# CHALLENGES ENCOUNTERED BY WOMEN WHO REQUESTED TERMINATION OF PREGNANCY SERVICES IN THE NORTH WEST PROVINCE OF SOUTH AFRICA

by

**NOMATHEMBA EMILY BLAAI MOKGETHI**

Submitted in accordance with the requirements

for the degree of

**DOCTOR OF LITERATURE AND PHILOSOPHY**

in the subject of

**Health Studies**

at the

**UNIVERSITY OF SOUTH AFRICA**

SUPERVISOR: PROF JH ROOS

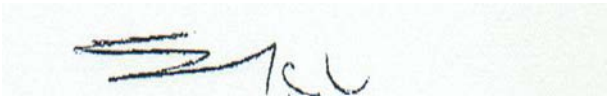
CO-SUPERVISOR: PROF VJ EHLERS

November 2011

Student number: 08824894

**DECLARATION**

I declare that **CHALLENGES ENCOUNTERED BY WOMEN WHO REQUESTED TERMINATION OF PREGNANCY SERVICES IN THE NORTH WEST PROVINCE OF SOUTH AFRICA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other institutions.



27 February 2012

_____ _____

**SIGNATURE** **DATE**

NOMATHEMBA EMILY BLAAI MOKGETHI

# CHALLENGES ENCOUNTERED BY WOMEN WHO REQUESTED TERMINATION OF PREGNANCY SERVICES IN THE NORTH WEST PROVINCE OF SOUTH AFRICA


**STUDENT NUMBER:** 08824894
**STUDENT NAME:** NOMATHEMBA EMILY BLAAI MOKGETHI
**DEGREE:** DOCTOR OF LITERATURE AND PHILOSOPHY
**DEPARTMENT:** HEALTH STUDIES, UNIVERSITY OF SOUTH AFRICA
**SUPERVISOR:** PROF JH ROOS
**CO-SUPERVISOR:** PROF VJ EHLERS


## ABSTRACT


In 1996 the South African government legalised the termination of pregnancy (TOP) services, allowing women to choose to terminate unplanned pregnancies at designated facilities. Although TOP services are available, pregnant women continue to use illegal abortion services, with potentially life-risking consequences.

The purpose of this study was to identify challenges encountered by women requesting TOP services, and to make recommendations for improved policies and practices, enabling more women in the North West Province (NWP) to access TOP services. This was a non-experimental, exploratory, descriptive and quantitative study. Structured interviews were conducted with 150 women who had used TOP services in phase 1, with 50 women who were unable to access TOP services in phase 2 and with 20 professional nurses providing TOP services in the NWP in phase 3.

In phase 1, 96.0% (n=144) of the women needed transport to access TOP services, and 73.2% (n=109) indicated that nurses put women's names on waiting lists, posing barriers to such access in the NWP. In phase 2, 92.0% (n=46) of these respondents had reportedly requested TOPs for the first time, but 89.0% (n=44) could not access TOP services.

In phase 3, only 14 out of 19 designated facilities in the NWP, and only 20 nurses, provided TOP services during the study period. Out of the 20 interviewed nurses, 74.0% (n=14) regarded the Choice on Termination of Pregnancy Act, Act 92 of 1996

(CTOP Act) was being unclear requiring a revision. These professional nurses provided TOP services in NWP, by choice.

Unless more facilities and more nurses can provide TOP services to the women of the NWP, these services will continue to remain inaccessible, necessitating the continued utilisation of illegal abortion services, in spite of the TOP Act's prescriptions. It is also recommended that management will provide sufficient support and training opportunities for professional nurses working in TOP services in the NWP.

**KEY CONCEPTS**

Reproductive health; TOP perceptions, nurses' attitudes towards TOPs; barriers to accessing TOP services; pre- and post-TOP counselling.

## ACKNOWLEDGEMENTS

I want to thank the following people for their respective contributions to this thesis:

- My late mother, Mrs Christina Blaai ,for her support, encouragement and prayers
- My three children, Fortunate, Kgalaletso and Sihle Mokgethi, for their understanding and support
- A special thank you to my supervisor, Prof JH Roos and my co-supervisor, Professor VJ Ehlers, for their guidance, support and encouragement
- My two research assistants, Ms Puleng Phelwane and Ms Fonny Seatlholo, for their support and willingness to go an extra mile
- Ms Marie Engelbrecht, my secretary, for the support and encouragement
- My former Municipal Manager, Mr Jacob Rabodila, for his support, understanding and encouragement
- Former Executive Mayor, Mr Des van Rooyen, for his support and encouragement
- Mr Frans Henning for the support and encouragement
- The North West Province: Department of Health, for giving me the permission to conduct the study
- My statistician, Mr Hennie Gerber, for his assistance, support and encouragement
- To all the women and nurses in the NWP, who were willing to participate in the study
- To nursing managers, for their support during the process of the study
- The Merafong City Local Municipality, for their financial support

# *Dedication*

*I dedicate this thesis to my late father*
*William, mother Christina and brother Seun Harry Blaai,*
*who passed away on 30 July 2008*
*in One Military Hospital in Pretroria.*

Table of contents Page

CHAPTER 1

Introduction and background information .....1

1.1 INTRODUCTION ..... 1

1.2 BACKGROUND ..... 2

1.3 PROBLEM STATEMENT ..... 6

1.4 PURPOSE OF THE STUDY ..... 6

1.5 RESEARCH QUESTIONS ..... 7

1.6 RESEARCH OBJECTIVES ..... 9

1.7 SIGNIFICANCE OF THE STUDY ..... 10

1.8 DEFINITIONS OF KEY CONCEPTS ..... 11

1.9 RESEARCH DESIGN AND METHODOLOGY ..... 13

1.9.1 Phase 1 of the study ..... 13
1.9.2 Phase 2 of the study ..... 14
1.9.3 Phase 3 of the study ..... 14

1.10 ETHICAL CONSIDERATIONS ..... 14

1.10.1 Respect for a person ..... 15
1.10.2 The principle of beneficence ..... 15
1.10.3 The principle of justice ..... 15
1.10.4 The principle of privacy ..... 16

1.11 LIMITATIONS OF THE STUDY ..... 17

1.12 THEORETICAL FRAMEWORK OF THE STUDY ..... 17

1.13 ORGANISATION OF THE REPORT ..... 17

1.14 SUMMARY ..... 18

CHAPTER 2

Literature review .....20

2.1 INTRODUCTION ..... 20

2.2 THE HEALTH BELIEF MODEL ..... 21

Table of contents Page

2.3 THE CONTEXT OF TERMINATION OF PREGNANCY INTERNATIONALLY IN RELATION TO THE HEALTH BELIEF MODEL ..... 24

2.3.1 Legislation and statistics in the termination of pregnancies in different countries ..... 24

2.4 TERMINATION OF PREGNANCY IN THE AFRICAN CONTEXT ..... 27

2.5 THE SOUTH AFRICAN LEGISLATION OF TERMINATION OF PREGNANCY ..... 29

2.5.1 The Constitution of the Republic of South Africa, 1996 ..... 29
2.5.2 The Children's Act 38 of 2005 ..... 29

2.5.3 The South African Choice of Termination of Pregnancy Act (no 92 of 1996) as amended by Act no 1 of 2008 ..... 29

2.6 WORLDWIDE CHALLENGES TO ACCESS TERMINATION OF PREGNANCY SERVICES ..... 30

2.6.1 Socio-cultural factors ..... 34
2.6.2 The level of satisfaction of women who requested termination of pregnancy services ..... 37
2.6.3 Likelihood of action of women seeking illegal termination of pregnancy services ..... 37
2.6.4 Perceived benefits of contraception usage to prevent TOPs ..... 40

2.7 CHALLENGES ENCOUNTERED BY NURSES WHO PROVIDE TERMINATION OF PREGNANCY SERVICES ..... 47

2.7.1 Perceived benefits of availability of resources in facilities ..... 48
2.7.2 Perceived nurses' barriers on providing termination of pregnancy services ..... 48
2.7.3 Perceptions/opinions of nurses regarding termination of pregnancy services ..... 50

2.8 SUMMARY ..... 54

CHAPTER 3

Methodology and research design ..... 55

3.1 INTRODUCTION ..... 55

3.2 RESEARCH DESIGN ..... 55

3.2.1 Non-experimental research design ..... 55
3.2.2 Exploratory descriptive design ..... 56
3.2.3 Quantitative approach ..... 57

3.3 RESEARCH METHOD ..... 57

3.3.1 Phase 1 ..... 58
3.3.2 Phase 2 ..... 62

Table of contents Page

3.4 RELIABILITY AND VALIDITY ..... 64

3.4.1 Validity ..... 64

3.5 RESEARCH METHOD PHASE 3 ..... 67

3.5.1 Research population ..... 67
3.5.2 Data collection ..... 68

3.6 VALIDITY OF THE RESEARCH INSTRUMENT PHASE 3 ..... 69

3.6.1 Face validity ..... 69
3.6.2 Construct validity ..... 70
3.6.3 Context validity ..... 70

3.7 RELIABILITY OF THE RESEARCH INSTRUMENT ..... 70

3.8 METHOD OF DATA ANALYSIS ..... 71

3.9 LIMITATION OF THE STUDY ..... 71

3.10 SUMMARY ..... 71

CHAPTER 4

Data analysis and discussion: Phase 1
Challenges encountered by women who had used TOP services ..... 72

4.1 INTRODUCTION ..... 72

4.2 DEMOGRAPHIC DATA ..... 73

4.2.1 Age ..... 73
4.2.2 Marital status ..... 74
4.2.3 Religion ..... 75
4.2.4 Employment ..... 76
4.2.5 Type of job ..... 76
4.2.6 Monthly incomes ..... 76
4.2.7 Number of children ..... 77
4.2.8 Number of times termination of pregnancy services had been used ..... 78

Table of contents Page


4.3 ACCESSIBILITY OF TERMINATION OF PREGNANCY SERVICE ..... 78

4.3.1 Transport to access termination of pregnancy facilities ..... 78
4.3.2 Distances travelled to access termination of pregnancy services ..... 79
4.3.3 Legal right to access termination of pregnancy ..... 79
4.3.4 Knowledge about the Choice of Termination of Pregnancy Act (no 92 of 1996), as amended by Act no 1 of 2008 ..... 80
4.3.5 Source of information about the Choice of Termination of Pregnancy Act (no 92 of 1996), as amended by Act no 1 of 2008 ..... 80
4.3.6 Experience with nurses rendering TOP services ..... 81
4.3.7 Number of weeks' gestation when requesting TOP services ..... 82
4.3.8 Test performed ..... 83

4.4 ILLEGAL TERMINATION OF PREGNANCY SERVICS AND THE USE OF CONTRACEPTIVES ..... 84

4.5 COUNSELLING ..... 86

4.5.1 Respondents' answer to open-ended questions ..... 87
4.5.2 The respondents' experiences relating to nurses and counselling about termination of pregnancy services ..... 88

4.6 LIKELIHOOD OF INFLUENCE OF CULTURE AND RELIGIOUS BELIEFS AND MORAL VALUES ON THE UTILISATION OF TOP SERVICES ..... 90

4.7 CONFIDENTIALITY ..... 91

4.7.1 Dislikes about TOP services ..... 92
4.7.2 Aspects the respondents liked about TOP services ..... 93
4.7.3 Respondents' one wish for the nurses providing TOP services ..... 93
4.7.4 Advice to other women about TOP services ..... 94
4.7.5 Advice for women concerning illegal TOP services ..... 94
4.7.6 Changes in TOP services facilities ..... 95
4.7.7 Respondents' views on the effectiveness of TOP counselling services ..... 95
4.7.8 Respondents' feelings about nurses' attitudes providing TOP services ..... 95
4.7.9 Major challenges encountered by women who had used TOP services in the NWP ..... 96
4.7.10 Circumstances under which nurses may refuse to provide TOP services to a woman ..... 97
4.7.11 Reasons why women seek TOP services in other provinces ..... 97
4.7.12 The influence of religious beliefs on accessing TOP services ..... 97
4.7.13 Major obstacles encountered to access TOP services in the NWP ..... 98
4.7.14 Respondents comments about TOP services in their areas ..... 99

4.8 TYPE OF SERVICE PROVIDED ..... 99

4.8.1 The procedure followed to terminate the pregnancy ..... 99
4.8.2 Weeks of gestation when TOPs were performed ..... 100
4.8.3 Pain experienced during TOP procedure ..... 100

4.9 SUMMARY ..... 101

Table of contents Page

CHAPTER 5

Analysis and discussion of research findings: Phase 2:
Women who wished to have TOP services but did not manage to access these services ..... 104

5.1 INTRODUCTION ..... 104

5.2 DEMOGRAPHIC DATA ..... 105

5.2.1 Age ..... 105
5.2.2 Marital status ..... 106
5.2.3 Religion ..... 106
5.2.4 Population groups ..... 107
5.2.5 Number of children ..... 108
5.2.6 Number of times termination of pregnancy was requested ..... 109
5.2.7 Employment ..... 109

5.3 ACCESSIBILITY OF TOP SERVICES ..... 109

5.3.1 Use of transport to access TOP ..... 110
5.3.2 Distances to be travelled to access TOP services ..... 110
5.3.3 Fees for TOP services ..... 111
5.3.4 Experience of respondents with nurses in TOP services ..... 111
5.3.5 Respondents' perceptions about nurses providing TOP services ..... 112
5.3.6 Respondents' satisfaction with TOP services ..... 114
5.3.7 The quality of TOP services and the role of policy makers ..... 114
5.3.8 The quality of pregnancy-related services provided by traditional healers ..... 114

5.4 TESTS PERFORMED TO CONFIRM PREGNANCY BEFORE PLACING WOMEN'S NAMES ON TOP WAITING LISTS ..... 115

5.5 THE MOST COMMON REASONS FOR WOMEN'S REQUESTS FOR TOPs ..... 116

5.6 ILLEGAL TERMINATION OF PREGNANCY SERVICES AND THE USE OF CONTRACEPTIVES ..... 117

5.7 BARRIERS ENCOUNTERED BY WOMEN TO ACCESSING LEGAL TOP SERVICES ..... 120

5.8 THE GREATEST BARRIERS FOR WOMEN TO ACCESS TOP SERVICE ..... 120

5.9 OPINIONS ABOUT THE GENERAL PRACTITIONERS (GPS) PROVIDING TOP SERVICES IN THE NORTH WEST PROVINCE ..... 122

5.10 RESPONDENTS' OPINIONS ABOUT TOP SERVICES AND THE USE OF CONTRACEPTIVES ..... 123

5.11 COUNSELLING ..... 125

5.11.1 Who offers counselling service in TOP facilities? ..... 125
5.11.2 The support received from the nurses providing TOP services ..... 127

Table of contents Page

5.12 RESPONDENTS' VIEWS ON COMMUNITY SUPPORT FOR WOMEN WHO HAD USED TOP SERVICES ..... 128

5.13 RESPONDENTS' OPINIONS AS TO WHO A WOMAN SHOULD CONSULT BEFORE TOP SERVICES ..... 128

5.14 IMPACT OF CULTURE AND RELIGIOUS BELIEFS AND MORAL VALUES ..... 131

5.15 CONFIDENTIALITY ..... 132

5.16 SUMMARY ..... 138

CHAPTER 6

Analysis and discussion of research results: Phase 3: Challenges encountered by nurses providing TOP services ..... 140

6.1 INTRODUCTION ..... 140

6.2 BIOGRAPHICAL DATA ..... 141

6.2.1 Age ..... 141
6.2.2 Gender ..... 142
6.2.3 Population ..... 142
6.2.4 Marital status ..... 143
6.2.5 Religious affiliation ..... 143
6.2.6 Registered midwives ..... 143
6.2.7 Number of grandchildren ..... 143
6.2.8 Working in TOP services ..... 144
6.2.9 Training received to perform TOP ..... 144
6.2.10 Period of time of working in TOP services ..... 144

