service providers to attend to everyone who requests TOP.
• Providing and encouraging on-going support of TOP service providers.
• Developing quality control indicators for TOP services.
• Providing adequate funds in line with the importance of the programme and the need as assessed in the community

6.4.2 Nursing education

Regarding nursing education, the researcher recommends the following:
• TOP training should be integrated into existing health care training programmes so that all health care providers are capacitated with the skill of terminating pregnancies. This will increase the number of trained TOP service providers and reduce reluctance to practise in TOP units as well as stigmatisation of those involved in TOP service provision.
• Training in TOP should cover appropriate levels of care, technology, drugs and quality of care.
• Regular refresher courses for different levels of providers to be conducted on different aspects of care including legislation that governs practice.
• Develop continuing educational programmes on TOP for nurses.
• Counselling should be inherent in the training for TOP.

6.4.3 Further research

The researcher recommends further research on the following topics:
• An examination of the best practice for recruiting, training and retaining TOP service providers.
• An investigation into the effects of unwanted pregnancy on the quality of life of families and communities.
6.5 CONCLUSION

This chapter outlined the final conclusions and the limitations of the study and made recommendations for nursing practice, education and research. It is envisaged that, if implemented, the guidelines developed from this study will improve the implementation of the CTOP Act, 92 of 1996 as amended as demonstrated in the provision of TOP services.
LIST OF SOURCES


DOH – see Department of Health.


MDOH - see Mpumalanga Provincial Department of Health


SABC see South African Broadcasting Cooperation.


Weitz, TA. 2010. Rethinking the Mantra that abortion should be “safe, legal, and rare” Journal of Women's History 22(3):161-172.

WHO – see World Health Organization.


ANNEXURE A

The Choice on Termination of Pregnancy Act, Act No. 92 of 1996 and amendments
THE PRESIDENCY

No. 213 18 February 2008

It is hereby notified that the President has assented to the following Act, which is hereby published for general information:—


AIDS HELPLINE: 0800-123-22 Prevention is the cure
GENERAL EXPLANATORY NOTE:

Words in bold type in square brackets indicate omissions from existing enactments.
Words underlined with a solid line indicate insertions in existing enactments.

(English text signed by the President.)
(Assented to 12 February 2008.)

ACT

To amend the Choice on Termination of Pregnancy Act, 1996, so as to amend a definition and to insert others; to empower a Member of the Executive Council to approve facilities where a termination of pregnancy may take place; to exempt a facility offering a 24-hour maternity service from having to obtain approval for termination of pregnancy services under certain circumstances; to provide for the recording of information and the submission of statistics; to enable a Member of the Executive Council to make regulations; and to provide for matters connected therewith.

BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:—

Amendment of section 1 of Act 92 of 1996

1. Section 1 of the Choice on Termination of Pregnancy Act, 1996 (hereinafter referred to as the principal Act), is hereby amended—

(a) by the insertion after the definition of “gestation period” of the following definition:

"Head of Department’ means the head of a provincial health department;”;

(b) by the insertion after the definition of “medical practitioner” of the following definition:

“Member of the Executive Council’ means the member of the Executive Council of a province who is responsible for health in that province;”;

(c) by the substitution for the definition of “registered midwife” of the following definition:

“registered midwife’ means a person registered as such under the Nursing Act, (Act No. 50 of 1978) 2005 (Act No. 33 of 2005), and who has in addition undergone prescribed training in terms of this Act;” and

(d) by the insertion after the definition of “registered midwife” of the following definition:

“registered nurse’ means a person registered as such under the Nursing Act, 2005 (Act No. 33 of 2005), and who has in addition undergone prescribed training in terms of this Act.”;
Substitution of section 8 of Act 92 of 1996

4. The following section is hereby substituted for section 8 of the principal Act:

"Delegation"

8. (1) The [Minister] Member of the Executive Council may, on such conditions as he or she may determine, in writing delegate to the [Director-General] Head of Department or any other officer in the service of the State, any power conferred upon the [Minister] Member of the Executive Council by or under this Act, except the power referred to in section 9.

(2) The [Director-General] Head of Department may, on such conditions as he or she may determine, in writing delegate to an officer in the service of the State, any power conferred upon the [Director-General] Head of Department by or under this Act [or delegated to him or her under subsection (1)].

(3) The [Minister or Director-General] Member of the Executive Council or Head of Department shall not be divested of any power delegated by him or her, and may amend or set aside any decision taken by a person in the exercise of any such power delegated to [him or her] that person.".

Substitution of section 9 of Act 92 of 1996

5. The following section is hereby substituted for section 9 of the principal Act:

"Regulations"

9. The [Minister] Member of the Executive Council may, in consultation with the Minister, make regulations relating to any matter which [he or she may consider] it is necessary or expedient to prescribe for [achieving the objects] the proper implementation or administration of this Act.".

Amendment of section 10 of Act 92 of 1996

6. Section 10 of the principal Act is hereby amended by the substitution for subsection (1) of the following subsection:

"(1) Any person who—

(a) is not a medical practitioner, or a registered midwife or registered nurse who has completed the prescribed training course, and who performs the termination of a pregnancy referred to in section 2(1)(a);

(b) is not a medical practitioner and who performs the termination of a pregnancy referred to in section 2(1)(b) or (c); or

(c) prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy; or

(d) terminates a pregnancy or allows the termination of a pregnancy at a facility not approved in terms of section 3(1) or not contemplated in section 3(3)(a), shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years.".