6.3 FEELINGS AND RELIGION ..... 145

6.3.1 Respondents' sleeping pattern ..... 146

6.4 RESPONDENTS' FEELINGS ABOUT THEIR INVOLVEMENT IN TOP SERVICES ..... 147

6.5 RESPONDENTS' PERCEPTIONS AND OPINIONS ABOUT TOP SERVICES ..... 148

6.5.1 Number of monthly TOPs performed at specific clinics ..... 148

6.6 RESPONDENTS' PERCEPTIONS ABOUT WHO SHOULD RECEIVE TOP SERVICES ..... 149

6.7 RESPONDENTS' VIEWS ON WOMEN'S APPROPRIATE AGES TO BE ALLOWED TO DECIDE ABOUT TOPS ..... 151

6.8 RESPONDENTS' OPINIONS ON WHO SHOULD BE CONSULTED PRIOR TO USING TOP SERVICES ..... 152

Table of contents Page

6.9 RESPONDENTS' KNOWLEDGE ABOUT THE CTOP ACT, (NO 92 OF 1996), AS AMENDED BY ACT NO 1 OF 2008 ..... 152

6.10 THE PERCENTAGES OF TOPs DONE AT DIFFERENT GESTATION PERIODS ..... 154

6.11 RESPONDENTS' PERCEPTIONS ABOUT NURSES PROVIDING TOP SERVICES ..... 155

6.12 RESPONDENTS' PERCEPTIONS ABOUT THE FOETUS ..... 155

6.13 RESPONDENTS' TOP EXPERIENCES ..... 156

6.14 RESPONDENTS' PERCEPTIONS ABOUT COUNSELLING SERVICES ..... 157

6.15 RESPONDENTS' VIEWS ON PROVIDING COUNSELLING SERVICES AT TOP FACILITIES IN THE NWP ..... 158

6.16 RESPONDENTS' PERCEPTIONS ABOUT TOP SERVICES ..... 159

6.17 RESPONDENTS' ATTITUDES TOWARDS THE PROVISION OF TOP SERVICES ..... 161

6.18 WHAT RESPONDENTS LIKED MOST ABOUT TOP SERVICES ..... 162

6.19 RESPONDENTS' DISLIKES ABOUT TOP SERVICES ..... 162

6.20 RESPONDENTS' WISHES FOR WOMEN UNDERGOING TOPs ..... 163

6.21 RESPONDENTS' WISHES FOR NURSES PROVIDING TOP SERVICES ..... 163

6.22 ADVICE TO BE GIVEN TO TOP CLIENTS ABOUT CONTRACEPTIVES ..... 164

6.23 THE DEPARTMENT/CARE FIELD WHERE RESPONDENTS WOULD CHOOSE TO WORK ..... 164

6.24 RESPONDENTS' CHOICES OF PREFERRED TOP METHODS ..... 164

6.25 RESPONDENTS' VIEWS ON THE SUPPORT RECEIVED FROM OTHERS FOR BEING INVOLVED IN TOP SERVICES ..... 165

6.26 COMPREHENSION OF THE NUCLEAR FAMILY ..... 166

6.27 FEELINGS ABOUT THE SUPPORT RECEIVED FROM NUCLEAR FAMILIES ..... 166

6.28 COMPREHENSION OF THE EXTENDED FAMILY ..... 167

6.29 FEELINGS ABOUT THE SUPPORT RECEIVED FROM THEIR EXTENDED FAMILY MEMBERS ..... 168

6.30 THE COMMUNITY'S COMPREHENSION ABOUT THE RESPONDENTS' TYPE OF WORK ..... 169

6.31 RESPONDENTS' FEELINGS ABOUT THE SUPPORT RECEIVED FROM COMMUNITIES ..... 170

6.32 RESPONDENTS' VIEWS ON OFFICIAL WORKPLACE COUNCELLING SERVICES AVAILABLE FOR NURSES RENDERING TOP SERVICES ..... 171

6.33 RESPONDENTS' VIEWS ON TYPES OF SUPPORT RECEIVED FROM MANAGEMENT ..... 172

Table of contents Page

6.34 SUPPORT RESPONDENTS EXPECTED FROM THEIR EMPLOYERS ..... 173

6.35 RESPONDENTS' STRESS RELIEVE MEASURES WITH OTHER COLLEAGUES ..... 174

6.36 RESPONDENTS' OPINIONS ABOUT UNDERSTANDING THE STRAIN EXPERIENCED BY RENDERING TOP SERVICES ..... 175

6.37 SUMMARY ..... 176

CHAPTER 7

Conclusions, limitations and recommendations ..... 178

7.1 INTRODUCTION ..... 178

7.2 RESEARCH DESIGN AND METHOD ..... 178

7.3 SUMMARY OF THE RESEARCH FINDINGS ACCORDING TO THE THREE PHASES OF THE STUDY ..... 179

7.4 RECOMMENDATIONS FOR FURTHER RESEARCH ..... 186

7.4.1 Contributions of the study ..... 187
7.4.2 Limitations of the study ..... 188
7.4.3 Concluding remarks ..... 188

LIST OF SOURCES ..... 191

# List of tables

Page


Table 1.1 Number of TOPs done from 1997 – 2007 in South Africa ..... 4

Table 1.2 Mid-year 2007 population estimates by year, province, gender and age ..... 5

Table 4.1 Response on the source of information about the Choice of Termination of Pregnancy Act (no 92 of 1996, (as amended by Act no 1 of 2008) ..... 80

Table 4.2 Experiences of respondents with nurses rendering TOP services and with the services as such ..... 81

Table 4.3 Respondents' experiences concerning TOP service and the use of contraceptives ..... 84

Table 4.4 Counselling services offered at TOP facilities ..... 87

Table 4.5 The respondents' experiences relating to nurses and counselling in termination of pregnancy services ..... 88

Table 4.6 The impact of culture and religious beliefs and moral values on women's access to termination of pregnancy services ..... 90

Table 5.1 Opinions of the respondents towards nurses providing TOP services ..... 111

Table 5.2 Respondents' perceptions about nurses providing TOP services ..... 112

Table 5.3 Tests performed to confirm pregnancy ..... 115

Table 5.4 Most common reasons for requesting TOPs ..... 116

Table 5.5 Experiences of respondents concerning legal and illegal TOP services and condom use ..... 118

Table 5.6 Perceived barriers experienced by women when accessing legal TOP services ..... 120

Table 5.7 The greatest barriers for women to access TOP services ..... 121

Table 5.8 Opinions of the respondents about the general practitioners providing TOP services ..... 122

Table 5.9 The respondents' opinions about TOP services and the use of contraceptives ..... 124

Table 5.10 Support respondents received from the nurses providing TOP services ..... 127

Table 5.11 Respondents' opinion on who a woman should consult before deciding to have TOP services ..... 129

Table 5.12 The impact of respondents' culture and religious beliefs and moral values on using TOP services ..... 131

Table 6.1 Respondents' feelings reflected by mean scores ..... 145

Table 6.2 Respondents' sleeping patterns ..... 146

Table 6.3 Respondents' feelings about their involvement with TOP services ..... 147

Table 6.4 Respondents' opinions about who should receive TOP services ..... 149

Table 6.5 Who should women consult before deciding to have TOP services ..... 152

## List of tables Page

Table 6.6 Respondents' knowledge about the CTOP Act (no 92 of 1996, (as amended by Act no 1 of 2008) ..... 153

Table 6.7 Experiences with nurses providing TOP services ..... 155

Table 6.8 Respondents' perceptions about the foetus ..... 156

Table 6.9 Respondents' perceptions of TOP services ..... 157

Table 6.10 Indicate respondents' perceptions about counselling services ..... 158

Table 6.11 Respondents' views on providers of counselling services at the TOP services in the NWP ..... 159

Table 6.12 Respondents' perceptions about providing TOP services as indicated by mean scores ..... 160

Table 6.13 Influence of others on TOP services ..... 161

Table 6.14 Respondents' experiences about the support received from their nuclear families ..... 166

Table 6.15 Respondents' experiences about the support received from their extended family members ..... 168

Table 6.16 Respondents' experiences about the support received from their communities ..... 170

Table 6.17 Official counselling services available in workplaces for nurses rendering TOP services ..... 172

Table 6.18 Support respondents expected from their employers ..... 173

Table 6.19 Rate of support received by the users of TOP services ..... 175

## List of figures

Page


Figure 1.1 Map of the North West Province ..... 2

Figure 1.2 Map of South Africa ..... 3

Figure 2.1 Elements of the Health Belief Model associated with TOP services ..... 23

Figure 4.1 Age distribution of respondents (n=150) ..... 74

Figure 4.2 Religion of respondents (n=150) ..... 75

Figure 4.3 Respondents' earnings per month (n=149) ..... 77

Figure 4.4 Respondents' number of children (n=150) ..... 78

Figure 4.5 Kilometres travelled by respondents to access TOP service (n=150) ..... 79

Figure 4.6 Gestation time when requesting TOP service (n=150) ..... 83

Figure 4.7 Respondents' experience of counselling service (n=133) ..... 86

Figure 4.8 Gestation period when TOP were done (n=146) ..... 100

Figure 4.9 Level of pain experienced by respondents during TOP procedure (n=147) ..... 101

Figure 5.1 Age of respondents (n=50) ..... 106

Figure 5.2 Respondents' religious affiliations (n=50) ..... 107

Figure 5.3 Respondents' population groups (n=50) ..... 108

Figure 5.4 Respondents' number of children (n=50) ..... 108

Figure 5.5 Distances travelled by respondents to access TOP services in the NWP (n=50) ..... 110

Figure 5.6 Respondents' level of satisfaction with TOP services (n=48) ..... 114

Figure 6.1 Age distribution of the respondents (n=20) ..... 141

Figure 6.2 Respondents' population group in phase III (n=20) ..... 142

Figure 6.3 Respondents' number of grandchildren (n=20) ..... 143

Figure 6.4 Number of years that respondents had worked in TOP services (n=20) ..... 144

Figure 6.5 Number of TOPs performed monthly at special clinics (n=20) ..... 148

Figure 6.6 Respondents' views on the age which woman could decide about using TOP services (n=20) ..... 151

# List of abbreviations

Abbreviations and their terms are supplied to ensure that readers have ready access to any abbreviation as a number of abbreviations are used repeatedly in this thesis.

| | | |
|---|---|---|
| AIDS | - | Acquired Immune Deficiency Syndrome |
| CTOP | - | Choice on Termination of Pregnancy |
| DENOSA | - | Democratic Nursing Organisation of South Africa |
| DoH | - | Department of Health |
| EC | - | Emergency Contraception |
| FP | - | Family Planning |
| GHS | - | General Household Survey |
| GP | - | Gauteng Province |
| HBM | - | Health Belief Model |
| HIV | - | Human Immune Deficiency Virus |
| HSRC | - | Human Sciences Research Council |
| HST | - | Health System Trust |
| IEC | - | Information education and communication |
| MPA | - | Medroxyprogresterone Acetate |
| MRC | - | Medical Research Council |
| NAF | - | National Abortion Federation |
| NWP | - | North West Province |
| PHC | - | Primary Health Care |
| RN | - | Registered Nurse |
| RRA | - | Reproductive Rights Alliance |
| RSA | - | Republic of South Africa |
| SA | - | South Africa |
| SANC | - | South African Nursing Council |
| SPSS | - | Statistical Package for the Social Sciences |
| TOP | - | Termination of Pregnancy |
| VSC | - | Voluntary Surgical Contraception |
| VSS | - | Voluntary Surgical Sterilization |
| UK | - | United Kingdom |
| Unisa | - | University of South Africa |
| USA | - | United States of America |
| WHO | - | World Health Organization |

# List of Appendices


| | |
|---|---|
| Annexure A | Letters requesting and granting consent to conduct the study from health care authorities |
| Annexure B | Ethical clearance certificate from UNISA |
| Annexure C | Consent form to be signed by each participant |
| Annexure D | Interview schedule: Phase I |
| Annexure E | Interview schedule: Phase II |
| Annexure F | Interview schedule: Phase III |
| Annexure G | Letter from statistician |
| Annexure H | Photocopies of newspaper reports relevant to the study |
| Annexure I | Bill of Rights |
| Annexure J | Guidelines for professional nurses providing TOP services |
| Annexure K | Guidelines for managers in charge of hospital/clinics providing TOP services |
| Annexure L | Proposed in-service training programme for professional nurses providing TOP services |
| Annexure M | Proposed programme for counselling and support of women requesting TOP services |

# CHAPTER 1

# Introduction and background information

## 1.1 INTRODUCTION

Globally, millions of women continue to die, suffer pain, ill health or permanent disabilities as a result of pregnancy and childbirth complications. Each year 20 million unsafe terminations of pregnancies (TOPs) are performed resulting in 70 000 deaths (Lang, Joubert & Prinsloo 2005:52).

In South Africa (SA), liberal laws, policies and guidelines are in place to allow women to access TOP services. The CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, has been implemented since February 1997. This Act allows women from the age of 12 years to terminate their pregnancies up to 12 weeks' gestational period without permission from their parents or spouses according to the provisions of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, in South Africa.

Prior to the promulgation of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, women were restricted to access legal abortions in South Africa, according to the Abortion and Sterilization Act 2 of 1975, and could only access legal abortions when:

- The continued pregnancy endangered the life of the pregnant woman or constituted a serious risk to her health.
- The continued pregnancy constituted a serious risk for the child to suffer from a physical or mental defect of such a nature as to be irreparably handicapped.
- Pregnancy was the result of unlawful sexual intercourse including rape, incest or intercourse with a mentally defective female, unable to appreciate the consequences of intercourse or bear parental responsibility.

The CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, allows women in South Africa the right to choose whether or not to use safe TOP services. Nurses could help to reduce these morbidity and mortality statistics by providing safe, effective and

accessible TOP services (Morroni, Myer & Tibazarwa 2006:1; Mokgethi, Ehlers & Van der Merwe 2006:33).

After the legalisation of TOP services, the role of the nurses expanded and ethical dilemmas increased. The number of women requesting TOP services continues to increase, thus putting pressure on the nurses working in TOP services (Mamabolo 2006:39) in South Africa.

Despite the South African liberal laws and policies, women continue to encounter challenges when seeking TOP services. According to Patel and Myeni (2008:739), the aim of the South African government, when introducing the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, was to allow women greater independence and reproductive freedom.

## 1.2 BACKGROUND

The North West Province (NWP) is one of the nine provinces in South Africa, established after the 1994 democratic elections. This province is further demarcated into four district municipalities.

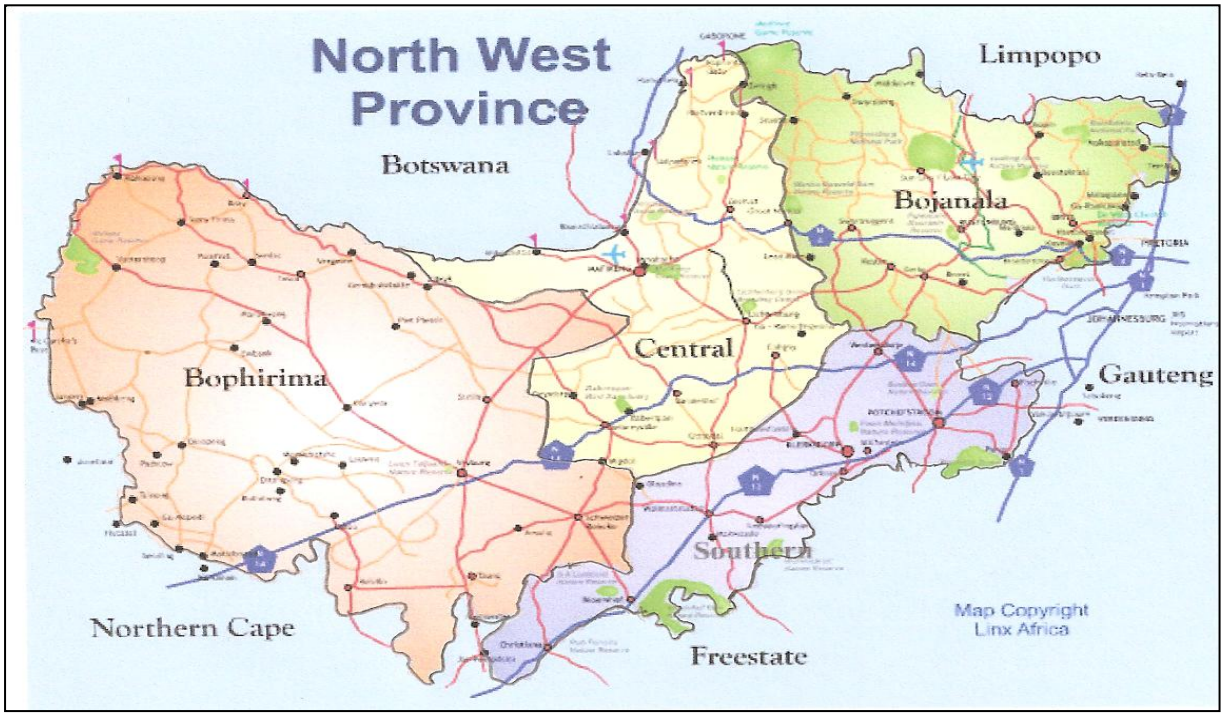



**Figure 1.1 Map of the North West Province**

http://www.linx.co.za/maps/map_north_west.html (accessed 17 May 2011)

It should be noted that the North West Province (NWP) has undergone name changes of the three districts. Hence the names on the map of the NWP are different from those mentioned in the discussions as the map had not been corrected according to the new names. The previous districts' names appear in brackets:

- Dr Kenneth Kaunda(Southern)
- Bojanala
- Ngaka Modiri Molema (Central)
- Dr Ruth Segomotsi Mompati (Bophirima)

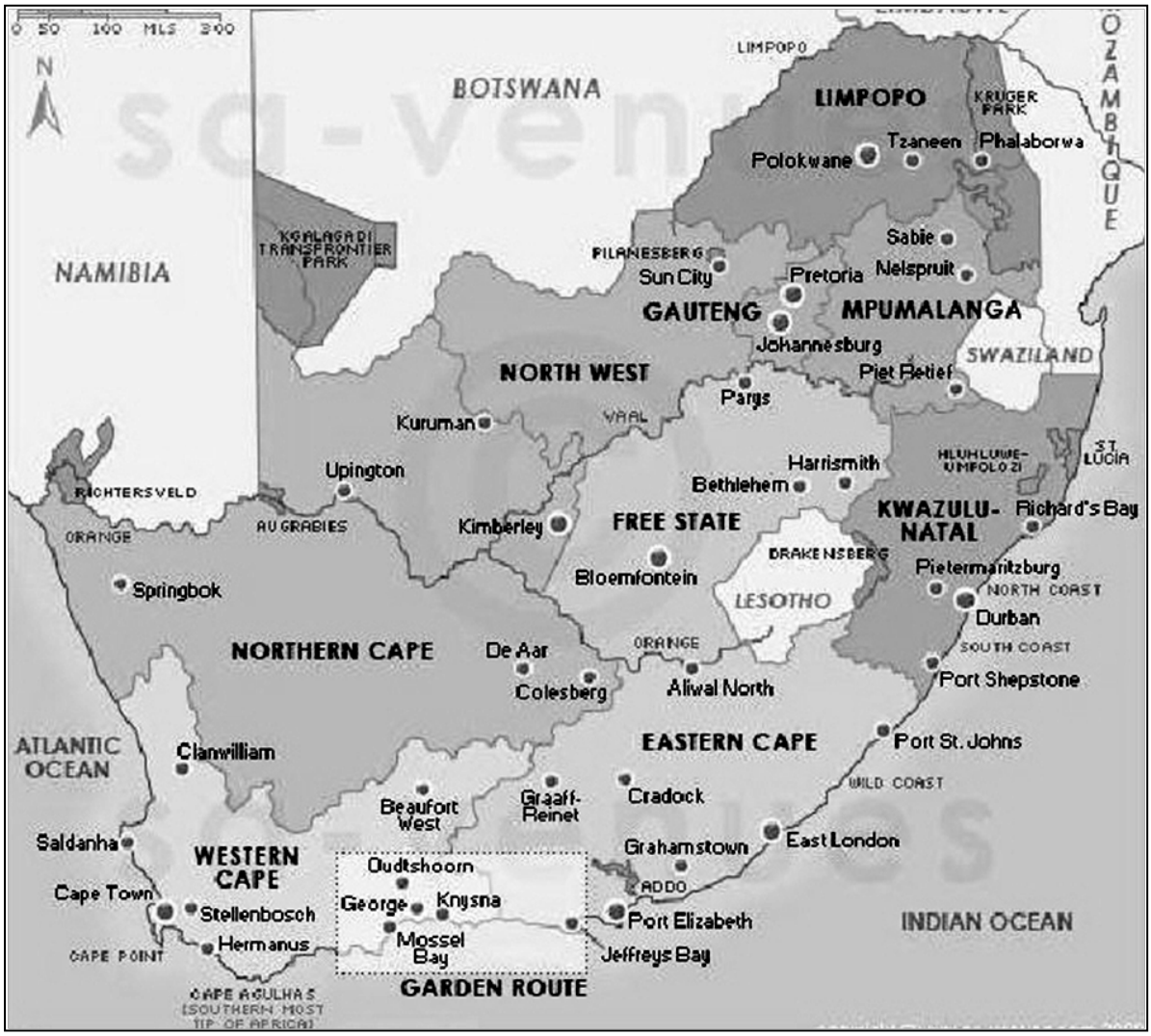



**Figure 1.2 Map of South Africa**

http://www.bing.com/images/search?q=south+africa+map_&view=detail&id=65867BAD51A8302272C6364AFBFD0DA48B9C1F0E&first=90&FORM=IDFRIR
(accessed 15 September 2011)

The total population in the NWP is estimated at 3 825 000 according to the General Household Survey (GHS) done in 2005 (The North West Province [NWP] 2007:16). The NWP's unemployment rate of males is reported to be 24.4% and females at 38.9% (The NWP 2007:16), suggesting that this population, especially the females, can be regarded as being poor.

In South Africa, during 2005, there were 246 designated health facilities providing TOP services across the nine provinces, 89 850 legal TOPs were done and only 14 health facilities in the NWP provided TOP services. Table 1.1 indicates the number of TOPs done from 1997 – 2007 per province.

**Table 1.1 Number of TOPs done from 1997 – 2007 in South Africa**

| YEAR | PROVINCE | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Eastern Cape | Free State | Gauteng Province | KwaZulu-Natal | Limpopo Province | Mpuma-Langa | Northern Cape | North West | Western Cape | Total |
| **1997** | 2693 | 2534 | 13505 | 1259 | 570 | 1509 | 435 | 218 | 3796 | 26519 |
| **1998** | 2938 | 4107 | 19417 | 5167 | 852 | 1857 | 552 | 455 | 5008 | 40353 |
| **1999** | 3109 | 4062 | 19298 | 6900 | 1728 | 2588 | 642 | 2231 | 5775 | 46303 |
| **2000** | 3265 | 6919 | 17408 | 11592 | 2493 | 3728 | 615 | 2329 | 6721 | 55070 |
| **2001** | 4671 | 4824 | 20321 | 7533 | 4512 | 3520 | 738 | 3120 | 8300 | 57539 |
| **2002** | 5814 | 3949 | 18227 | 9592 | 4706 | 3218 | 910 | 3070 | 10065 | 59551 |
| **2003** | 6819 | 4952 | 29021 | 11015 | 4236 | 2206 | 779 | 2011 | 10513 | 71552 |
| **2004** | 6210 | 8343 | 37806 | 10602 | 4587 | 3757 | 1408 | 3165 | 11157 | 87035 |
| **2005** | 10034 | 8890 | 33727 | 12706 | 4357 | 1346 | 1305 | 2336 | 15149 | 89850 |
| **2006** | 10015 | 7834 | 32464 | 9679 | 4241 | No data | 1418 | 4948 | 13314 | 83913 |
| **2007** | No data | 7142 | 21844 | 3833 | 6506 | No data | 1734 | 1377 | 13959 | 56445 |

Source: (Health Systems Trust 2005)

According to the statistics (as outlined in table 1.2), there appears to be a difference between the percentage of childbearing women in the NWP and other provinces. In the NWP the women in their reproductive years presents 6.69% of the country's population, while the percentage for TOPs in NWP was 2.68%. These statistics seem to indicate that some of the NWP's women might access TOP services in other provinces.

Only 20.25 % of South Africa's women in their reproductive years live in the Gauteng province but 38.55% of TOPs were done in this province. This might indicate that pregnant women from other provinces might access TOP services in the Gauteng province.

**Table 1.2 Mid-year 2007 population estimates by year, province, gender and age**

| PROVINCES | FEMALE AGES | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 2007 | 10 – 14 | 15 – 19 | 20 - 24 | 25 – 29 | 30 – 34 | 35 – 39 | 40 - 44 | 45 – 49 | 50 – 54 | 55 – 59 |
| **Eastern Cape** | 363300 | 407800 | 367700 | 297700 | 230400 | 195800 | 151200 | 144500 | 145600 | 121200 |
| **Free State** | 147400 | 148100 | 145300 | 134600 | 118400 | 105400 | 80800 | 71400 | 65000 | 55100 |
| **Gauteng Province** | 477400 | 447400 | 481400 | 537700 | 556600 | 494600 | 349200 | 301300 | 272200 | 216400 |
| **Kwa-Zulu Natal** | 589400 | 601100 | 559100 | 512600 | 429800 | 360600 | 255400 | 231700 | 207300 | 171400 |
| **Limpopo Province** | 320600 | 335700 | 297400 | 250900 | 202700 | 168100 | 119400 | 109300 | 97200 | 84400 |
| **Mpumalanga** | 214800 | 204400 | 194800 | 172800 | 146300 | 126800 | 90600 | 78500 | 66500 | 56800 |
| **Northern Cape** | 63700 | 57300 | 53400 | 46600 | 42100 | 38200 | 30300 | 27300 | 26400 | 22700 |
| **North West** | 167400 | 163300 | 158100 | 138600 | 126600 | 112600 | 83900 | 73200 | 67700 | 55400 |
| **Western Cape** | 239100 | 233300 | 239900 | 247000 | 225500 | 202900 | 158400 | 140600 | 129700 | 105500 |

Source: (Statistics South Africa 2007)

Prior to 1996, reportedly 800 to 1000 TOPs were legally performed each year in South Africa. Those women who could not access these services might have resorted to illegal and dangerous TOP services (Jewkes, Gumede, Westaway, Dickson, Brown & Rees 2005:1236). Illegal TOP services continue in the inner city of Pretoria in South Africa despite the accessibility of legal TOP services in terms of the provision of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008 (*The Sunday Sun* 2007:7) (see annexure H).

In South Africa, only half of the health facilities, including primary health care (PHC) services in the NWP are authorised to provide safe and legal TOP services (*The City Press* 2007:10) (see annexure H).

## 1.3 PROBLEM STATEMENT

Moule and Goodman (2009:393) describe a research problem as a broad topic area of interest that has perplexing or troubling aspects which can be solved by the accumulation of relevant information or evidence. In South Africa, TOP services has been legalised since 1996 and the implementation of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, in February 1997.

However, many studies reveal that nurses might still have judgemental attitudes towards women who request TOPs, denying them access to TOP services. According to Morroni et al (2006:1), TOP services are still inaccessible to many women because of the stigma, nurses' resistance to provide TOPs and the lack of trained nurses providing TOP services.

Similarly, a number of nurses (36.0%) reported that nurses refused to provide TOP services to women who requested it. The nurses' refusal to provide TOPs led to complex and fragmented levels of services and the inaccessibility of TOPs throughout many health care facilities (Harries, Stinson & Orner 2009:10; Mokgethi et al 2006:37).

Another contributory factor to the inaccessibility of TOP services is the lack of public health facilities designated by national and provincial departments to provide TOP services in rural areas. It is further stated that illegal TOP services still occur due to the challenges experienced by women requiring TOP services (Morroni et al 2006:1). In order to improve TOP services in the NWP, challenges encountered by women requesting TOP services have to be identified and addressed. The research problem can thus be stated as follows:

Although TOP services are legalised and available in the NWP, some barriers remain that prevent women from accessing and using these services at the designated facilities.

## 1.4 PURPOSE OF THE STUDY

South Africa legalised TOP services in 1996, which allows women to choose to terminate unplanned pregnancies at designated facilities. However, disparities might

exist between the availability and quality of TOP services in more developed provinces like Gauteng and services provided in poorer rural provinces like the NWP. Public health care facilities throughout South Africa do not have sufficient staff, training and equipment to meet the needs of TOP services (*The Mail & Guardian* 2007:2) (see annexure H).

Women who request TOP services face these challenges even though they are protected by the Constitution of the Republic of South Africa and the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, in the sense that they cannot access these services when they need to do so. Harries et al (2009:2) argue that the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, allows the nurses the right to conscientious objections to provide TOP services. Furthermore, this right is supported by the constitutional rights of all South Africans to freedom of thought, belief and opinion. Nurses may refuse to perform TOP services based on the right of their freedom of beliefs.

However, these nurses are obliged to inform a woman of her reproductive right to choose to undergo a TOP and to refer her to another nurse or facility providing TOP services. Therefore, the purpose of this study will be to develop best practice guidelines for implementing the CTOP Act's provisions, and suggest recommendations for improved policies so that every woman in the NWP who wants to do so can access TOP services.

## 1.5 RESEARCH QUESTIONS

This study was conducted in three phases. The research problem led to the following questions concerning the challenges encountered by women who requested TOP services.

**Phase 1**

- Why are TOP services not accessible to all women who request it?
- What are the obstacles experienced by women requesting TOP services?
- What is the level of satisfaction of women requesting TOP services?
- Why do women still seek illegal TOP services?

- Why do women not use contraceptives provided free of charge at the public health facilities to prevent unplanned pregnancies?
- Why can women not negotiate safe sex (condom use) to prevent unwanted pregnancies?
- Do women who seek TOP services receive pre- and post-TOP counselling?
- Do women receive contraceptive counselling post-TOP services?
- What impact do women's culture, religion, values and beliefs have on their access to TOP services?
- Is confidentiality of the TOP services maintained?

**Phase 2**

- What factors contributed to the inaccessibility of TOP services for women who requested it?
- What are the opinions and feelings of these women about the TOPs?
- What are the perceived barriers to accessing TOP services in the NWP?

**Phase 3**

- Do public health facilities, providing TOP services have a sufficient number of trained nurses to provide TOP services in the NWP?
- What are the perceptions and opinions of nurses regarding TOP services?
- What impact do nurses' religious values, morals and beliefs have on providing TOP services?
- What are the attitudes of nurses towards women who request TOP services?
- What are the obstacles in the implementation of the CTOP Act's provisions?
- How are nurses' personal lives influenced by the fact that they are rendering TOP services?
- What kind of support do nurses, providing TOP services, receive from their families, colleagues, managers and communities?
- What are the circumstances of nurses working in TOP services?
- How do nurses who provide TOP services view the TOP service guidelines?
- Do nurses provide pre- and post-counselling to women who requested TOP services?

## 1.6 RESEARCH OBJECTIVES

The objectives of this study focusing on the challenges of women who had used TOP services in phase 1 were to

- determine why TOP services are not accessible to all women who request it
- identify the obstacles experienced by women requesting TOP services
- ascertain whether women requesting TOP services are satisfied with the services provided
- establish why women still seek illegal TOP services
- determine why women are not using contraceptives provided freely at the public health facilities to prevent unplanned pregnancies
- identify reasons why women cannot negotiate safe sex (condom use) to prevent unwanted pregnancies
- establish whether women who seek TOP services receive pre- and post-TOP counselling
- ascertain whether women receive contraceptive counselling post-TOP services
- determine to what extent do women's culture, religion, values and beliefs influence them to access TOP services
- verify to what extent the confidentiality of the TOP services is ensured

The objectives of this study focusing on the challenges encountered by women who requested TOP services but could not access it in phase 2 were to

- establish the contributory factors for inaccessibility of TOP services to women who requested it
- identify the opinions and feelings of these women about TOPs
- describe the perceived barriers they encountered to access TOP services in the NWP

The objectives of this study, focusing on the challenges encountered by nurses providing TOP services, in phase 3 were to:

- establish whether the public health facilities providing TOP services have a sufficient number of trained nurses to provide TOP services
- identify the perceptions and opinions of nurses regarding TOP services
- describe the religious values, morals and beliefs of nurses providing TOP services and its influence on the nurses providing TOP services
- explore and describe the attitudes of nurses towards women who requested TOP services
- identify obstacles experienced by nurses in the implementation of the CTOP Act
- explore and describe to what extent the personal lives of nurses might be influenced by their rendering of TOP services
- ascertain the kind of support nurses, providing TOP services, receive from their families, colleagues, managers and communities
- determine the circumstances under which nurses, rendering TOP services, are working in TOP facilities
- ascertain the views of nurses providing TOP services regarding the TOP guidelines
- determine whether nurses provide pre- and post-counselling to women who requested TOP services

## 1.7 SIGNIFICANCE OF THE STUDY

This study will identify specific challenges encountered by women who request TOP services in the designated public health facilities in the NWP as well as challenges faced by nurses who provide TOP services. The study will also assist the policy makers to improve the TOP guidelines in order to improve health facilities in the NWP.

Brink, Van der Walt and Van Rensburg (2006:61) state that a study should have the potential to contribute to health sciences knowledge in a meaningful way. Therefore, if the challenges of women requesting TOP services could be identified, this knowledge would help in:

- Improving the provision of TOP services in the NWP by creating an environment in TOP facilities where women could access their TOP services freely without intimidation or judgement from nurses.

- Designing guidelines for TOP services that would benefit both nurses and women who request TOP services.
- Providing or improving the pre- and post-counselling of women requesting TOP services.
- Improving the accessibility to TOP services in the NWP.
- Expanding the knowledge and education of women with regard to the CTOP Act.
- Expanding the in-service training of nurses on TOP services.
- Extending the utilisation of reproductive health services in the NWP.
- Providing useful information to the policy-makers regarding identified needs of the women requiring TOP services as well as the nurses offering TOP services.

## 1.8 DEFINITIONS OF KEY CONCEPTS

The definition of concepts used throughout this thesis is:

- **Abortion** – deliberate ending of a pregnancy at an early stage (*Oxford Dictionary* 2005:3). For the purpose of this study, abortion means the removal of the foetus from the womb by legal or illegal means, before the foetus can survive independently outside the uterus.
- **Attitude** – the way that you think and feel about somebody or something, the way that you behave towards somebody or something that shows how you think and feel (*Oxford Dictionary* 2005:81). For the purpose of this study, "attitude" refers to the feelings of nurses about the CTOP Act.
- **Challenge** – according to the *Oxford Dictionary* (2005:231) "challenge" refers to a new or difficult task that tests somebody's ability and skill. With respect to this study, "challenge" refers to anything that makes it difficult for women to access TOP services or for health care providers to deliver TOP services.
- **Choice on termination of pregnancy (CTOP)** – for the purpose of this study "CTOP" means the choice a woman makes to terminate her pregnancy under the provision of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008.
- **Counselling** refers to professional advice about a problem (*Oxford Dictionary* 2005:332). For the purpose of this study "counselling" refers to the "professional advice" women receive pre- (before) and post- (after) the TOP procedure.