Substitution of certain expression in Act 92 of 1996

7. The principal Act is hereby amended by the substitution for the expression "registered midwife", wherever it appears, of the expression "registered midwife or registered nurse", except in the circumstances contemplated in section 2(1)(c).
Substitution of section 3 of Act 92 of 1996

2. The following section is hereby substituted for section 3 of the principal Act:

"Place where termination of pregnancy may take place

3. (1) Termination of a pregnancy may take place only at a facility which—
   (a) gives access to medical and nursing staff;
   (b) gives access to an operating theatre;
   (c) has appropriate surgical equipment;
   (d) supplies drugs for intravenous and intramuscular injection;
   (e) has emergency resuscitation equipment and access to an emergency referral centre or facility;
   (f) gives access to appropriate transport should the need arise for emergency transfer;
   (g) has facilities and equipment for clinical observation and access to in-patient facilities;
   (h) has appropriate infection control measures;
   (i) gives access to safe waste disposal infrastructure;
   (j) has telephonic means of communication; and
   (k) has been approved by the Member of the Executive Council by notice in the Gazette.

(2) The Member of the Executive Council may withdraw any approval granted in terms of subsection (1)(k).

(3) (a) Any health facility that has a 24-hour maternity service, and which complies with the requirements referred to in subsection (1)(a) to (j), may terminate pregnancies of up to and including 12 weeks without having to obtain the approval of the Member of the Executive Council.

   (b) The person in charge of a health facility contemplated in paragraph (a) must notify the relevant Member of the Executive Council that the health facility has a 24-hour maternity service which complies with the requirements referred to in subsection (1)(a) to (j).

(4) The Member of the Executive Council shall once a year submit statistics of any approved facilities for that year to the Minister.

(5) Notwithstanding anything to the contrary in this Act, the Minister may perform any of the functions that the Member of the Executive Council may or must perform, if it is necessary to perform such function in order to achieve any of the objects of this Act ".

Amendment of section 7 of Act 92 of 1996

3. Section 7 of the principal Act is hereby amended—
   (a) by the substitution in subsection (3) for the words preceding the proviso of the following words:

   "The person in charge of a facility referred to in section 3 shall, within one month of the termination of a pregnancy at such facility, collate the prescribed information and forward it by registered post confidentially to the [Director-General] relevant Head of Department"; and

   (b) by the substitution for subsection (4) of the following subsection:

   "(4) The [Director-General] Head of Department shall—
   (a) keep record of the prescribed information which he or she receives in terms of subsection (3); and
   (b) submit to the Director-General the information contemplated in paragraph (a) every six months ". 
Transitional provision

8. Any facility designated in terms of section 3(1) of the principal Act prior to the commencement of this Act must be regarded as having been approved by the Member of the Executive Council in terms of section 3(1)(a) of the principal Act as amended by this Act.

Short title

9. This Act is called the Choice on Termination of Pregnancy Amendment Act, 2008.
MPUMALANGA PROVINCIAL DEPARTMENT OF HEALTH AND SOCIAL SERVICES

POLICY FOR THE IMPLEMENTATION OF THE CHOICE ON TERMINATION OF PREGNANCY ACT;
ACT 92 OF 1996, AS AMENDED

FOREWORD

7 YEARS ON: CHOICE ON TERMINATION OF PREGNANCY

The year 2008 marked 12 years of the passing of the Choice on Termination of Pregnancy Act, Act no 92 of 1996, a jubilee and 2 years for National Women’s Day in August, and 12 years for the implementation of the Constitution. As the MEC for Mpumalanga Provincial Health and Social Services, I commemorate with you in all these historical events by making available the provincial policy on the implementation of the Choice on Termination Pregnancy Act.

I acknowledge that my Department has failed women in Mpumalanga, as termination of pregnancy services has not been easily accessible. This policy aims to address the challenges that made the service inaccessible to those in need.

Let us be reminded that the CTOP Act affords women the right to safely terminate unwanted pregnancies and that it is the individual woman’s choice whether to terminate or keep a pregnancy. As health care providers we have to respect the woman’s right to choose an early legal and safe TOP. As rightfully stated in the Act as well as in the policy, no one should hamper access to TOP services.

I appeal to all my staff to make sure that this policy should not gather any dust in your drawers or be lost in your cabinets. Let us all take the initiative to familiarise ourselves with this policy. Let us all create a favourable environment for women who are faced with the challenge of terminating a pregnancy. One death from unsafe abortion is one death too many, we cannot afford to loose our sisters and mothers to back-street abortions.

I would like to remind the managers of all designated facilities that you have a duty to ensure that the facilities provide the service. We have a national target to reach, and that is: to have at least 70% of Community Health Centres providing the service by 2009. Your dedication and commitment are valuable in reaching the national goal. We all have a role in the prevention of maternal mortality from unsafe abortions.

While some health care providers may object to the provision of safe TOP services on the grounds of conscientious objection, a number of health care providers saw an opportunity for saving lives. I believe that the provision of services under the CTOP Act has not been an easy task. I would therefore like to congratulate all health care providers who stood against all the odds and went ahead and implemented a service of this kind. On behalf of all the women whose lives you saved I say “Thank you!”. It is you who have made the development of this policy a possibility.
However, I would like to take this opportunity to appeal to women in South Africa, not to use termination of pregnancy as a contraceptive method. Let us all, as South Africans, work towards creating a caring environment where women would have no need to terminate a pregnancy. It is our duty as a society to respect and care for one another.

I am looking forward to a day where no woman shall have an unplanned/unwanted pregnancy, and therefore, no need to terminate a pregnancy.

Mr F. MAHLALELA  
MEC for Health and Social Services  
Mpumalanga
ACKNOWLEDGEMENTS

The Mpumalanga Department of Health would like to extend their sincere gratitude to and acknowledge the efforts of all the people who contributed towards the development of our Provincial TOP Policy.