- **Need** – according to the *Oxford Dictionary* (2005:979) “need” refers to require somebody or something because they are essential or very important, not just because you would like to have them. For the purpose of this study “needs” refers to what women require in order to exercise their rights to access and utilise TOP services.
- **Obstacle** – according to the *Oxford Dictionary* (2005:1007) “obstacle” refers to a situation or an event that makes it difficult for you to do or achieve something. In this research “obstacle” refers to anything which obstructs progress in the implementation of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, which in turn denies women access to TOPs.
- **Perception** – according to the *Oxford Dictionary* (2005:1079), “perception” refers to the way you notice things especially with the senses. With respect to this study “perception” refers to the way of understanding and interpreting TOP services by nurses working in the public health facilities in the NWP.
- **Professional** is connected to a job that needs special training or skill especially one that needs a high level of education (*Oxford Dictionary* 2005:1159). For the purpose of this study “professional” will refer to a nurse or midwife providing TOP services.
- **Professional nurse** – denotes a type of a job that involves looking after people, the caring profession or having the skills of a professional (*Oxford Dictionary* 2005:1159). For the purpose of this study, a professional nurse shall mean an individual who has undergone training to perform TOP services and is registered with the South African Nursing Council (SANC) as a midwife.
- **Support** – to encourage somebody by saying or showing that you agree with them (*Oxford Dictionary* 2005:1486). For the purpose of this study “support” refers to anybody who provides emotional support, equipment, training and guidelines to nurses or midwives providing TOP services or who make sure that systems are in place to allow women to access TOPs including those who requested TOP services but could not manage to access it.
- **TOP** according to the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, refers to the separation and the expulsion by medical or surgical means of the contents of the uterus of a pregnant woman. For the purpose of this study, “TOP” means termination of pregnancy by medical or surgical means.

- **Woman** – an adult female human (*Oxford Dictionary* 2005:1692). With respect to this study "woman" shall mean any female aged 12 and older who is legally able to terminate her pregnancy up to 12 weeks' gestational period without permission from her parents or spouse according to the provisions of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, in South Africa.
- **Women who requested TOP services** – Any woman aged 12 and older who had requested TOP services. This category includes women who (1) acquired TOP services and also those (2) who could not access TOP services. In order to limit unnecessary repetitions of phrases, the first group of women will be referred to as women who had used TOP services or who had undergone TOPs. This implies that these women had requested and used TOP services. The second group of women will be referred to as women who requested but failed to access TOP services.

## 1.9 RESEARCH DESIGN AND METHODOLOGY

Terre Blanche, Durrheim and Painter (2010:563) define a research design as a strategic framework or plan that guides research activity to ensure that sound conclusions are reached. Polit and Beck (2008:765) describe research methodology as the technique used to structure a study, gather and analyse information in a systematic manner. This study used a descriptive, quantitative and non experimental research design. Structured interviews were used to collect data from women who requested TOP services, those who requested TOP services but who could not manage to access these services and nurses providing TOP services at the clinics and hospitals providing TOP services in the NWP (Polit & Beck 2006:414; Brink et al 2006:151-152).

### 1.9.1 Phase 1 of the study

Phase 1 of the study used a quantitative, descriptive method and the study population comprised all South African women of all races, groups, educational status and socio-economic status in the NWP. A convenient sample was used to collect data from women who had used TOP services in the NWP and the researcher used structured interviews to collect data. The data collected were coded and entered in the Microsoft Excel programme by a statistician (Polit & Beck 2006:15-262). A total of 150 women, who had used TOP services, participated in the study.

### 1.9.2 Phase 2 of the study

Phase 2 of the study followed a quantitative descriptive research design. According to Burns and Grove (2007:240), a descriptive study is designed to gain more information about characteristics within a particular field of the study. The descriptive design can be used to develop theories, identify problems with the current practice, justify current practice, make judgements or determine what other practitioners in the similar situations are doing. The study population comprised women who requested TOP services but could not manage to access it in the NWP. A convenient sample of 50 women who requested TOP services but could not manage to access it, was selected on the days where the researcher was at the research sites at the clinics and hospitals providing TOP services in the NWP (Polit & Beck 2006:497).

### 1.9.3 Phase 3 of the study

In this phase of the study a quantitative, descriptive, exploratory research design was used. An exploratory research design should detail how the researcher plans to collect information and where she or he will do so (Terre Blanche et al 2010:44). This population comprised 20 nurses who provided TOP services in the identified clinics and hospitals in the NWP. Nurses who were not directly involved with TOP services were excluded from the study. The researcher personally conducted structured interviews with the nurses providing TOP services in the NWP.

## 1.10 ETHICAL CONSIDERATIONS

According to Brink et al (2006:31) there are three fundamental ethical principles that guide researchers, namely respect for a person, beneficence and justice. These principles are based on the human rights that need to be protected in research. In this study the researcher had an ethical responsibility to recognise and protect the rights of human participants.

The researcher adhered to the following principles:

- respect for a person
- the principle of beneficence

- the principle of justice
- the principle of privacy

Permission to conduct the study was requested from and granted by the authorities of the identified public health facilities providing TOP services in the NWP, namely: the Director Policy, Planning and Research, Chief Director Corporate Services and Superintendent General (see annexure A). The researcher also sought approval from the ethics committee in these institutions and from the Research and Ethics Committee of the Department of Health Studies, UNISA and from the Department of Health of the NWP, including the managers of the 14 sites visited for data collection purposes.

### 1.10.1 Respect for a person

The respondents were given freedom to decide whether or not to participate in the research (Brink et al 2006:32). The respondents were informed that they could withdraw from the study at any time, without incurring any negative consequences whatsoever. The researcher respected this right by avoiding any form of coercion.

### 1.10.2 The principle of beneficence

The respondents were not exposed to any physical, emotional, spiritual, social or economical harm. TOP services are a very sensitive matter and the researcher identified an environment that was conducive to conduct the structured interviews privately (Brink et al 2006:32; Polit & Beck 2006:87).

The respondents were continuously monitored for any signs of distress. Should these occur, the researcher facilitated debriefing by giving respondents the opportunity to ask questions or air complaints and if necessary, referred the respondents for further counselling (Brink et al 2006:33 cite Polit, Beck & Hungler 2001).

### 1.10.3 The principle of justice

This principle includes the respondents' right to fair selection and treatment. The available respondents were selected for reasons directly related to the study problem (Brink et al 2006:33).

### 1.10.4 The principle of privacy

TOP services are a very sensitive and private matter, therefore, the researcher ensured that the information gathered during the process of the interviews remained strictly confidential and anonymous (Brink et al 2006:33). The researcher ensured that no name was written on the interview schedule. No completed interview schedule could be linked to any specific respondent.

The researcher, supervisors and the statistician were the only people who had access to the completed interview schedules. The interview schedules were kept locked up and would be destroyed after the acceptance of the research report.

- **Informed consent**

According to Polit and Beck (2006:93), informed consent means that respondents have adequate information regarding the research, are capable of comprehending the information and have the power of free choice, enabling them to consent to or decline participation, voluntarily. Therefore, the respondents were informed in writing that participation was voluntary.

The respondents were also told that they had the right to withdraw from the study without any penalty at any time (Polit & Beck 2006:93). The purpose of the study, data collection method and the participation needed from the respondents were explained (Brink et al 2006:36). The respondents gave consent to participate in the study by agreeing to be interviewed and were not expected to sign a consent form as was indicated in the attached letter (see annexure C).

- **Benefits from the research**

The researcher informed the respondents that there were no financial benefits for participating in the study. However, the research findings could benefit each participating public health facility to improve access to TOP services and enhance the level of support from management, families, colleagues and the community (Polit & Beck 2006:92).

## 1.11 LIMITATIONS OF THE STUDY

Generalisation of the study's results would be limited to the NWP. Therefore, the study would have to be repeated in the other eight provinces in SA prior to generalisation of the research results to the entire country.

Women who request TOP services might want the procedure to be confidential, that no one should know about it and the interview might be perceived as a break of confidentiality and they might withhold some information.

## 1.12 THEORETICAL FRAMEWORK OF THE STUDY

This study will be guided by the major tenets of the Health Belief Model (HBM) described by Mackey (2002:8). These major tenets of the HBM include:

- Modifying factors
- Individual perceptions
- Likelihood of action

The HBM will be discussed in detail in chapter 2.

## 1.13 ORGANISATION OF THE REPORT

The report of this study will be organised as follows:

Chapter 1: This chapter introduced and presented information about the study. The background of the study, problem statement, purpose of the study, research questions and objectives, significance of the study, definitions of the concepts, research methodology, ethical considerations, research settings, limitations of the study, the theoretical framework, data analysis and the organisation of the research report are addressed in chapter 1.

Chapter 2: The second chapter of this thesis presents a review of literature related to TOP services globally and in South Africa. The HBM will be discussed in more detail in this chapter.

Chapter 3: This chapter outlines the research methodology employed to obtain data to answer the research questions guiding this research project. The research populations, samples, instruments, ethical and legal issues pertaining to each phase of the research process will be addressed. Data collection and analysis methods as well as the validity and reliability of the research instruments will be discussed.

Chapter 4: This chapter presents the research results of phase 1, based on structured interviews conducted with women who had used TOP services in the NWP.

Chapter 5: This chapter discusses the research results received from data collected in phase 2, based on 50 structured interviews conducted with women who could not access TOP services in the NWP.

Chapter 6: The results of phase 3 will be analysed and discussed in this chapter. During phase 3, 20 interviews were conducted with nurses providing TOP services in the NWP.

Chapter 7: This chapter will comprise recommendations to improve the accessibility of TOP services in the NWP and present guidelines to improve the TOP services and conditions of nurses providing TOP services. It will also address the limitations and conclusions of the study.

## 1.14 SUMMARY

Women in South Africa might still face challenges when requesting TOP services even after its legalisation by the CTOP Act's (no 92 of 1996), as amended by Act no 1 of 2008. Therefore, the questions to be answered by this study are: What are the challenges, encountered by women who had used TOP services? What challenges did women encounter who wished to use TOP services but could not manage to access it? What challenges do nurses, providing TOP services in NWP encounter? What measures can be instituted to improve access of TOP services in the NWP?

The literature review, relevant to TOP services generally and to challenges in accessing TOP services specifically in South Africa, will be presented in chapter 2. The theoretical framework will also be discussed in more detail in chapter 2.

# CHAPTER 2

# Literature review

## 2.1 INTRODUCTION

Literature relevant to TOP services globally and in South Africa, was reviewed. In this chapter, literature will be reviewed from empirical and theoretical sources based on the research questions. The research was guided by the major tenets of the HBM stipulated in Mackey (2002:8).

- **Reasons for doing a literature review**

The main reasons for conducting a literature review is to minimise the possibility of duplication and to identify baseline data about what is known about TOP services in order for this study to address the challenges encountered by women requesting and nurses providing TOP services. Unisa's subject librarian consulted the following databases to obtain sources relevant to TOPs:

- http://www.healthlink.org.za (health information)
- Computerised Index to Nursing and Allied Health Literature (CINAHL)
- Oasis library catalogue – accessed via Unisa website: http://www.unisa.ac.za
- References to South African materials
- References to journal articles
- Public health facilities
- Magnet search of references for material in South African libraries
- International nursing index

The key concepts used to obtain relevant literature included:

- Termination of pregnancy (TOP) in South Africa
- Attitudes of nurses towards TOP services
- Reproductive health

- Pre- and post-TOP counselling
- Perceptions about TOP services
- Health Belief Model

## 2.2 THE HEALTH BELIEF MODEL

Boskey (2010:1) describes the HBM as a tool that a scientist uses to try and predict health-related behaviours. It is based on the theory that a person's willingness to change his/her health behaviours primarily depends on their perceived susceptibility to the condition, perceived severity of the disease/condition, perceived benefits from healthcare actions and perceived barriers to access services.

- **Perceived susceptibility**

People will not change their health behaviours unless they believe that they are at risk. Pregnant women who think they are at risk of complications and death when using illegal TOP services, will request legal TOP services. However, if pregnant women should be unable to access legal TOP services, they might continue to resort to illegal TOPs.

- **Perceived severity**

The probability that persons will change their health behaviours to avoid consequences depends on how serious they consider these consequences to be. If women do not avoid unplanned pregnancies, they might require TOP services. If the perceived severity of undergoing a TOP is less than that of raising an unwanted child, then they are likely to resort to TOPs.

- **Perceived benefits**

It is difficult to convince people to change their behaviours when there are no perceived advantages for them. The pregnant women who need safe TOPs will not stop undergoing illegal TOPs unless they are convinced that legal TOPs are safer than illegal TOPs.

- **Perceived barriers**

One of the major reasons why people do not change their health behaviours is that they think that doing so is going to be hard. Changing one's behaviour can cost time, money and effort (Boskey 2010:1).

Barriers could be encountered by women requesting TOP services (and by those women who wished to receive TOP services but who could not access these services). These barriers could include a lack of knowledge about legal TOPs, lack of money for transport, personal and religious and community attitudes towards TOPs and nurses' attitudes towards women seeking TOPs.

The most influential aspects of the HBM and perceived barriers which could lead to perceived threats of illegal TOP services, complications and death are portrayed in figure 2.1.

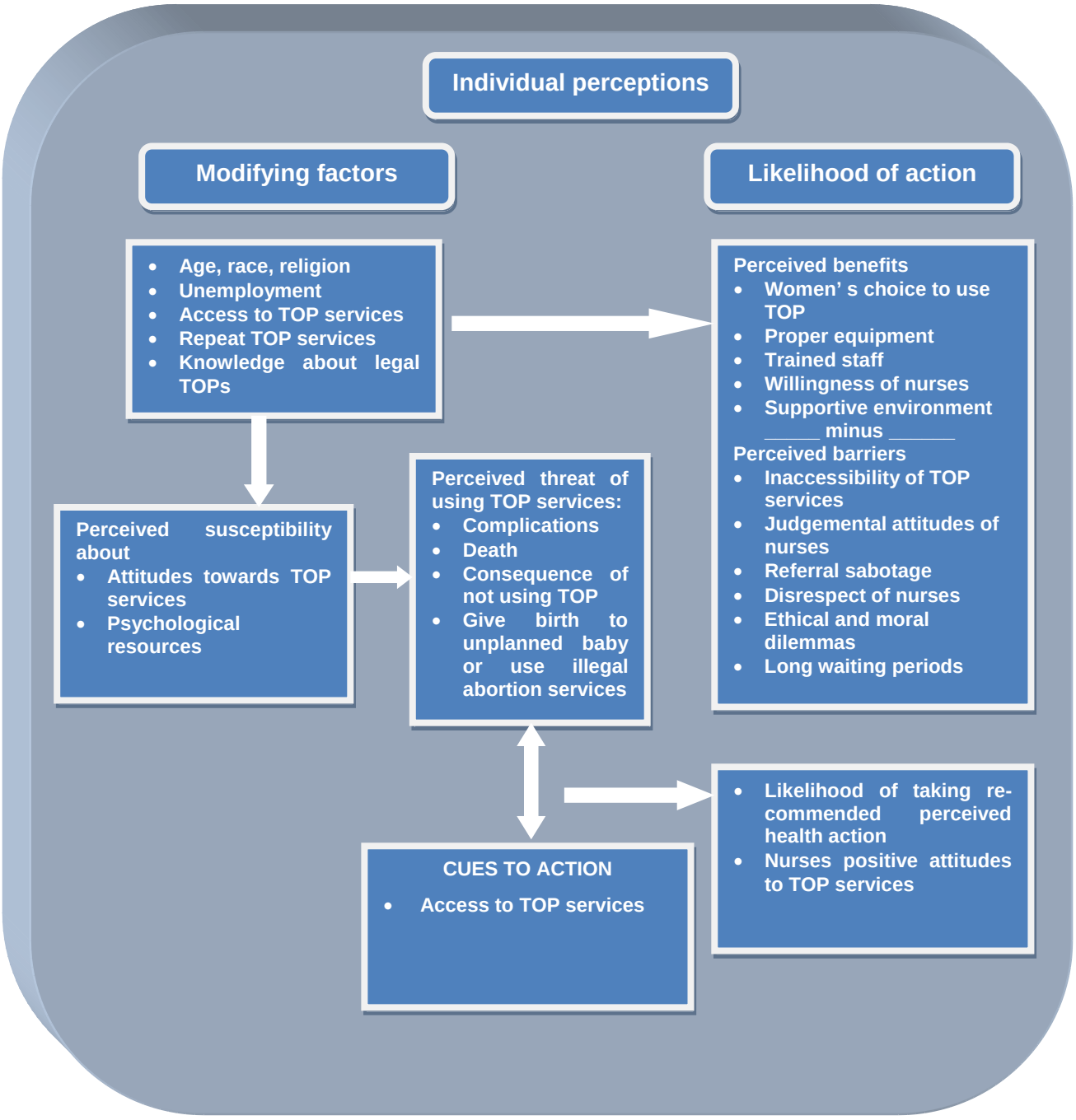



**Figure 2.1 Elements of the Health Belief Model associated with TOP Services**

Source: Mackey (2002:8)

## 2.3 THE CONTEXT OF TERMINATION OF PREGNANCY INTERNATIONALLY IN RELATION TO THE HEALTH BELIEF MODEL

Voluntary TOP services had been legalised in more than one hundred countries in the developed world. However, it remains a controversial procedure in medical practice. Providing greater access to safe TOP services reduces the public health burden of unsafe TOPs, causing on estimated 68 000 deaths and five million permanent or temporary disabilities per annum, primarily in developing countries (Lang et al 2005:52; Harries et al 2009:2; Gipson & Hindin 2008:1827).