The members of the Provincial Task Team who worked tirelessly to produce this policy document:

Nonhlanhla Lubisi       Cheryl Nelson
Sparara Masinga          Thoko Ramachela
Nompumelelo Poyo        Vusi Tsenani
Judith Nkambule          Kholekile Mabunda

And the late Nana Nkomondela and Suzan Mhlanga both of whom passed away before they could see the fruits of their hard work, ladies you are sadly missed!

The Mpumalanga Provincial Management team would also like to extend their special thanks to Ms Siyane Marima from the MCWH directorate of the National Department of Health for sharing her expertise and giving us direction. We would also like to thank Mrs Mosotho Gabriel and Mrs Karen Trueman from Ipas South Africa for sharing their expertise as well as for Ipas SA's financial support for our policy development workshops and meetings. Sandra Mabila for her commitment, dedication and continuous support all done on voluntary basis.
ACRONYMS AND DEFINITION OF TERMS

ACRONYMS:

- CEO: Chief Executive Officer
- CBO: Community Based Organizations
- CTOPA: The Choice on Termination of Pregnancy Act No. 92 of 1996 as amended
- HIV: Human Immuno Virus
- AIDS: Acquired Immune Deficiency Syndrome
- HR: Human Resources
- MDHSS: Mpumalanga Department of Health and Social Services
- MVA: Manual Vacuum Aspiration
- NGO: Non Governmental Organization
- PEP: Post Exposure Prophylaxis
- PHC: Primary Health Care
- RH: Reproductive Health
- SANC: South African Nursing Council
- SRH: Sexual and Reproductive Health
- STI's: Sexually Transmitted infections
- TOP: Termination Of Pregnancy
- WHO: The World Health Organization
TERMINOLOGY:

'Counselling' means a socio-psychological advice provided to a patient/client
In preparation to administering or after the administration of a
TOP service

'Health Workers' means People who work in a health facility, who provide
health services or auxiliary services such as administrative, catering
and security staff.

'Health Professionals' means people who work in a health facilities or in a
private practices who in terms of the C.T.O.P Act are eligible to provide
T.O.P services which includes Medical Practitioners, Registered Nurses
and Registered Midwives. It excludes Enrolled Nurses and Enrolled
Nurse Auxiliaries.

'Patient/Client' means a person (female or male) at any age who
request service/consultation for T.O.P or counselling
1. **TITLE OF THE POLICY:**
This policy shall be known as the Termination of Pregnancy Implementation Policy (for Mpumalanga Province).

2. **PROBLEM STATEMENT**

The alarming rate at which unsafe and illegal Abortion was being practised over the years has caused untold human suffering with the result that a number of women died and sometimes developed sickness.

The study conducted by MRC in 1994 found that: 44, 686 women presented with incomplete abortions in public health facilities in SA.
State spent R18 700 000.00 on treatment of complications from backstreet abortions
Impact of safe TOP implementation reduced maternal deaths due to unsafe abortion by 91% nationally in 2006 (Maternal Deaths Notification Report)

They have also caused serious socio-psychological problems for women across the country and hence the deliberate and conscious decision by the National Government to develop means and ways of ensuring that these social ills are minimized and reduced.

Mpumalanga Province, like all other eight provinces could not be untouched by these illegal and unsafe practises. Because of its rural nature, there are obvious religious and cultural barriers that fuelled the secrecy around these practises for fear of being ostracised and marginalized.

The need to put into expression the Choice on Termination of Pregnancy Act thus became a real reality.

3. **BACKGROUND**

Since the promulgation of the CTOPA and its subsequent implementation in February 1997, the government took deliberate and conscious steps to support the Act by conducting National Values Clarification Workshops, the training of midwives to provide Termination of Pregnancy (TOP) services.

The government further designated health facilities for the provision of TOP services, developed a National Strategic Plan to guide the implementation of the Act and also instituted maternal death notification process, as a way of monitoring the maternal mortality rate from incomplete abortions and whether women were accessing the right to a safe legal termination of pregnancy under the Act.

Mpumalanga Province like all other nine Provinces in the country has had to make sure that this Act is a real living document that stands to provide women with rights and access to these essential services.

The Province has faced very specific challenges in relation to TOP service provision, resulting in only a few facilities providing the service. The Province is, however, working towards a well functioning reproductive health service characterized by adequate human and material resource allocation, quality services and supportive management.
4. **OBJECTIVE OF THE POLICY**

The Provincial TOP Policy is primarily for SRH service providers, TOP providers, managers, doctors, supervisors and trainers to facilitate the implementation of CTOPA in their institutions.

The policy will attempt to reduce the illegal terminations of pregnancies which have taken a number of lives and also increased serious reproductive hazards to women around not only the Province but the entire country.

The Policy will serve as a useful resource for other stakeholders in TOP service provision throughout Mpumalanga Province which will enable women to exercise their TOP choice safely and freely. The Policy will seek to link up the Sexually Assault Policy of the HIV and AIDS.

5. **AUTHORITY FOR DESIGNATION**

The Provincial MEC is mandated by the Minister to designate a facility as according to the TOP amendment Act No. 38 of 2004.

6. **CONSISTENCY WITH NATIONAL POLICIES**

6.1. This Policy is not developed in a vacuum. Prior to 1994 the widespread incident of illegal and unsafe abortion had been a concern in South Africa. The main objective of the CTOPA is to reduce maternal morbidity and mortality, as a consequence of unsafe and incomplete abortion.

6.2. The Choice on Termination of Pregnancy Act (CTOPA) Act No. 92 of 1996 as amended, enables all women of any age in South Africa, to access a safe, legal termination of pregnancy within the first 12 weeks on demand and from 13 to 20 weeks under specified circumstances.


6.4. The Mpumalanga Department of Health and Social Services (MDHSS) believes that in order to provide a humane service that will benefit clients, all health care professionals must make a commitment to act and work within the following ethical and legal framework:

- Rules, Regulations and Acts that govern the practice of nurses and medical personnel
- Batho Pele Principles
- Patient Rights Charter

norms and standards for abortion care. Chapter 4 highlights Primary Health Care (PHC) responsibilities with regard to TOP services. The document recognizes the need for interdepartmental and inter-sectoral collaboration in service delivery.

6.6. The following Acts of Parliament and Regulations apply to the provision of Sexual and Reproductive Health (SRH) services of which TOP is an essential part

- Constitution of the Republic of South Africa, Act 108 of 1996 (Chapter 2; The Bill of Rights
- Choice on Termination of Pregnancy Act 92 of 1996 as amended
- Nursing Act 50 of 1978 as amended
- Medical and Dental and Supplementary Health Service Professions Act 56 of 1974 as amended
- Medicine and Related Substance Act 101 of 1985 as amended
- R2488: Regulations under which a Midwife may practice
- R2490 R387 Feb'82; as amended R888 April '87 as amended Rules setting out Acts and Omissions in respect of which the SANC may take disciplinary steps
- R2589: Scope of Practice
- R2418: Regulations relating to the keeping, supply, administering or prescribing of medicines by a Registered Nurse
- Any other relevant legislation

7. REQUIREMENTS

7.1. Designated TOP facilities should meet the requirements as stipulated in the Choice on Termination of Pregnancy Act No. 92 of 1996 as amended and should have a person trained on abortion care and. According to CTOP Act 92 of 1996 as amended

7.2. TOP Services must be provided free of charge in all designated public facilities

7.3. An enabling environment for the provision of TOP services shall be created.

7.4. Barriers restricting clients from having access to TOP services should be removed

7.5. All clients requesting TOP services must receive the appropriate information, treatment and or referral including those who have been Sexually Assaulted.

7.6. TOP services shall be provided through a well defined system with clear referral pathways.

7.7. Counselling and TOP services must be made available to all clients including minors, following the principles of informed choice.

7.8. All facilities shall respect and promote human and RH rights for each client seeking TOP services
7.9. A member of staff at facilities providing this service in terms of the Legislative prescripts must have received the necessary training in management with regards to SRH Care.

7.10. The training shall include contraception, pre and post abortion counselling.

7.11. Staff in non-designated facilities should assist and refer clients to designated facilities providing TOP services.

7.12. When a clients presents at a facility with an unwanted pregnancy, they should be treated with respect including those that have been sexually assaulted.

7.13. The department will seek to decentralise TOP Services to PHC level.

7.14. The department will seek to develop facility based TOP protocols which are in line with the Provincial TOP Policy.

7.15. The department designate accessible, efficient TOP care services for the holistic management of clients with unwanted pregnancies.

7.16. Clients who have been Sexually Assaulted shall be treated in line with the Sexual Assault Policy in relation to VCT, prophylactic treatment for HIV as well as emergency contraception.

7.17. Management of designated facilities do not have the right to refuse the implementation of TOP services where there is a trained provider available.

8. POLICY IMPLICATIONS

This Policy will require consistent Monitoring as it practically has a bearing on human lives, particularly on those communities that are attached to Traditional Leaders and Healers. In other words the Cultural and Religious aspects which often are so sensitive calls into effect, effective monitoring of the processes.

The Department will also be expected to train additional professionals as it commits itself to providing this service. This therefore calls for additional finances from time to time.

9. POLICY IMPLEMENTATION

The policy has taken into account Religious considerations which may arise as a result of the implementation of this policy and will always seek to respect and recognize those.

It is further conscious of the Cultural and ethical issues that may arise and will further seek to openly embrace those issues.

It is therefore in the interest of this policy to engage community organisations and formations to obtain a buy-in of this policy without attempting to ram it down the throats of communities and at the same time without depriving those who would opt for this service as promulgated by law.
Against this background therefore the department will seek to further collaborate with the following structures in its implementation of this policy

- Healthcare facilities
- Other governmental departments, e.g. education, police, justice department, social services, etc
- Other relevant stakeholders
- General Medical Practitioners
- Traditional Medical Practitioners
- Traditional Birth Attendants
- Non-Governmental Organisations (NGO's) and Community Based Organisations (CBO's)
- Violence shelters/Victim Empowerment Centres

Health Workers are therefore, in this Policy reminded of the imperative to ensure a deliberate, seamless and flawless engagement of relevant structures/stakeholders where clarity on the policy appear to be lacking.

Further the department will put up signage on facilities that provide this service.

10. MONITORING AND EVALUATION

The Policy shall be a direct responsibility of the department and therefore the Monitoring and Evaluation of the Policy shall be the responsibility of the Department in consultation with relevant stakeholders

- General monitoring and evaluation principles will be followed. Relevant process and outcome indicators should be developed.

- The department shall regularly Monitor and evaluate this service to ensure meticulous practice and quality TOP service delivery.

- Facilities shall submit monthly statistics using the relevant forms. Internal audits will be conducted quarterly by hospital management.

- External audits will be conducted by the district/province twice a year.

- Feedback will be given to the facility in the following manner:

- Written and verbal feedback will be given within one calendar month of the audit.

- Remedial action will be taken where necessary
10.1 PENALTIES

10.2. Anybody who commits one of the listed offences, could if found guilty, in terms of the CTOPA, be liable to a fine or a term of imprisonment not exceeding 10 years.