### 2.3.1 Legislation and statistics in the termination of pregnancies in different countries

Different countries have different legislations with regard to TOP services, therefore it is important to analyse and review the literature of the contextualisation of this study.

- **Sweden**

According to Hammarstedt, Lalos and Wulff (2006:229) the TOP law was implemented in 1975 in Sweden. The Swedish law stipulates that:

- Gynaecologists are supposed to perform TOP services without questions at a woman's request before 18 weeks' gestational age. Women are supposed to decide for themselves liberalised whether to terminate their pregnancies or not. Since the end of 1990, the annual number of legal TOPs ranged from 32 000 to 35 000 in Sweden.
- TOPs are permitted up to 18 weeks' of gestation and after 22 weeks with permission from the National Board of Health and Welfare (of Sweden).

- **United Kingdom**

According to Griffith (2007:514) the TOP Act was introduced in 1967 in the UK. However, both pro-life and pro-choice groups were dissatisfied with the TOP law and called for changes. The pro-life group asks for reduction in the time limit of TOP services and a statutory cooling off period. The pro-choice group demands fewer

regulations and increased choices for women by allowing nurses to provide TOP services. The TOP Act of 1967 section (1) provides four grounds for TOP services in the UK:

- Risk to the physical or mental health of the pregnant woman or the existing children
- Prevention of grave permanent physical or mental injury of a child or mother
- Risk to the life of the mother
- A substantial risk that the child will suffer from physical or mental abnormalities so as to be seriously handicapped

Therefore, the time limit for the seriously handicapped as the only ground imposed by the provisions the TOP Act of 1967, is currently at 24 weeks' gestation in the UK. The Human Embryology and Human Fertilisation Act of 1990, updated the TOP Act of 1967, reducing the legal time limit for TOP services from 28 to 24 weeks' gestation. A total of 186 400 TOP services were performed in England and Wales during 2005 (Davis 2007:19).

- **Australia**

According to Morris and Orr (2007:709), the Australian states originally based their TOP legislation on the British law, which was incorporated into their Crimes Act. However, in 1997 most Australian states also liberalised their laws. The Australian Capital Territory is the only State or Territory that does not refer to termination of pregnancy in its criminal code. Therefore, the new law is the most liberal, but varies in different Australian states, allowing women to have TOPs at any time during the first 24 weeks of pregnancy and later if they obtain the agreement of two doctors (Austin & Rood 2008:1; Morris & Orr 2007:710).

South Australia, Western Australia, Tasmania and the Northern Territory have legislation stipulating when TOP is illegal. In Australia, the foetus is not recognised as a person in the eyes of the law. Morally, respect for foetal life increases after viability which is considered as the beginning of life. Furthermore, once the foetus reaches viability, there is conflict between the rights of the mother and those of the foetus because of ethical issues (Morris & Orr 2007:709-710).

- **India**

The Medical Treatment of Pregnancy Act of 1971 was promulgated to provide for legal TOP services by physicians, and this TOP law influenced the perception of the foetus in terms of “maternal-foetal medicine” in India. The Act provides for legal termination of a pregnancy not exceeding 12 weeks’ gestation. With agreement of two physicians, based on risks to the woman’s life, mental or physical health, and mental or physical handicaps to the child, termination up to 20 weeks’ gestation is permitted (Myser 2008:51).

- **Turkey**

According to the TOP law in Turkey married women who request TOP services must have the consent of their husbands. Single women who are older than 18 years can have TOP services on request without consent. Those women who are under 18 years of age must have consent of their parents before requesting TOP services in terms of the Family Planning Law of 1983 in Turkey. The latest statistics of TOPs performed in Turkey is 1 958 501 illegal termination of pregnancies still took place and only 454 373 per annum of those TOP services were terminated legally (Kavlak, Atan, Saruhan & Sevil 2006:6).

- **Poland**

According to Wikipedia (2008:1), parental consent is always required if a woman seeking TOP services is a minor in Poland. It is further stated that persuading a woman to carry out illegal TOP services is a criminal act in the same way as an actual illegal TOP.

- **Indonesia**

During 2005 doctors and pressure groups working in women’s health in Indonesia have been pushing to decriminalise and change the law that penalises trained doctors for performing TOP services. Doctors can face up to 15 years in prison for performing TOP services and the woman requesting TOP services up to 4 years (Bakkalapulo 2005:1).

Although TOP services are illegal in Indonesia, women each year access TOP services accounting for 70% of all the TOP services in South-East Asia. The majority of TOPs are carried out by traditional healers who might use dangerous practices, possibly causing deaths and disabilities (Randhawa, Hull & Herdiyami 2008:2).

- **Italy**

TOP services were legalised in 1978 in Italy. According to Italian law, voluntary TOP services can be accessed within 90 days of gestation, on the grounds of physical, psychological, economic, social or family conditions. The Italian Roman Catholic Church argues that the Italian TOP services law must be re-evaluated and changed. Italy's 30 years old TOP services law, allows TOPs up to three months and thereafter only if the unborn child is malformed. Ethical and philosophical opposers to Italy's TOP laws, continue to campaign against TOPs (Colley 2007:1).

- **New Zealand**

The Medical Termination of Pregnancy law was implemented in 2002 in New Zealand. During the 2004 period, 18211 TOPs were performed. The majority of these TOPs were performed surgically in the first trimester under local anaesthesia. The surgical TOP takes place at 9-12 weeks' gestation in public hospitals. A pregnant woman requesting a TOP in New Zealand, often has to wait several weeks after the initial consultation with the doctor (Goodyear-Smith, Knowles & Masters 2006:193).

## 2.4 TERMINATION OF PREGNANCY IN THE AFRICAN CONTEXT

Different legislations are used to regulate TOP services in specific African countries.

- **Kenya**

According to Mushtaq (2008:1), the TOP law in Kenya dates back to 1897 and it states "Any person who with intent to procure miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious things or uses force of any kind or uses any other means whatever, is guilty of a felony and is liable to imprisonment for fourteen years".

According to a 2004 study by the Ministry of Health, funded by the Rockefeller Foundation and titled “A national assessment of the magnitude and consequences of unsafe abortion in Kenya”, 300000 women get abortions in Kenya each year, nearly half of them are aged 14-24. More than 20000 of them end up in hospitals with complications after unsafe TOPs (Mushtaq 2008:1).

- **Nigeria**

TOP is legal in Nigeria only to preserve the mother’s life, but health specialists report that large numbers of procedures are performed both in the predominately Christian South and Muslim North. In 2008 the Society of Gynaecology and Obstetrics of Nigeria reported that 11% of maternal deaths in Nigeria are caused by unsafe TOPs (Ralston & Podrebarac 2008:3; Nwogu-Ikojo & Ezegwui 2007:835).

- **Senegal**

In Senegal legalisation of TOP is based on the 1810 Penal Code which makes TOPs illegal in Senegal, except to save the mother’s life. For a woman to qualify for a TOP, two physicians must concur that her life is in danger and one of these physicians must be on a court approved list (Ralston & Podrebarac 2008:3).

- **Zimbabwe**

The country’s TOP law was changed in 1977 to allow the procedure when the mother’s physical health is at risk, when the pregnancy is a result of “unlawful intercourse” such as rape or incest, when the foetus is at risk of physical or mental defects or when the life of the mother is endangered. Formal authorisation and certification is required in all these circumstances, a process that some TOP rights advocates say drives many women to seek illegal TOP services (Ralston & Podrebarac 2008:3).

## 2.5 THE SOUTH AFRICAN LEGISLATION OF TERMINATION OF PREGNANCY

The need for TOP services in South Africa increased since the legalisation of TOPs in 1996. This requires that more and more nurses should work in TOP services regardless of their beliefs, morals and values.

### 2.5.1 The Constitution of the Republic of South Africa, 1996

According to the Constitution of the Republic of South Africa Act (no 108 of 1996:13), everyone has the right to have access to health care services, including reproductive health care. Relating to the HBM, the constitution is a modifying factor to enable women to access TOP services in South Africa (Mackey 2002:8). Furthermore, the state must take reasonable legislation and other measures, within its available resources to achieve the progressive realisation of each of these rights and no one must be refused emergency medical treatment.

### 2.5.2 The Children's Act 38 of 2005

The Children's Act (no 38 of 2005) allows access to contraceptives to children aged 12 years in South Africa, stating that every person of a reproductive age should have such access in addition to reproduction information without a parent's or a guardian's consent, including TOP services.

### 2.5.3 The South African Choice of Termination of Pregnancy Act (no 92 of 1996), as amended by Act no 1 of 2008

According to the provisions of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, in South Africa, TOP services can be accessed on request of a woman during the first 12 weeks of pregnancy. During this period, a pregnant woman can access TOP services without giving any reason for requesting a TOP service. However, from the 13$^{th}$ to the 20$^{th}$ week, TOP is only available on the following grounds:

- If the continued pregnancy would pose a risk of injury to the woman's physical or mental health

- If there exists a substantial risk that the foetus would suffer a severe physical or mental abnormality
- If the continued pregnancy would significantly affect the social or economic well-being of a woman
- If the pregnancy resulted from rape or incest

Furthermore, TOPs are also available after the 20th week of gestation, provided two medical practitioners or a medical practitioner and a registered midwife, who has completed the prescribed TOP training, are of the opinion that the continued pregnancy would

- endanger the woman's life
- result in severe malformation of the foetus
- pose a risk of injury to the foetus

## 2.6 WORLDWIDE CHALLENGES TO ACCESS TERMINATION OF PREGNANCY SERVICES

The study conducted in Australia by Rowe, Kirkman, Hardiman, Mallett and Rosenthal (2009:69), revealed that women can access TOP services for unwanted pregnancies in both private and public hospitals. Women with unplanned or unwanted pregnancies can contact these services, usually by telephone, for information about their options, including TOP services, continued pregnancy support, advocacy and counselling. This advice is provided by health professionals, social workers and counsellors.

Over 800 000 pregnancies occur among adolescents annually in the United States of America (USA). However, adolescents experience unique barriers to access TOP services that delay care and increase the cost and complexity of TOPs (Dragoman & Davis 2008:281).

According to Harries, Gabriel and Mitchell (2007:1), despite the changes to the TOP legislation in South Africa in 1996, barriers to woman's access to TOP services still exist. It is further stated by the same authors that the other challenge is the nurses' attitudes towards TOP services and also towards trained and willing TOP providers. These challenges to access TOP services undermine the availability of safe and legal TOPs.

MacPhail, Pettifor, Pascoe and Rees (2007:1) argue that in South Africa, large numbers of adolescent women reported unwanted pregnancies but only a few had accessed available TOP services.

According to Sedgh, Henshaw, Singh, Bankole and Drescher (2007:219), the review of TOP services provision in 2000 revealed that access to TOP services remained limited, inequitable and that many hospital-based providers were openly hostile towards women requesting TOP services.

Mokgethi et al's (2006:38) study reported that nurses would prefer to work in TOP services out of their own free will, and not be coerced to work in TOP services, without fear of retaliation should they refuse to do so. Jewkes et al (2005:1241) confirmed that the success of the TOP services would be enhanced by nurses who choose to work in TOP services rather than by nurses who provide TOP services as part of general female patient care.

Furthermore, Rakhudu, Mmelesi, Myburgh and Poggenpoel (2006:57) argue that the success of TOP services depends on the views of the health workers, the communities and the traditional healers. These authors base their argument on the fact that traditional healers form part of people who might contribute to the success or failure of TOP services. They are influential members of the communities, thus their opinions are important.

According to Ratlabala, Makofane and Jali (2007:26) teenage pregnancies, unsafe TOP methods and the high incidence of HIV infections among young people are serious concerns in South Africa. If adolescents continue to lack information about TOP services, they will be unable to utilise these services to terminate unplanned and unwanted pregnancies. If TOP services remain inaccessible to the youth, the problem of illegal TOP services will not be addressed.

Harries et al (2009:7) argue that many nurses felt uncomfortable about the second trimester TOP services and found it more traumatic to deal with TOPs performed around 17-20 weeks, than a termination at 14 weeks' because in the latter, it is dealing with an embryonic sac rather than a formed foetus. Similarly, Lindström, Jacobsson, Wulff and Lalos' (2007:234) study reveals that the occurrence of surgical, medical and

repeat TOP services caused misgivings among a minority of those who were working in TOP services at time of their study in Umea, Sweden.

Furthermore, Goodyear-Smith et al (2006:196) argue that more than 3 million women worldwide have had medical TOPs in the past decade. They also indicated that for many women there were advantages in having TOPs at early gestation periods. Moreover for some women, having the option of either a surgical or a medical termination offers them the opportunity to be involved in the decision-making process.

However, the medical TOP services were currently unavailable in South Africa in the public sector. The medical TOP services for the second trimester, using misoprostol alone, which requires a hospital admission of several days was used in some tertiary hospitals. The Western Cape was the only province in South Africa where dilatation and curettage (D&C) procedures for second trimester TOP services were performed on a limited scale (Harries et al 2009:3).

According to Mesce (2006:25-26), in the USA the legal status of TOP is one of the factors that determines the extent to which the procedure is safe, affordable and accessible. In countries where TOP services are legally permitted, TOP services are performed by trained health professionals, TOP services are more available and less costly. However, women might be unable to access safe TOP services due to:

- Lack of trained TOP providers
- Providers being unwilling to perform TOPs
- Lack of adequately equipped medical facilities and stigma attached to TOP service providers and users.
- Government restrictions on the type of facilities that provide TOP services
- Lack of resources.

Similarly, in South Africa, despite liberal TOP laws there are still major barriers to women accessing TOP services. These include provider opposition, stigma associated with TOP, poor knowledge of TOP laws, a lack of providers trained to perform and facilities designated to provide TOP services particularly in the rural areas (Harries et al 2009:2).

It was reported in *The Sunday World* (2009:18) (see annexure H) that in South Africa, women are legally entitled to access free TOP services at government hospitals or clinics during the first 12 weeks of pregnancy. In terms of the HBM, these identified challenges can be barriers because they can prevent women from accessing TOP services and/or nurses from providing TOP services (Mackey 2002:8).

- **Perceived barriers**

The following discussion outlines different types of barriers that could prevent women from accessing TOP services:

*Information barriers*

According to Lie, Robson and May (2008:6-7), the role of TOP providers is examined in most of the studies and British studies have focused especially on health services' access and quality. These authors argue that the process of seeking TOP services in the UK is sometimes confusing because of inadequate information. Furthermore, they state that women who are well informed and supported in their choices, experience good psychosocial outcomes from TOP services. Most women received information about TOP procedures from the media such as books, magazines and the Internet as revealed in the study conducted by Lipp (2008:3) citing Goss (2004).

Furthermore, the study conducted by Harries et al (2009:4) revealed that knowledge of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, varied amongst both providers and non-providers in South Africa. The nurses who were performing TOP services were aware of the CTOP Act. However, some of the nurses who were supporting a woman's right to choose were not all that familiar with this legislation.

According to Smith and Scullion (2010:27), more sex education and information on TOP services should be taught to young girls in the UK. In South Africa, Jewkes et al (2005:1241) argue that the greatest barrier to the use of designated TOP facilities in their study was lack of knowledge of the CTOP Act. Further findings indicated that women's specific knowledge of the circumstances under which TOPs could be obtained and facilities providing services, was even lower.

Relating to the HBM, lack of knowledge about the availability of TOP services on request and unavailability TOP services could pose barriers to the accessibility of TOP services (Mackey 2002:8).

*Distance and transport barriers*

Hughes, Semelka, Heaven, and Meyer (2007:1) argue that women who request TOP services in Columbia should not travel 2-3 hours to obtain vital health care. Rakhudu et al (2006:57) indicate that 60% of the NWP comprises rural areas. Therefore, those women who request TOP services in these rural parts of the province have to travel long distances and will need transport before they could access TOP services. However, in the Gauteng province less than 1% of women in the province live outside 50 km from a TOP facility and public transport around the province is relatively easily available (Jewkes et al 2005:1237).

Relating to the HBM, transport can be a barrier for women to access TOP services especially those who cannot afford transport to these facilities (Mackey 2002:8).

### 2.6.1 Socio-cultural factors

In terms of the HBM (Mackey 2002:8), perceived barriers, relating to this study include the accessibility of legal TOP services. The variables that will be analysed include religion, culture and moral values.