10.3. Anybody who is not a medical practitioner or registered nurse/registered midwife who has completed the prescribed training, and who performs a termination of pregnancy.

10.4. Anybody who prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy.

10.5. It is an offence for any person to terminate a pregnancy unlawfully or allow a termination of a pregnancy at a facility which has not been approved/designated.

10.6. Confidentiality should be maintained at all times. Failure to do so is an offence and is punishable by law, according to the Rules setting out Acts and Omissions in respect of which the South African Nursing Council may take disciplinary steps (R2490 R 387 Feb' 82; as amended R888 April '87; as amended)

11. IMPERATIVES

11.1 Conscientious Objection:

The Health Care Professional must notify his/her supervisor in writing should s/he wish to conscientiously object to TOP procedures.

Irrespective of any conscientious objection a nurse MUST provide the following to clients:

1. Nursing care assessment, planning, implementation, monitoring and evaluation.

2. Basic assistance with activities of daily living.

3. Emotional, physical and psychological support.

4. Prescribed medication including contraception.

5. Comfort and pain relief measures.

11.2 Role of Human Resources (HR)

- Conduct work studies to actively define workload, staff needs including psychosocial support.

- Liaise with academic institutions to review and adapt curriculum for staff in training.
- Review and adapt post-basic curriculum in collaboration with colleges and facilities.

- Ensure employee assistance programme meets the needs of staff experiencing stress as a result of providing TOP services.

11.3 TOP Service Provider Needs:

- All TOP providers working in the TOP clinic to receive a mandatory extra day off each month to access support services.

- TOP Providers should NOT be excluded from personnel development programmes and should be considered for relevant career pathing.

- Debriefing of TOP Providers should be conducted annually and is coordinated by a Provincial Women's Health Programme manager.

- A TOP facility should be well equipped to render quality care. See Appendix 1 for guidance.

11.4 Allocation of TOP Providers:

Allocation and rotation of TOP providers must never be done at the expense of TOP services.

11.5 Training:

- The department shall develop training structures, guidelines and standards.

- TOP Training includes the following:

The training of Healthcare Providers, who meet the requirements stipulated in the CTOPA, in pre and post TOP care counselling and in the management of TOP care (MVA & Medical Abortion)

On completion of abortion care training providers must be allowed to implement TOP with immediate effect in the designated facilities where they are employed.

11.6 Quality Assurance Criteria:

Ideally, a fit for purpose unit must be available with the following staff compliment as the minimum requirement:

3 Professional Nurses
1 Enrolled Nurse
1 General Assistant
1 Admin Clerk

TOP Services shall be provided with regular briefing and debriefing sessions.
References:

1. National Strategic plan for the implementation of The Choice on Termination of Pregnancy Act 92 of 1996 as amended; National Department of Health and Ipas South Africa
2. Termination of Pregnancy Care Manual (Facilitator’s Guide); Ipas South Africa and The Reproductive Health Research Unit
3. National Contraception Service Delivery Guidelines; National Department of Health
4. Conscientious Objection and the Implementation of the Choice on Termination of pregnancy Act No. 92 of 1996 in S.A Nikki Naylor and Michelle O’ Sullivan Woman’s Legal Centre and Ipas South Africa
7. Policies from Western Cape, Eastern Cape, Gauteng and Department of Health
8. Ten Steps to developing standards and guidelines for safe abortion care; Amanda B Huber, Ipas Consultant-January 19 2005
Appendix 1

Check list of Equipment and drugs needed for provision of T.O.P and Abortion care.

Equipment and Supplies

Basic instruments and consumables needed to perform M.V.A

- Vaginal speculum (small, medium and large).
- Uterine Tenaculum or Vulsellum forceps.
- Sponge or ring forceps (2).
- Manual Vacuum Aspirators (Sufficient for number of cases performed per day).
- Flexible canulae of different sizes.
- Adapters for double valve syringes.
- Light source (to see cervix and inspect tissues).
- Swabs (gauze).
- Antiseptic solutions (such as iodine).
- Gloves, sterile or high level disinfected surgical gloves or new examination gloves.
- Gloves utility
- Strainer (for tissue inspection).
- Clear container or basin.
- Patient gowns, linen, procedure gowns for staff
- Surgical disposables such as syringes, needles, IV sets, etc

Furniture

- Examination table/ couch
- Strong light
- Seat or stool (optional)
- Plastic bucket for decontamination solution (0.5 chlorine)
- Container for Cidex
- Puncture-proof container for disposal of sharps (needles)
- Leak-proof container for infectious waste.
Essential Drugs Needed For Abortion Care

Local anesthetics
Atropine
Lignocaine, 1% without epinephrine

Analgesics
Acetylsalicylic acid (Asprin)
Brufen/Voltaren
Pethidine (or suitable substitute)

Antibiotics:
Broad-spectrum antibiotics such as:
Ampicillin
Benzy! penicillin
Chloramphenicol
Metronidazole
Sulfamethazole
Sulfamethazole –trimethoprim
Doxycycline
Ceftriazone
Oxilofloxacin

Antiseptics
Chlorhexidine 4% (Hibitane, Hibiscrub)
Iodophors (Betadine)
Iodine preparations 1-3 %
Sodium hypochlorite 5-10% (commercial chlorine bleach solution)
Formaldehyde, 8% (Formalin)
Glutaraldehyde, 2% (Cidex)

Oxytocics
Ergometrine injection
Ergometrine tablets
Oxytocin injection

Intravenous solutions
Water for injections
Sodium lactate (Ringers)
Glucose 5% and 50%
Glucose with isotonic saline
Potassium chloride
Sodium chloride 0,9%

LEAD DRUGS and CPR Equipment
No. 1891.

It is hereby notified that the President has assented to the following Act which is hereby published for general information:


KANTOOR VAN DIE PRESIDENT

No. 1891. 22 November 1996

Hierby word bekend gemaak dat die President sy goedkeuring geheg het aan die onderstaande Wet wat hierby ter algemene inligting gepubliseer word:

No. 92 van 1996: Wet op Keuse oor die Beëindiging van Swangerskap, 1996.
ACT

To determine the circumstances in which and conditions under which the pregnancy of a woman may be terminated; and to provide for matters connected therewith.

(Afrikaans text signed by the President.)
(Assented to 12 November 1996.)

PREAMBLE

Recognising the values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the advancement of human rights and freedoms which underlie a democratic South Africa;

Recognising that the Constitution protects the right of persons to make decisions concerning reproduction and to security in and control over their bodies;

Recognising that both women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and that women have the right of access to appropriate health care services to ensure safe pregnancy and childbirth;

Recognising that the decision to have children is fundamental to women's physical, psychological and social health and that universal access to reproductive health care services includes family planning and contraception, termination of pregnancy, as well as sexuality education and counselling programmes and services;

Recognising that the State has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm;

Believing that termination of pregnancy is not a form of contraception or population control;

This Act therefore repeals the restrictive and inaccessible provisions of the Abortion and Sterilization Act, 1975 (Act No. 2 of 1975), and promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs.

BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:—

Definitions

1. In this Act, unless the context otherwise indicates—
   (i) "Director-General" means the Director-General of Health; (iii)
   (ii) "gestation period" means the period of pregnancy of a woman calculated from the first day of the menstrual period which in relation to the pregnancy is the last; (iv)
   (iii) "incest" means sexual intercourse between two persons who are related to each other in a degree which precludes a lawful marriage between them; (ii)
(iv) "medical practitioner" means a person registered as such under the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974); (v)
(v) "Minister" means the Minister of Health; (viii)
(vi) "minor" means any female person under the age of 18 years; (vii)
(vii) "prescribe" means prescribe by regulation under section 9; (x)
(viii) "rape" also includes statutory rape as referred to in sections 14 and 15 of the Sexual Offences Act, 1957 (Act No. 23 of 1957); (ix)
(ix) "registered midwife" means a person registered as such under the Nursing Act, 1978 (Act No. 50 of 1978); (vi)
(x) "termination of a pregnancy" means the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman; (i)
(xi) "woman" means any female person of any age. (xi)

Circumstances in which and conditions under which pregnancy may be terminated

2. (1) A pregnancy may be terminated—

(a) upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;

(b) from the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that—

(i) the continued pregnancy would pose a risk of injury to the woman’s physical or mental health; or

(ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or

(iii) the pregnancy resulted from rape or incest; or

(iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or

(c) after the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy—

(i) would endanger the woman’s life;

(ii) would result in a severe malformation of the fetus; or

(iii) would pose a risk of injury to the fetus.

(2) The termination of a pregnancy may only be carried out by a medical practitioner, except for a pregnancy referred to in subsection (1)(a), which may also be carried out by a registered midwife who has completed the prescribed training course.

Place where surgical termination of pregnancy may take place

3. (1) The surgical termination of a pregnancy may take place only at a facility designated by the Minister by notice in the Gazette for that purpose under subsection (2).

(2) The Minister may designate any facility for the purpose contemplated in subsection (1), subject to such conditions and requirements as he or she may consider necessary or expedient for achieving the objects of this Act.

(3) The Minister may withdraw any designation under this section after giving 14 days’ prior notice of such withdrawal in the Gazette.

Counselling

4. The State shall promote the provision of non-mandatory and non-directive counselling, before and after the termination of a pregnancy.

Consent

5. (1) Subject to the provisions of subsections (4) and (5), the termination of a pregnancy may only take place with the informed consent of the pregnant woman.

(2) Notwithstanding any other law or the common law, but subject to the provisions of subsections (4) and (5), no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.
(3) In the case of a pregnant minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated. Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.

(4) Subject to the provisions of subsection (5), in the case where a woman is—

(a) severely mentally disabled to such an extent that she is completely incapable of understanding and appreciating the nature or consequences of a termination of her pregnancy; or

(b) in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy in terms of section 2,

her pregnancy may be terminated during the first 12 weeks of the gestation period, or from the 13th up to and including the 20th week of the gestation period on the grounds set out in section 2(1)(b)—

(i) upon the request of and with the consent of her natural guardian, spouse or legal guardian, as the case may be; or

(ii) if such persons cannot be found, upon the request and with the consent of her curator personae:

Provided that such pregnancy may not be terminated unless two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course consent thereto.

(5) Where two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course, are of the opinion that—

(a) during the period up to and including the 20th week of the gestation period of a pregnant woman referred to in subsection (4)(a) or (b)—

(i) the continued pregnancy would pose a risk of injury to the woman’s physical or mental health; or

(ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or

(b) after the 20th week of the gestation period of a pregnant woman referred to in subsection (4)(a) or (b), the continued pregnancy—

(i) would endanger the woman’s life;

(ii) would result in a severe malformation of the fetus; or

(iii) would pose a risk of injury to the fetus,

they may consent to the termination of the pregnancy of such woman after consulting her natural guardian, spouse, legal guardian or curator personae, as the case may be: Provided that the termination of the pregnancy shall not be denied if the natural guardian, spouse, legal guardian or curator personae, as the case may be, refuses to consent thereto.