- **Religious beliefs**

In the USA, pro-life arguments against TOP services portray images of destructive acts often explicitly being called “murder” leading some women to think that they had killed their babies (Lie et al 2008:[6]). Similarly, some authors state that the pro-life side considers a TOP as “murder” (Kadayifçi, Kadayifçi & Ürünsak 2007:62).

Other studies in the USA indicate that the Evangelicals and members of other conservative religious traditions remain highly opposed to most types of TOP services. However, several groups appear to have become more permissive about TOP services. Studies conducted in the USA, revealed that whatever the religious beliefs, women of all

religions make use of TOP services (Hoffman & Johnson 2005:1; Kadayifçi et al 2007:62 citing Beller & Zlatnik 1992).

According to Harries et al (2009:6), in South Africa religious beliefs influenced some nurses' decisions not to be involved in TOP services, such as Roman Catholicism, influenced their decisions. It is further stated that some health care providers had experienced negative attitudes from colleagues on religious and moral grounds. Many TOP providers were regarded as "murderers" and "baby killers" who were expected to preserve and not to take life. According to the study conducted in Australia and New Zealand by Wainer (2008:36), Roman Catholics were labeling young women who had undergone TOP services as "narrow minded, just goody-goody churchgoers".

It is further stated by Harries et al (2009:9) that the study conducted in South Africa, revealed that religious beliefs did not prevent some nurses from being strong supporters of women's reproductive right to choose, whereas for others, it was the main reason for not taking part in TOP services.

- **Cultural values**

Culture is a patterned behavioural response developed over time as a consequence of imprinting the mind through social, religious structures including intellectual and artistic manifestations (Harkreader, Hogan & Thobaben 2007:1342).

According to Lie et al (2008:[6]), women's cultural beliefs and affiliations also have a bearing on their emotional experiences. It states that Israel: women tended to interpret TOP as a personal failure, whereas Russian immigrants looked upon it as bad luck or a mistake. Internationally, TOP services also vary between and within countries with complex laws and even more complex historical and cultural influences. It should also be mentioned that nurses face distress daily as they support women through the traumatic experience of TOP services, risking discrimination if they become involved in TOP services and discrimination if they refuse to do so (Lipp 2007:1683-1684).

- **Moral values**

Issues surrounding the legislation of TOP services generate moral and clinical dilemmas for health professionals concerned with its provision. The differences arise between the perceived moral wrongness and legality. Ethics is defined as a disciplined study of morality, a concept that encompasses right and wrong behaviour (Jomeen & Cairns 2005:340; Kadayifçi et al 2007:61 citing Chervenak & McCullough 1992). Therefore, relating to the HBM, women might find themselves in a dilemma between accessing TOP services and their cultural and moral values which can be viewed as a barrier to accessing TOP services.

According to Harries et al (2009:[6]), TOP involves a moral choice and providers who were not directly involved, based their objections to TOP services on moral grounds. It is further stated by the same authors that one of the nurses in their study felt that it was "sinful" to bring children into the world when they were at risk of being neglected and with inadequately provisions. She mentioned:

> *"When I speak to anybody about preserving life, I am thinking of the life of this woman. I also think I bring them back to the fact that abortion, being pregnant, has many options, that women will, or people who are there will say," what about the life of the unborn?" Now what would the quality of life be if the unborn was born, and it was not born into happy circumstances, and where it could not be provided with basic needs?"*

Relating to the HBM, the moral issues could also prevent a pregnant woman from accessing TOP services. According to Goodwin and Ogden (2007:231) in their study, those women who conceptualised the foetus in a negative appraisal were entwined with a more human view of the foetus. They felt a lack of social support and a belief that the society was either judgemental or negated the impact that a TOP could have on a woman's health, wellbeing and life.

Nurses' views concerning the morality or immorality of TOPs could be determined by their philosophical perspectives on the moral status of the foetus (Mokgethi et al 2006:33 citing Jali 2001). In terms of the HBM, nurses' perceptions of TOP services

may result in negative attitudes to TOP services, which can limit access to women requesting TOP services in the NWP (Mackey 2002:8).

### 2.6.2 The level of satisfaction of women who requested termination of pregnancy services

According to Lindström et al (2007:232) in Sweden, in order to optimise reproductive health care for women and offer good working conditions for staff, it is of great importance that the decision makers assess and are aware of staff experiences and attitudes of TOP service providers. Similarly, women's choices about whether, where and how TOPs should be undertaken are mainly pragmatic ones related to household and psychological resources (Lie et al 2008:7).

To provide quality TOP services, resources need to be available to support the TOP providers. Unless sufficient resources are available, TOP services will remain inadequate in South Africa (Engelbrecht 2005:82). According to Jewkes et al (2005:1237), in Zambia, lack of service provision and perceived poor quality of care, particularly negative attitudes of staff, have been barriers to the utilisation of TOP services.

In South Africa, discussions around current service provision suggested concerns about the quality of care within the public sector's health facilities. Nurses' concerns were about problems associated with a general lack of adequate pre- and post-TOP counselling, punitive staff attitudes towards younger women, overcrowded facilities, overburdened and fragmented services and difficulties with recruitment and retention of nurses (Harries et al 2009:8). Relating to the HBM, this can also be seen as a barrier to accessing TOP services (Mackey 2002:8).

### 2.6.3 Likelihood of action of women seeking illegal termination of pregnancy services

Worldwide, an estimated 46 million TOP procedures are performed each year,19 million of them are outside the legal system and considered unsafe because they are performed by people who lack the necessary skills or in places that do not meet minimal medical standards (Mesce 2006:5).

Nepal's maternal mortality rate is among the highest in South Asia, where it is estimated that half of those deaths result from TOP complications. It is further stated that whenever TOP is illegal or services are limited and difficult to access, women are willing to risk their lives to obtain illegal TOP services which are often unsafe, especially after the 13th week of gestation and carried out with a total lack of empathy (Regmi & Madison 2009:44).

Kadayifçi et al (2007:64) argue that globally, there is a ratio of one unsafe TOP for every seven live births, but in some regions the ratio is higher. In Latin America and the Caribbean there is one unsafe TOP for every three live births, especially where access to TOP services is legally restricted.

According to Griffith and Tengnah (2007:317) in the UK, it is an offence for a pregnant woman to induce her own TOP. In addition, a person who unlawfully induces a TOP to any pregnant woman will be guilty of an offence. Furthermore, if the woman dies as a result of any unlawful TOP service, then the charge becomes one of manslaughter.

Studies have consistently indicated that large numbers of Nigerian woman experience unwanted or mistimed pregnancies and births. Unintended pregnancies pose significant risks to public health and the consequence of any unwanted pregnancy is an induced TOP (Sedgh, Bankole, Oye-Adeniran, Adewole, Singh & Hussain 2006:175). Induced TOPs are widespread in Nigeria, despite restrictive laws (Onah, Ogbuokiri, Obi & Oguanuo 2009:415 citing Etuk et al 2003).

In Africa, an estimate of 3.7 million unsafe TOPs were performed annually with approximately 23 000 deaths as a result of unsafe procedures (Ratlabala et al 2007:27). In South Africa, many women were inducing their own TOPs, using self medications. The extent to which these self-induced TOPs are preventable through the provision of formal health services is probably limited. Some of the consequences of illegal TOP services in South Africa, were reported as death, the risk of contracting sexually transmitted infections (STDs) and HIV/AIDS, excessive bleeding, incomplete TOPs, injury of the reproductive organs leading to infertility, risk of psychosis and depression (Jewkes et al 2005:1241; Ratlabala et al 2007:29).

According to Mesce (2006:13) unsafe methods of inducing illegal TOPs include:

- Swallowing large doses of drugs, such as anti-malaria or oral contraceptives (birth control pills)
- Inserting a sharp object into the uterus
- Drinking or flushing the vagina with caustic liquids such as bleach
- Physical abuse such as jumping or falling from high places, vigorous dancing, or sustained and vigorous sexual intercourse over long periods of time
- Prolonged and hard massage to manipulate the uterus, or repeated blows to the stomach.

In South Africa women use misoprostol, only obtainable through a doctor's prescription, or a herbal uterine stimulant "isihlambiso" to induce TOPs, which carries an increased risk of uterine rupture in pregnancy exceeding 24 weeks' gestation (Essilfie-Appiah, Hofmeyer & Moodley 2005:10). *The City Press* (10 August 2007:10) (see annexure H) reported that in South Africa, only a small number of women used legalised TOP services during its first decade with less than 2% of pregnancies ending in safe TOPs between 1997 and 2006. *The Sowetan* (2009b:8) reported that more teenagers continued to seek illegal TOP services than legal ones to end unwanted pregnancies. In terms of the HBM (Mackey 2002:8), perceived threats to legal TOP services include illegal TOP services with possible complications and even death.

Furthermore, in South Africa, *The Sunday Sun* (2007:7) (see annexure H) reported that in the inner city of Pretoria illegal TOP services were still rife and women could access illegal TOP services up to eight months' gestation for just R400.00. The same newspaper stated that the TOP procedures were conducted by unregistered doctors who did not give their physical addresses on their advertisements and only said "one day abortions, safe and pain free". Some of these advertisements provide cell phone numbers only and also only respond to cell phone calls (*The Sunday Sun* 2007:7) (see annexure H). It was reported in one of the newspapers that an illegal TOP was allegedly performed on a 17-year-old girl without her consent (*The Sowetan* 2009a:2) (see annexure H).

Unless sufficient resources are available, TOP services might remain ineffective in South Africa. Therefore, if the TOP services are not available, pregnant women will make use of illegal TOP services (Mokgethi et al 2006:34 citing Engelbrecht et al 2000).

### 2.6.4 Perceived benefits of contraception usage to prevent TOPs

According to Lang et al (2005:52), globally millions of females and males do not have access to reliable contraceptives. Many women continue to die and suffer pain, ill health and permanent disability as a result of pregnancies and complications of childbirth and/or abortions.

Abigail and Power (2008:2951) indicate that fertility patterns are changing and there is evidence that the number of older women conceiving for the first time are increasing, probably because of better usage of contraception**.** Similarly, there are new methods of contraception available and little is known about the implications of these on termination patterns. In addition, informing women about the benefits and possible side effects of available contraceptive methods should enable women to choose appropriate methods and avoid unwanted pregnancies and TOPs.

According to Novikova, Weisberg and Fraser (2009:39), in Australia over half of the women of reproductive age have experienced unplanned pregnancies, many of whom could have been avoided by using emergency contraception. It is further stated that emergency contraception is estimated to prevent up to 74% of unwanted pregnancies. Access to emergency contraception has improved during the last few years as these regimens became available over the counter in many countries.

In Brazil, the Minister of Health's report revealed that women who underwent TOPs were predominantly using contraceptives but mentioned inconsistent or erroneous use. Promoting the use of contraceptive methods could prevent unwanted pregnancies, reduce TOP rates, and reduce maternal morbidity and mortality rates (Ferreira, Souza, Lima & Braga 2010:1).

In the UK, emergency contraception is available free of charge from sexual health clinics, accident and emergency departments and most pharmacies. In spite of the

widespread availability of free and effective contraceptive methods, the rate of terminations and repeated terminations increased (Palanivelu & Oswal 2007:832).

To reduce the risk of unintended pregnancies women should receive information about their chances of becoming pregnant after TOP or childbirth, during breastfeeding, or when they are approaching menopause and they should be counseled about appropriate family planning methods (Mesce 2006:23). Despite a decrease in USA, birth rates among adolescents and young females over the past 15 years, rates of unintended pregnancies remain high. Furthermore, prevention of pregnancy methods, are limited to abstinence and/or withdrawal methods (Marcell, Plowden & Bowman 2005:3078 citing Martin et al 2003).

Provision of comprehensive reproductive health care services, including contraception, TOP and miscarriage management is well-suited to the strengths of family physicians. It is further stated that contraceptive management and counselling about pregnancy options are included in the family medicine residency programme requirements in the USA (Nothnagle, Prine & Goodman 2008:204).

Although the USA supports family planning programmes globally, former president George W Bush blocked funds for TOPs. President Barack Obama lifted a ban on federal funding for foreign family planning agencies that promote or provide information about TOP services (Lister 2009:1) in the USA.

International studies have indicated that a lack of contraceptive use is often the result of social stigma or lack of knowledge. It is further stated that it is only after the first pregnancy that young women are educated about, and subsequently offered, contraceptive services, with preference being given to hormonal methods (MacPhail et al 2007:5). The government of India launched a family planning welfare programme, with the main objective to spread the knowledge of family planning methods and developing attitudes favourable for adopting contraceptive methods (Mao 2007:1).

According to Rasch, Yambesi and Massawe (2008:1), post-TOP contraceptive services in Tanzania appear to be well accepted by women who are admitted with complications following illegal TOPs and recognised as an important means for addressing the problem of unsafe TOP services.

Studies conducted in South Africa, by Ratlabala et al (2007:29) indicate that the use of condoms, abstinence and the proper use of family planning methods are effective ways of preventing unwanted pregnancies. However, some of the adolescents who participated in this study indicated severe lack of understanding of the prevention of pregnancies. The essence of their misunderstanding is captured by the following responses:

> *"One should not have sex while menstruating to prevent an unwanted pregnancy, the reason being that the mixing of blood between a male and female during sex would lead to pregnancy."*

> *"One should use traditional herbs to prevent an unwanted pregnancy. These herbs are well known by villagers and are readily available in the local vegetation."*

Lang et al (2005:53) revealed that 84.3% of pregnant school girls in their study confirmed that, they had previously received contraceptive information from clinics and schools. Another study revealed that among young South African women, contraceptive use was associated with previous pregnancies. In particular, women who were pregnant were more likely to report using hormonal methods and less likely to report to using condoms compared to those young women who had never been pregnant (MacPhail et al 2007:5). In South Africa where large numbers of young people live in conditions of poverty, a lack of access to reproductive health services could translate into increased levels of unwanted pregnancies and sexually transmitted infections(STIs) among this group (MacPhail et al 2007:2).

Palanivelu and Oswal (2007:834) argue that teenagers are generally considered to exhibit risk taking behaviours with poor contraceptive practices. In addition they indicate that a routine follow-up appointment after TOP services could improve contraceptive compliance and might be an effective tool for preventing repeat TOPs (Palanivelu & Oswal 2007:834 citing Westfall & Kallail 1995).

Therefore, according to the HBM, the likelihood of women's use of contraceptives will be reduced by barriers like social, cultural, normative factors and effects which will then

predispose women to unplanned pregnancies which might result in requests for TOP services (Mackey 2002:8).

- **Benefits of condom use to prevent unwanted pregnancies**

According to the WHO (2005:2), some women who use female condoms have reported using the same condom more than once, either because they could not afford to use a new one for each act or because female condoms were not easily available. The availability of female condoms might enable more women to practice safe sex, if the women can make decisions concerning the use of female condoms.

Myer, Rebe and Morroni (2007:1487) conducted a study about condom use at the last sexual intercourse encounter. They reported decreased used of condoms with age and one-third of the participants stated that they had unprotected intercourse at least once since their HIV diagnosis. MacPhail et al (2007:1) argue that the relationship between discussing condom use with partners and condom use, indicates the importance of involvement of male partners in women's contraceptive decisions. It is further stated by the same authors, that women in their study who reported that they talked to their partners about condom use, were more likely to be using contraceptives than women who did not talk to their partners about using condoms.

A study conducted among Swazi women indicated that sexual negotiations between partners were severely limited by women's inferior social positions. This situation of women, being unable to negotiate safe sex with their partners, led to physical violence, marital rape, unplanned pregnancies and HIV infections (Ziyane 2006:50).

According to Bellamy (2007:1), the HBM emphasises that patient education improves health by enabling individuals to make informed decisions about their own health-related behaviours. Therefore, the purpose of patient education is to promote healthy lifestyles including safer sexual practices.

- **Perceived counselling benefits of women who request termination of pregnancy services**

According to the WHO (2007:4), counselling should assist women to make informed decisions about TOP services. Women's experiences of patient care during TOP services are also affected by the TOP method used. In the USA trials on medical TOP, women relied on health professionals to assure them about the safety of the new procedure and to determine if the termination had been successful. It is further stated that women need more counselling from clinical staff about the procedure of medical termination (Lie et al 2008:6).

The review done by Major and Appelbaum (2008:1) identified several factors that predicted negative psychological responses following TOP in the first trimester among women in the USA. Those factors included:

- Perception of stigma, need for secrecy and low or anticipated social support for TOP decision
- A prior history of mental health problems
- Personality factors such as low self esteem and use of avoidance and denial coping strategies
- Characteristics of a particular pregnancy including the extent to which the woman wanted and felt committed to it.

Another author indicated that:

> *"You might feel relief that you made a difficult decision about your life and pride that you handled the procedure well. You might also feel loss, sadness, depression or anxiety. It can help to share these feelings with someone close to you"* (Gryte 2010:1).

Joyce, Henshaw, Dennis, Finer and Blanchard (2009:3) argue that many American states require a waiting period between the time a woman has been counselled about TOP and the actual procedure. Furthermore, proponents of mandatory counselling and waiting period laws argue that the state has a duty to ensure that before a woman

decides to terminate a pregnancy she has been given ample time, after having been given information, about her pregnancy and TOP to weigh her options.

Similarly, Weldon (2010:1) argues that women reported sleeping disorders, nightmares or insomnia and memory loss after TOP services. Though these might seem to be on the milder end of possible emotional effects of TOP, they could be quite severe.

In South Africa, even though the provision of counselling before and after the TOP services is mandatory according to the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, it appears as though some adolescents would require such services to assist them in dealing with their emotions and fears which might impede their social functioning in the future, as is implicit in the following account:

> *"I will not be able to request for termination of an unwanted pregnancy at any health facility that does not provide counseling because I do not think I will be able to deal with the guilt feelings"* (Ratlabala et al 2007:29).

Harries et al (2009:2) stated that in their study, facilities provided a range of representative services from pre TOP counselling and referral, to the provision of first and second trimester TOP services, post-counselling and contraceptive services. Poggenpoel and Myburgh (2006:6) indicated that some women in their study who had used TOP services, experienced psychological discomforts. However, these women were initially uncertain and confused about their decision to terminate their pregnancies.

Lipp (2009:29) suggested that some women could benefit from psychological support after using TOP services. Before the TOP procedure, nurses should ensure that women are targeted appropriately, ensuring that their post-TOP needs are met in both the short and long term. Women who underwent TOP services might experience psychological distress and/or "post abortion syndrome", and post-traumatic stress disorder (Charles, Polis, Sridhara & Blum 2008:436).

Similarly, there are psychological and emotional factors involved in TOPs, including ambivalence about the decision and concerns about the possible future impact on fertility. The opponents of TOP also argue that having TOP increases a woman's

chances of experiencing a barrage of negative mental health outcomes later in life (Pud & Amit 2005:144; Gold & Nash 2007:5).

- **Contraceptive counselling after utilisation of termination of pregnancy services**

Ceylan, Ertem, Saka and Akdeniz (2009:3) stated that in Turkey, nurses and physicians indicated that they never provided post counselling to women after TOP services because of overcrowding. Although physicians believed in the benefit of post-TOP family planning counselling, they never had enough time to give appropriate counselling.

Another study conducted in the USA, revealed nonutilisation, incorrect or inconsistent use of contraception might be related to limited support of male partners. Men who accompanied their partners to TOP clinics presented an opportunity for health providers to involve them in counselling sessions (Becker, Bazant & Meyers 2008:1).

Lang et al (2005:55) argue that in Nigeria post-counselling increased the percentage of women using contraception from 27.8% at the time of the TOP to 49.1% at time of the follow-up. Access to information and education regarding contraception is the crucial first step. Families should have access to effective, dependable and safe contraception. The effective utilisation of contraceptives would then decrease the demand for TOP services (Start 2005:137).

- **Ensuring confidentiality of the termination of pregnancy services**

In terms of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, the number of TOP services performed at each site prior to 20 weeks' gestation in both public health and private institutions must be notified to the National Department of Health (NDOH). However, the notification is strictly anonymous in order to protect the confidentiality of the women undergoing the procedure. The information on women who requested or obtained TOP services shall be forwarded to the Director General by registered post. Confidentiality should be maintained and the names and addresses of these women should not be included in the prescribed information according to the provisions of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008.

The confidentiality of information concerning the clients' diagnosis in the public health service and that would also include TOP services, is also emphasised by the National Health Act (no 61 of 2003). Relating to the HBM, individual perceptions about the TOP services, will influence the women's decisions to opt for TOP services, if they could be assured that confidentiality would be maintained about the users of TOPs, their access to TOP services could be enhanced. According to the HBM, psychological variables like counselling can impact negatively on the woman's accessibility to TOP services if it is not effectively done or not done at all (Mackey 2002:8).

## 2.7 CHALLENGES ENCOUNTERED BY NURSES WHO PROVIDE TERMINATION OF PREGNANCY SERVICES

Nurses are faced with a dilemma of being obligated to save lives, provide care and support to the patients and provide TOP services to those women who need TOP services which might be in contravention with these nurses' moral, cultural and religious beliefs.

- **Modifying factors**

According to the HBM, attitudes of nurses towards TOP services can obstruct women's access to TOP services when they want it (Mackey 2002:8).

The Democratic Nurses Organisation of South Africa (DENOSA) states that midwives have a right of freedom of conscience that they may not be denied employment, may not be victimised either for choosing to participate or not to participate in TOP services. It is further stated that a nurse may not be coerced to participate directly in providing TOP. However, DENOSA states that the nurses have a responsibility to declare, make their view-point known in good time, so that suitable staff can be arranged if they do not wish to participate in direct TOP services (Mayers, Parkes, Green & Turner 2005:2 citing DENOSA position paper on TOP 1998).

### 2.7.1 Perceived benefits of availability of resources in facilities

Regmi and Madison (2009:46) argue that it is important that comprehensive TOP services, with proper equipment and properly trained practitioners, should not only be available but also acceptable to the larger population of Nepal. Acceptable means meeting patients' expectations about quality care.

According to the study conducted by Harries et al (2009:1), complex patterns of service delivery were prevalent throughout many of the health care facilities, and fragmented levels of services provision operated in order to accommodate health care providers' willingness to be involved in different aspects of TOP services.

Furthermore, these authors argue that in order to develop and sustain a pool of TOP providers and programmes which attract prospective providers, these providers should receive financial compensation for providing TOP services. Similarly, Engelbrecht (2005:11) also argues that to provide quality TOP services, resources need to be available to support the TOP providers.

Mayers et al (2005:3) indicated that nurses experience a number of obstacles when assisting with TOP services. These problems hindered them, not only when it comes to providing quality care to the women, but also in their own coping with the situations they faced and for which they felt unprepared.

The AIDS Legal Network and Out Lesbian, Gay, Bisexual and Transgender Well being Society (2007:3) were concerned about the lack of an enabling and supportive environment for adequate and effective application and implementation of the TOP services. Opportunities for values clarification training designated to promote more tolerant attitudes by service providers, should continue and extend to health providers working within all areas of reproductive health (Harries et al 2007:13).

### 2.7.2 Perceived nurses' barriers on providing termination of pregnancy services

Some of the nurses' religious beliefs, morals and values could pose barriers to providing TOP services to women requesting these services. According to Cohen (2006:1), most anti-TOP activists oppose TOPs for moral and religious reasons. In their effort to win

broader public support and legitimacy, their leaders might assert that TOPs are not only wrong, but could also harm women physically and psychologically.

- **Religious beliefs**

According to the study conducted by Harries et al (2009:6), most of the health care providers in their study had experienced colleagues' opposition to TOPs on a mix of religious and moral grounds in the working environment. It is further stated that religious beliefs played a role for some providers in deciding not to be involved in TOP services.

There is a strong relationship between church attendance and attitudes towards TOP services. Nurses attending church more frequently, had more negative attitudes towards TOP services (Lipp 2007:1686). Harries et al (2009:2) revealed that religious beliefs, the reasons for seeking TOP such as rape or incest and gestational age, affected nurses' attitudes and willingness towards TOP provision.

- **Cultural and moral values**

Morality gives an orientation to an individual, providing meaning in life (Humpel & Strydom 2005:343 citing Kretzschmar & Hulley 1998). Moral acceptability identified TOP services as murder, against their beliefs, and as sins against God by respondents in Patel and Myeni's study (2008:742). It is further stipulated that nurses who personally oppose the TOP procedure, might face professional dilemmas of how to care for these patients while remaining true to their own personal convictions (Mamabolo 2006:37 citing Marissa & Ventures 1999).

Consequently some of the nurses refuse to cooperate or even sabotage the referral of pregnant women to TOP service facilities. In terms of the HBM, the nurses' attitudes towards TOP services pose barriers towards women's accessibility to TOP services (Mackey 2002:8).

### 2.7.3 Perceptions/opinions of nurses regarding termination of pregnancy services

According to Lindström et al (2007:233), the majority of the nurses supported the view that medical TOP services should be managed by PHC within the foreseeable future. It is further stated by the same authors that the right to refuse to provide TOP services on personal grounds, was indicated by more than half of the respondents in their study in Sweden.

Perceptions play an important role in ensuring that pregnant, women requesting TOP services, are not discriminated against, based on issues of ethics and morality (Humpel & Strydom 2005:343).

- **Attitudes of nurses towards terminations of pregnancies**

According to Lie et al (2008:7), the attitudes of health providers to TOP were relative to the marital status of the women. Indonesia medical staff endorsed TOPs as a form of birth control for married women, but held disapproving attitudes towards pre-marital sex which impacted on young women's feelings of guilt and shame. In the UK, differences between professionals working within TOP services were found to be influenced by reasons for undergoing TOPs and the length of gestation (Lipp 2007:1687). According to Harries et al (2009:9), late gestational age beyond 13 weeks' complicated TOP services and was particularly difficult for all providers and impacted on service provision, resulting in doctors from the private sector providing these services.

A study conducted in the Gauteng province of South Africa, revealed that the majority of nurses were of the opinion that the women, as well as the health service delivery staff involved in TOPs were murderers (Rakhudu et al 2006:58 citing Poggenpoel et al 1998).

Messe (2010:1) argues that one of the biggest concerns women face in visiting TOP services clinics, is the attitude of the staff. Friendly, respectful and educated staff members will not only help and answer all questions but create a safe atmosphere befitting the women requesting TOP services.

Harries et al (2009:2) indicate that in South Africa little is known about the personal and professional attitudes of individuals who were working in TOP services. However, attitudes of nurses are an obstacle when the client perceives nurses to be disrespectful or indifferent. In terms of the HBM, attitudes of nurses can be seen as a barrier limiting women's access to TOP services (Mackey 2002:8).

- **Influence of providing termination of pregnancy services on the personal lives of nurses**

The shortage of health care providers who are willing or trained to perform TOP services undermine the provisions of the CTOP by limiting the availability of safe, legal TOP and has serious implications for women's access to TOP services (Harries et al 2009:2). According to Mayers et al (2005:3), nurses experienced a number of obstacles when providing TOP services. These problems affected nurses not only when it came to giving quality care to the women, but also in coping with the situations faced by the nurses. Furthermore, nurses also felt unprepared emotionally indicating that nobody prepared them for providing the TOP services.

Relating to the HBM, perceptions about TOP services by nurses, might influence their attitudes towards TOP services in the NWP and might prevent nurses from providing TOP services and limit women's access to TOP services in the NWP (Mackey 2002:8).

- **Feelings experienced by nurses providing termination of pregnancy services**

Harries et al (2009:6) indicated that nurses who stated that they were pro-choice talked about women's right to choose whereas those who were pro-life found it difficult to separate their personal feelings from their professional conduct. Another nurse in the same study indicated that she refused to give misoprostol to a woman requesting TOP services because she did not think it was right to take a life.

In terms of the HBM, this is viewed as a barrier that can prevent some of the nurses from making TOP services accessible to all women. This could be a challenge to those nurses who provide TOP services (Mackey 2002:8).

- **The support nurses receive from families, colleagues, managers and their families**

Regmi and Madison (2009:46) argue that emotional support requires a trusting relationship with a caring and empathetic person. Such support could come from a family member, a friend or health professionals. According to Harries et al (2009:[10]), access to training and further opportunities for health care providers to attend values clarification workshops and TOP training, needs to be encouraged and strengthened. The South African Nursing Council (SANC) should consider incorporating TOP training into the nursing curriculum.

Nurses who provide TOP services need support from their colleagues, management and communities. Providing TOP services could involve conflicts of interests between the nurse's professional, community, and religious beliefs and the employer's expectations (Mokgethi et al 2006:34).

Stigma and passive resistance remains barriers to the full realisation of reproductive equality in South Africa. Myths about women's motivation for TOPs and pervasive misperceptions about the aspiration procedure itself continue to hamper access to TOP services for the country's most disadvantaged women. Furthermore, the institutionalisation and sustainability of TOP services remain challenging due to this absence of community-wide support (Mitchell, Trueman, Gabriel, Fine & Manentsa 2005:11).

Relating to the HBM, lack of support to the nurse providing TOP services can be regarded as a barrier for nurses to improve accessibility of pregnant women to TOP services (Mackey 2002:8).

- **Obstacles encountered in the implementation of the Choice of Termination of Pregnancy Act**

Major (2010:1) argues that the latest war on anti TOP services in the USA was fought less over women's bodies than over their minds. Under the banner of 'a woman's right to know' some American states have passed laws mandating that women seeking TOP

services, be told that going ahead with the procedure would expose them to mental health risks including post-traumatic stress and a greater danger of suicide.

The CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, allows TOP services to women who request it during the first 12 weeks of their pregnancies in South Africa. The legalisation of TOP services in South Africa increased the need for TOP services, requiring more and more nurses to work in TOP services, regardless of their attitudes and feelings about the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008.

In Ratlabala et al's (2007:28) study, the majority of their respondents did not know or think about the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008. Only one respondent confidently stated that she had heard about the Act from her aunt who was a professional nurse. However, she was not familiar with the contents. Others had not even heard that TOP in South Africa was legal. Therefore this could have a direct impact on access to TOP services.

Recent research in South Africa, suggests that health service related barriers, coupled with personal circumstances contribute to women's delays in seeking TOP services until the second trimester of pregnancy. Furthermore, the high rate of second trimester TOPs in South Africa is a public concern, given that every additional week of gestational age incurs a significant increase in the risk of serious complications or death of women (Harries et al 2009:9).

The CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, on the other hand also contains penalties for nurses obstructing access to TOP services in South Africa. Section 10(2) states that any person who contravenes or fails to comply with any provision or section of this act, shall be guilty of an offence and be liable on conviction to a fine or imprisonment for a period not exceeding six months. Such an offence of this act includes prevention of accessing legal TOP services or obstructing access to legal TOP services. Therefore, the legalisation of TOPs Act in South Africa, have put nurses in both ethical and moral dilemmas. In terms of the HBM, these moral and ethical dilemmas can prevent nurses from participating in the implementation of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, which can be a barrier obstructing accessibility to TOP services.

- **Nurses' counselling of women requesting termination of pregnancy service**

The study conducted by Mayers et al (2005:4) indicated that participants in their study expressed concern that no formal counselling preparation or training had been given to them, to enable them to give adequate information and support to women undergoing TOPs. Relating to the HBM, structural variables can lead to inaccessibility to TOP services and inadequate counselling services can also be seen as a barrier to the accessibility of TOP service. Therefore, counselling poses a challenge to nurses who provide TOP services without adequate resources and time.

## 2.8 SUMMARY

This chapter provided a literature review relevant to TOP services globally and in South Africa with regard to challenges encountered by women who request TOP services, including those who requested TOP services but could not manage to access these services, and nurses providing TOP services in South Africa. The next chapter will explain the research methodology adopted to conduct this study.

# CHAPTER 3

# Methodology and research design

## 3.1 INTRODUCTION

Chapter 3 outlines the research design and research method, incorporating aspects such as population, sampling, data collection and setting. The reliability and validity of the research instruments are addressed. Ethical considerations pertaining to the research and limitations are also presented. The study was conducted in three phases and the research methodology of every phase will be presented separately.

## 3.2 RESEARCH DESIGN

A research design is the overall plan for obtaining answers to the research questions and for addressing the objectives identified in chapter 1 of this thesis, including specifications for enhancing the study's integrity (Polit & Beck 2006:509, 552 ).

This study used a descriptive, explorative, quantitative and non-experimental research design. The purpose of this study was to describe and explore challenges encountered by women who had used TOP services, including those who wished to have TOP services but could not access them, and nurses who provide TOP services in the NWP. The research methodology includes aspects such as research design, population, sampling, research instruments, data collection, setting and data analysis.

### 3.2.1 Non-experimental research design

Polit and Beck (2006:505) refer to non-experimental research as studies in which the researcher collects data without introducing any intervention. In the experimental design, the researcher can control the specific actions of the specified variable being studied, which was not suitable to this study (Brink et al 2006:92).

### 3.2.2 Exploratory descriptive design

This study was exploratory and descriptive because it described and explored the challenges encountered by women who had used TOP services, and women who could not manage to access TOP services, and nurses providing TOP services in public health facilities in the NWP (Brink et al 2006:120).

- **Descriptive design**

According to Polit and Beck (2006:498) descriptive studies provide an accurate account of characteristics of an individual, situation or group and the frequency in which certain phenomena occur. This study was descriptive because the researcher collected detailed descriptions of women who had used TOP services, including those women who wished to have TOP services but could not access them and who provide TOPs in the NWP. The purpose of a descriptive study is to observe, describe and document aspects of a situation as they naturally occur (Polit & Beck 2006:189).

- **Exploratory design**

According to Polit and Beck (2006:500), an exploratory research design is a study that explores the dimensions of a phenomenon, which develops or refines hypotheses about relationships between phenomena.

This study will meet these criteria, because it will explore the full nature of challenges encountered by the women requesting TOP services in public health facilities in the NWP, women who did not manage to access TOP services, and the nurses providing TOP services.