Information concerning termination of pregnancy

6. A woman who in terms of section 2(1) requests a termination of pregnancy from a medical practitioner or a registered midwife, as the case may be, shall be informed of her rights under this Act by the person concerned.

Notification and keeping of records

7. (1) Any medical practitioner, or a registered midwife who has completed the prescribed training course, who terminates a pregnancy in terms of section 2(1)(a) or (b), shall record the prescribed information in the prescribed manner and give notice thereof to the person referred to in subsection (2).

(2) The person in charge of a facility referred to in section 3 or a person designated for such purpose, shall be notified as prescribed of every termination of a pregnancy carried out in that facility.

(3) The person in charge of a facility referred to in section 3, shall, within one month of the termination of a pregnancy at such facility, collate the prescribed information and forward it by registered post confidentially to the Director-General. Provided that the name and address of a woman who has requested or obtained a termination of pregnancy, shall not be included in the prescribed information.
CHOICE ON TERMINATION OF PREGNANCY ACT, 1996

(4) The Director-General shall keep record of the prescribed information which he or she receives in terms of subsection (3).
(5) The identity of a woman who has requested or obtained a termination of pregnancy shall remain confidential at all times unless she herself chooses to disclose that information.

Delegation

8. (1) The Minister may, on such conditions as he or she may determine, in writing delegate to the Director-General or any other officer in the service of the State, any power conferred upon the Minister by or under this Act, except the power referred to in section 9.
(2) The Director-General may, on such conditions as he or she may determine, in writing delegate to an officer in the service of the State, any power conferred upon the Director-General by or under this Act or delegated to him or her under subsection (1).
(3) The Minister or Director-General shall not be divested of any power delegated by him or her, and may amend or set aside any decision taken by a person in the exercise of any such power delegated to him or her.

Regulations

9. The Minister may make regulations relating to any matter which he or she may consider necessary or expedient to prescribe for achieving the objects of this Act.

Offences and penalties

10. (1) Any person who—
(a) is not a medical practitioner or a registered midwife who has completed the prescribed training course and who performs the termination of a pregnancy referred to in section 2(1)(a);
(b) is not a medical practitioner and who performs the termination of a pregnancy referred to in section 2(1)(b) or (c); or
(c) prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy,
shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years.
(2) Any person who contravenes or fails to comply with any provision of section 7 shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding six months.

Application of Act

11. (1) This Act shall apply to the whole of the national territory of the Republic.
(2) This Act shall repeal—
(a) the Act mentioned in columns one and two of the Schedule to the extent set out in the third column of the Schedule; and
(b) any law relating to the termination of pregnancy which applied in the territory of any entity which prior to the commencement of the Constitution of the Republic of South Africa, 1993 (Act No. 200 of 1993), possessed legislative authority with regard to the termination of a pregnancy.

Short title and commencement

12. This Act shall be called the Choice on Termination of Pregnancy Act, 1996, and shall come into operation on a date fixed by the President by proclamation in the Gazette.
### SCHEDULE

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<thead>
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<th>No. and year of law</th>
<th>Short title</th>
<th>Extent of repeal</th>
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<td>Abortion and Sterilization Act, 1975</td>
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ANNEXURE E

INFORMED CONSENT
CONSENT FORM

TITLE:
THE EVALUATION OF THE TERMINATION OF PREGNANCY PROGRAMME
IN THE MPUMALANGA PROVINCE

INTRODUCTION

I am Ramaite Edith Mookamedi, a Doctoral student at the University of South Africa (UNISA). I am doing a research on the evaluation of the termination of pregnancy programme in the Mpumalanga Province. The purpose of the study is to evaluate the impact of the TOP programme in South Africa, using Mpumalanga Province as the focal area for the study and to develop guidelines to assist service providers in the implementation of the promulgated Act in Termination of Pregnancy Programme.

I am therefore requesting you to participate in the study. Please feel free to ask for clarification where you don’t understand. Remember that your participation is voluntary, and you are free to withdraw from the study should you wish to do so.

I .................................................. (informant) have read the above information about the evaluation of the TOP programme and have been verbally informed about my role as a participant. I am therefore voluntarily accepting the participation thereof.

Informants’ signature: ............................... 

Researcher’s signature: ...............................
ANNEXURE F

INTERVIEW GUIDE FOR PARTICIPANTS,
TOP PROVIDERS
INTERVIEW SCHEDULE FOR TOP PROVIDERS

TITLE:
THE EVALUATION OF THE TERMINATION OF PREGNANCY PROGRAMME
IN THE MPUMALANGA PROVINCE

INTRODUCTION

I am Ramaite Edith Mookamedi, a Doctoral student at the University of South Africa (UNISA). I am evaluating the impact of the termination of pregnancy programme Mpumalanga Province so that I could develop guidelines to assist service providers in the implementation of the promulgated Act on Termination of Pregnancy.

I am therefore requesting you to participate in the study. Please feel free to ask for clarification where you don’t understand. Remember that your participation is voluntary, and you are free to withdraw from the study should you wish to do so and there will be no penalties to you in any way. The information you will provide will not be attached to your name in any manner, so you will remain anonymous and information confidential.

Before we start with the interview, I would like you to request that you sign an informed consent.
SECTION 1: DEMOGRAPHY

1. Age: 

2. Gender: 

3. No. of years working in the programme: 

SECTION 2: KNOWLEDGE REGARDING THE CONTENTS OF CTOP ACT.

1. Which legislation regulates the practice on the termination of pregnancy?

2. What are the circumstances in which and conditions under which pregnancy may be terminated?

3. Who is allowed to perform termination of pregnancy?

4. Where should termination of pregnancy take place?
5. What should happen before termination of pregnancy?

6. What should happen after termination of pregnancy?

7. In case of a pregnant minor, who should give consent for termination of pregnancy?

8. Legally what should happen to any health provider who prevents lawful termination of pregnancy?
9. How does the law protect employees who are not keen to procure legal abortions?

10. What are the stipulations in the Mpumalanga policy document for the implementation of the CTOP Act which support the provision of TOP services?

SECTION 3: THE PROGRAMME

1. What is/are your feelings about Terminating Pregnancies as you do it in your job?
2. In your view, what is the impact of the programme to:

a. Individuals

b. Communities

c. Country
3. What is the impact of providing this service on you?

4. What support did you have?

5. In your view, what are the challenges in the provision of TOP services?
ANNEXURE G

INTERVIEW GUIDE FOR PARTICIPANTS,
TOP FACILITY MANAGERS
ANNEXURE G

INTERVIEW SCHEDULE FOR FACILITY MANAGERS

TITLE:

THE EVALUATION OF THE TERMINATION OF PREGNANCY PROGRAMME
IN THE MPUMALANGA PROVINCE

INTRODUCTION

I am Ramaite Edith Mookamedi, a Doctoral student at the University of South Africa (UNISA). I am evaluating the impact of the termination of pregnancy programme Mpumalanga Province so that I could develop guidelines to assist service providers in the implementation of the promulgated Act on Termination of Pregnancy.

I am therefore requesting you to participate in the study. Please feel free to ask for clarification where you don’t understand. Remember that your participation is voluntary, and you are free to withdraw from the study should you wish to do so and there will be no penalties to you in any way. The information you will provide will not be attached to your name in any manner, so you will remain anonymous and information confidential.

Before we start with the interview, I would like you to request that you sign an informed consent.
SECTION 1: DEMOGRAPHY

1. Age: 

2. Gender: 

3. No. of years working in the programme: 

SECTION 2: KNOWLEDGE REGARDING THE CONTENTS OF CTOP ACT.

1. Which legislation regulates the practice on the termination of pregnancy?

2. What are the circumstances in which and conditions under which pregnancy may be terminated?

3. Who is allowed to perform termination of pregnancy?

4. Where should termination of pregnancy take place?
5. What should happen before termination of pregnancy?

6. What should happen after termination of pregnancy?

7. In case of a pregnant minor, who should give consent for termination of pregnancy?

8. Legally what should happen to any health provider who prevents lawful termination of pregnancy?
9. How does the law protect employees who are not keen to procure legal abortions?

10. What are the stipulations in the Mpumalanga policy document for the implementation of the CTOP Act which support the provision of TOP services?

SECTION 3: THE PROGRAMME.

1. What is your view/ what has been your experience about the unit and its utilisation?
2. How are those procuring TOP service supported to ensure continued service delivery?

3. Did you see the documentary on the M-Net, Carte Blanche about TOP service provision in the province?

Yes
No

If “Yes” please provide your views.

4. What has been your experience in the TOP programme?

- Did it address the needs for self determination amongst women?
- Did it address the needs of morbidity and mortality as a result of backstreet abortion?

-How is the programme designed?

5. From your management point of view, what do you consider the impact of this programme to be on:

a. Individuals

b. Communities
c. Country

6. In your view, what are the challenges in the management of TOP services?
ANNEXURE H

INTERVIEW GUIDE FOR PARTICIPANTS,
HEALTH CONSUMERS
INTERVIEW SCHEDULE FOR HEALTH CONSUMERS

TITLE: THE EVALUATION OF THE TERMINATION OF PREGNANCY PROGRAMME IN THE MpUMALANGA PROVINCE

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# SECTION 1: DEMOGRAPHIC DATA

## 1. AGE

<table>
<thead>
<tr>
<th>Age Range</th>
<th></th>
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<tbody>
<tr>
<td>15-25</td>
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<tr>
<td>26-35</td>
<td></td>
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<tr>
<td>36-45</td>
<td></td>
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<tr>
<td>46-55</td>
<td></td>
</tr>
<tr>
<td>56 and above</td>
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## 2. MARITAL STATUS

<table>
<thead>
<tr>
<th>Status</th>
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<tbody>
<tr>
<td>Single</td>
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<tr>
<td>Married</td>
<td></td>
</tr>
<tr>
<td>Separated</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
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</tbody>
</table>

## 3. EMPLOYMENT STATUS

<table>
<thead>
<tr>
<th>Status</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Employed</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
</tr>
</tbody>
</table>

## 4. AREA WHERE YOU LIVE

<table>
<thead>
<tr>
<th>Area</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td></td>
</tr>
</tbody>
</table>
SECTION 2: CORE QUESTION

1. What are your experiences regarding TOP service provision and facility you are in?

Alternatively:

How do you experience TOP service provision and facility which provide the service?
Possible probing questions:

1. Who informed you about the abortion being legal?
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2. How do you feel about the service you received?
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3. What does this mean to you?
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4. What support did you have or how would you describe the support received in the facility you are in?
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ANNEXURE I

REVIEW OF RECORDS IN TOP FACILITIES
ANNEXURE I

REVIEW OF RECORDS FOR TOP FACILITIES

TITLE:
THE EVALUATION OF THE TERMINATION OF PREGNANCY PROGRAMME
IN THE MPUMALANGA PROVINCE

1. Number of trained TOP providers employed in the institution.

2. Number of trained TOP providers offering TOP services.

3. Average number of clients seen in the TOP unit per month/annually?

<table>
<thead>
<tr>
<th>Monthly</th>
<th>Annually</th>
</tr>
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