Therefore, women who had used TOP services, and those who wished to have TOP services but could not access these services at the health facilities, would describe their challenges, through structured interviews. The nurses providing TOP services at the public health facilities, would also describe their challenges, through structured interviews.

The data collected in the three phases were then analysed, using the Statistical Package for Social Sciences (SPSS) (version 13), with the assistance of a statistician (see the statistician/s details in annexure G).

### 3.2.3 Quantitative approach

A quantitative research design is an objective, systematic process in which numerical data are used to obtain information that result from formal measurement and that is analysed with statistical methods. The purpose of quantitative research is to measure concepts objectively and to examine numerical and statistical procedures and the relationships between them (Polit & Beck 2006:15).

In this study the researcher investigated in phase 1 the challenges encountered by women who had used TOP services, in phase 2 barriers encountered by those women who requested but could not access TOP services in the public health facilities in the NWP and in phase 3, experiences of nurses who provide TOP services in the NWP. The quantitative design was regarded as suitable to collect sensitive data from respondents that might find the topic of abortion difficult to talk about and share with others. The quantitative data collected were analysed using the SPSS (version 13) program.

Data were grouped, analysed, summarised and presented in tables, graphs and figures. The services of a statistician were employed to assist with the calculation and interpretation of the statistics.

## 3.3 RESEARCH METHOD

Polit and Beck (2006:509) describe a research method as the techniques used to structure a study, to gather and analyse information in a systematic manner. This section will discuss the methodology, population, sample and sampling procedure, setting, ethical considerations and limitations. The research was conducted in three phases.

### 3.3.1 Phase 1

The purpose of phase 1 of this study was to determine the challenges encountered by women who had used TOP services in the NWP. Structured interviews were conducted to collect data from 150 women who had used TOP services.

- **Population**

A population is a totality of all the respondents that conform to a set of specifications that meet the criteria in which the researcher is interested. The population to which the researcher has access, is known as the accessible population or the study population (Brink et al 2006:123; Polit & Beck 2006:506).

In this study the population will comprise all South African women of all races, all age groups, educational status, religions and socio-economic status requesting TOP services in the NWP where TOP services may take place up to 12 weeks' gestational period as determined by the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008. The accessible population will be those women who had used TOP services in the public health services of the NWP from August 2009 to November 2009.

- **The eligibility criteria**

According to Polit and Beck (2006:499), eligibility criteria refer to the specific attributes of the target population or characteristics that people in the population must possess in order to participate in the study.

The eligibility criteria in this study included that respondents had

- agreed to participate in the study
- utilised TOP services in the NWP's public services

- **Sampling**

According to Brink et al (2006:124), a sample is a part of a whole or a subset of a larger set, selected by the researcher to participate in the study. In phase 1, a non-probability

convenience sampling design was used. In a non-probability sample, elements are selected by non-random methods (Polit & Beck 2006:261).

Convenience sampling entails the selection of the most readily available persons to participate in the study. Therefore, it is difficult to estimate the probability that each element has been included in the sample (Polit & Beck 2006:262). The sample for this study comprised 150 women who had used TOP services at the public health facilities authorised by the Minister of Health at the time of the researcher's visits at 14 participating public health facilities in the NWP from August to November 2009.

- **Data collection**

According to Polit and Beck (2006:498), data collection involves the gathering of information to address a research problem. The researcher conducted structured interviews to collect data in phase 1 from August to November 2009. A structured interview schedule is a data collection instrument whereby a good deal of information can be gathered by questioning people. The purposes of these questions are to identify persons' thoughts, perceptions, attitudes, feelings, motives, plans, experience, knowledge levels and memories (Brink et al 2006:14) about a specific phenomenon. Data collection in a quantitative study proceeds according to a pre-established plan. The data collection plan typically specifies procedures for actual collection of data (Polit & Beck 2006:57).

The researcher used self designed structured interview schedules to conduct structured interviews with women who had used TOP services in 14 participating public health facilities providing TOP services in the NWP. Respondents were asked to respond to the same questions in the same order and with the same set of response options (Polit & Beck 2006:502).

The questions were designed by the researcher before the initial data collection. The order of questions was specified and the researcher estimated the duration of the interview and presented the same questions to participants in the same order (Moule & Goodman 2009:295).

*Research instrument*

In phase 1, the researcher used structured interviews to collect data from 150 women who had used TOP services in the NWP. Since the structured interview is the tool of data collection it is subject to validity and reliability threats (Parahoo 2006:320). The purpose of structured interviews is to collect quantitative data from predetermined and structured questions and it is a quantitative method of data collection (Parahoo 2006:319).

*Format of the questions*

Each interview schedule was accompanied by a covering letter (see annexures D-F) identifying the person undertaking the research and providing a brief description of the purpose of the study. The name, address and telephone number of the researcher appeared on the covering letter so that respondents could contact the researcher should they wish to do so for whatever reasons (De Vos 2005:170; Bowling & Ebrahim 2005:403).

Section A of the interview schedule comprised questions relating to demographic data, including

- age
- marital status
- religion
- number of children
- employment history
- number of TOPs undergone in the past

Section B of the interview schedule comprised closed-ended questions relating to the accessibility of TOPs, obstacles in accessing TOP services and the level of satisfaction of women who had used TOP services in the NWP.

Section C of the interview schedule comprised closed-ended questions relating to illegal TOPs, the uses of contraceptives and the negotiation of safe sex (condom use) to prevent unplanned pregnancies.

Section D of the interview schedule comprised closed-ended questions relating to pre-, during and post-TOP counselling and contraceptive counselling post-TOP services.

Section E of the interview schedule comprised open- and closed-ended questions relating to the impact that women's cultural and religious values and beliefs could have on their access to TOP services in the NWP.

Section F of the interview schedule comprised open-ended questions relating to the confidentiality maintained by the TOP providers.

Section G of the interview schedule comprised questions relating to the distance women had to travel to access TOP services.

Section H of the interview schedule comprised questions relating to the availability and method of transport used to travel to the public health facility to access TOP services.

*Pre-testing of the instrument*

The researcher pre-tested the instrument in one of the institutions which did not form part of the research sites before the formal use of the instrument at the selected research sites. According to Polit and Beck (2006:507), a pre-test is the trial administration of a newly developed instrument to identify flaws or assess time requirements.

- **Research setting**

In phase 1, the researcher conducted the study in the 12 hospitals, 1 community health centre and 1 clinic providing TOP services in the NWP, South Africa.

- **Ethical considerations**

The researcher ensured that before the actual study could commence, all relevant authorities had granted permission to conduct the study. The rights of the respondents were not violated as the researcher respected those women who did not want to participate in the study.

- **Recruitment of the research assistants**

The criteria that were used to recruit the research assistants included:

- Good communication skills
- Good personal skills
- Read, write and speak English and Afrikaans
- Understand Tswana, Xhosa and Zulu

- **Training of the research assistants**

After the approval of the interview schedules and granting of permission by the relevant authorities to conduct a study in all the designated facilities in the NWP, the researcher embarked on a one day training session of the two research assistants on how to interview the women who had used TOP services in the identified 14 research sites. The research assistants were requested to be honest and treat the information they gathered for the purpose of the research confidentially. No names were to be used and women should not be forced to participate in the study. The researcher was always available in case the research assistants needed clarity and the researcher collected the completed interview schedules immediately after the interview sessions were done.

### 3.3.2 Phase 2

The purpose of phase 2 of the study was to determine why women who wished to use TOP services, did not access these services in the NWP.

- **Population**

The research population for phase 2 comprised 50 women who wished to have TOP services but could not access TOP services when they had requested TOP services in public health facilities in the NWP.

The respondents had to

- o be pregnant when requesting TOP services
- o reside in the NWP when they wanted to access TOP services
- o be willing to participate in the study

- **Sampling**

A sample of 50 women who wished to have TOP services but could not access TOP services after requesting it in the NWP were interviewed.

- **Convenience sampling**

The sample of women who did not manage to access TOP services in the NWP were accessed on the day the researcher was at the research site for data collection and included those women who could not access TOP services because their pregnancies had advanced beyond 12 weeks' gestation and those who had been admitted in gynaecological wards with incomplete TOPs. Available respondents were included in the study until the desired sample size of 50 women who did not manage to access TOP services, had been interviewed (Polit & Beck 2006:497).

- **Data collection**

The researcher conducted structured interviews with 50 women who could not access TOP services in the NWP from August to November 2009.

The interview schedule in phase II comprised the following sections:

Demographic data including

- age
- marital status
- religion
- number of children
- employment history
- number of TOPs

Section B of the interview schedule comprised closed-ended questions relating to the accessibility of TOPs.

Section C of the interview schedule comprised closed-ended questions relating to the feelings and opinions of the women about TOP services in the NWP.

Section D of the interview schedule comprised closed-ended questions relating to the barriers to accessing TOP services.

Section E of the interview schedule comprised open- and closed-ended questions relating to the impact that women's cultural and religious values and beliefs could have on their access to TOP services in the NWP.

Section F of the interview schedule comprised open-ended questions relating to illegal TOP services, the use of contraceptives and the negotiation of safe sex to prevent unplanned pregnancies.

## 3.4 RELIABILITY AND VALIDITY

### 3.4.1 Validity

It implies the degree to which an instrument measures what it is supposed to measure (Polit & Beck 2006:512). The interview schedules were given to two clinical experts in the field of TOP services and a statistician at the University of South Africa (UNISA) to evaluate its content validity as well as its conceptual clarity and investigative bias.

- **Internal validity**

Brink et al (2006:203) describe internal validity as the degree to which changes in the dependent variable can be attributed to the independent variable. This concept indicates the extent to which the challenges of women, requesting TOP services in the study are truly reflected rather than being attributable to extraneous or chance variables which do not necessarily indicate the challenges of women who requested TOP services in the NWP.

*Threats to internal validity*

Brink et al (2006:99) describe threats to internal validity as the occurrence of an event, which may be unrelated to the study but can affect the results of the study, pose possible threats to the internal validity of the data. Therefore, factors related to the history of respondents' previous TOP services might be a threat to the internal validity.

The process of selection of respondents to participate in the study and the type of group selected might influence the results and compromise its validity (Brink et al 2006:99). Therefore, the challenges encountered by women who had used TOP services, including women who wished to have TOP services but could not access them, and nurses who provide TOP services in the NWP, were explored, adding to the validity of the findings.

- **External validity**

Brink et al (2006:101) refer to external validity as the degree to which the study results can be generalised to other people and other settings. The focus of this study was to interview women at all 14 public health facilities in the NWP, requesting TOP services but who did not manage to access TOP services.

*Threat to external validity*

According to Brink et al (2006:101) the threat to external validity might be influenced by the measuring instrument and these might influence the score. Several threats to

external validity that need to be considered by the researcher include the Hawthorne effect, the researcher's influence and reactive effects to respondents' answers.

*Reactive effects*

The respondents might try to please the researcher and provide the information that they believed was desired (Brink et al 2006:101). This type of threat to external validity was minimised by explaining to the respondents, that they did not have to please anybody and they had to answer the questions honestly.

*Hawthorn effect*

This occurs when respondents react in a certain manner because they are aware that they are being observed. Being aware that they participates in the study relating to their challenges to access TOP services, the respondents in this study might have provided information that would satisfy the researcher instead of giving honest information about their real life experiences (Brink et al 2006:101).

The researcher minimised this threat by explaining to respondents the importance of being honest during the interview process. No respondents were coerced to participate in the study and the respondents had the right to refuse to participate and to refuse to answer specific questions.

*Researcher effects*

Brink et al (2006:101) state that the researcher might influence the results when the researcher's characteristics or behaviour (like verbal or non-verbal cues, facial expressions, clothing, age and gender) influence the respondent's behaviour. The study on challenges of women who request TOP services in the NWP is a sensitive matter and some respondents might consider this to be private and confidential.

The researcher might have unconsciously, through facial expressions, clothing, age or gender, communicated expectations of the study to the respondents. To minimise this threat to external validity, the researcher avoided making any comments or to show any facial expressions that could give away any expectation of the study. The researcher

did not wear a nurse's uniform but dressed similarly to the women utilising the health services at a specific clinic/hospital. The researcher and research assistants treated every respondent respectfully and with empathy.

- **Research setting**

The researcher visited all 14 sites designated to provide TOP services in the NWP, South Africa, to collect data from the 50 women who wished to have TOP services but could not access these services in the NWP, South Africa.

- **Ethical considerations**

Privacy and confidentiality were ensured, understanding that TOP is a very sensitive matter, those women who were admitted were also treated with a high level of privacy. To ensure confidentiality, no patient names and patient numbers were mentioned during the interview.

## 3.5 RESEARCH METHOD PHASE 3

The purpose of phase 3 of the study was to determine the challenges encountered by nurses providing TOP services in the NWP. Structured interviews were conducted with all the nurses working at the 14 public health facilities providing TOP services in the NWP.

### 3.5.1 Research population

The research population for phase 3 comprised all nurses registered with the South African Nursing Council (SANC) as midwives and providing TOP services at the 14 public health facilities in the NWP.

- **Criteria for the inclusion of respondents**

To ensure inclusion in the study population, respondents had to be nurses:

- employed by the institutions where TOP services are provided in the NWP
- providing TOP services
- registered with the SANC as midwives

### 3.5.2 Data collection

The purpose of data collection in phase 3 was to identify the challenges encountered by nurses providing TOP services in the NWP.

- **Data collection instrument**

The researcher conducted the structured interviews personally in phase 3 of the study for the period October and November 2009. The interview schedule for phase 3 comprised the following sections:

Section A was used to collect demographic data including:

o age
o marital status
o religion
o number of children
o number of years working in TOP services
o number of grand children
o whether respondents had undergone TOP training

Section B of the interview schedule comprised questions relating to the impact that nurses' religion, values, morals and beliefs could have on their provision of TOP services.

Section C of the interview schedule comprised questions relating to the perceptions and opinions of nurses regarding who should utilise TOP services.

Section D of the interview schedule comprised questions relating to the attitudes of nurses towards women who request TOP services.

Section E of the interview schedule comprised questions relating to the nurses' choices to work in TOP services and the obstacles encountered in the implementation of the CTOP Act's provisions.

Section F of the interview schedule comprised questions relating to the availability of resources to support nurses who provide TOP services.

Section G of the interview schedule comprised questions relating to how nurses' personal lives were being influenced by the fact that they were rendering TOP services.

Section H of the interview schedule comprised questions relating to the support nurses received from their families, colleagues, managers and communities.

Section I of the interview schedule comprised questions relating to the nurses' feelings and opinions about rendering TOP services and the implementation of the CTOP Act's provisions.

Section J of the interview schedule comprised questions relating to the nurse's views on the TOP guidelines.

Section K of the interview schedule comprised questions relating to the provision of pre- and post-counselling of women who requested TOP services and what recommendations could be made to improve the circumstances of nurses working in TOP services.

## 3.6 VALIDITY OF THE RESEARCH INSTRUMENT PHASE 3

### 3.6.1 Face validity

To ensure face validity, the interview schedule was subjectively assessed by the promoters for presentation and relevance of the questions related to the challenges encountered by nurses who provide TOP services in the NWP.

### 3.6.2 Construct validity

The structured interviews were constructed so that it could measure the attributes to be studied which are the challenges encountered by the nurses who provide TOP services in the NWP.

### 3.6.3 Context validity

In this study the context of the structured interview, was derived from the literature review related to TOP services.

## 3.7 RELIABILITY OF THE RESEARCH INSTRUMENT

The pre-test of the interview schedule was conducted in one of the public health facilities in the Gauteng province that did not form part of the actual study due to the minimum number of facilities providing TOP services in the NWP. Where appropriate Cronbach Alpha Coefficient was calculated as indicated in Annexure G. Not all Cronbach Alpha Coefficient could be regarded as being statistically acceptable. Nevertheless these items were included in the instrument in an effort to obtain information relevant to the research questions.

- **Research setting**

The researcher conducted the study at 14 sites designated to provide TOP services by the Minister of Health in the NWP, South Africa. The researcher visited 12 hospitals, 1 community health centre and 1 clinic providing TOP services in the NWP. This allowed the researcher to generalise the research findings to the NWP.

- **Ethical consideration**

The researcher paid attention to the ethical considerations pertaining to the study and reassured the nurses who participated in the study that the information provided would be treated anonymously and confidentially and it would not be linked to any respondent. The researcher further indicated that no person will be identified in the report. It was

also clarified that the results could benefit the participating institutions to improve the level of managerial support offered to nurses providing TOP services.

## 3.8 METHOD OF DATA ANALYSIS

Brink et al (2006:171) state that the most powerful tool available to the researcher in analysing quantitative data is statistics. The data collected were coded and entered in the Microsoft Excel program by the statistician. The Statistical Package for Social Sciences (SPSS version 13) was used to analyse the data.

## 3.9 LIMITATION OF THE STUDY

Generalisation of the study to South Africa was limited as the study was only conducted in one province. Therefore, the study will have to be repeated in all other provinces in South Africa. TOP services might be considered as a confidential and private matter, that no one should know about it and the interview schedules might be perceived as a break of confidentiality and the respondents might have withheld some information. Non-random sampling could also be a limitation of this study.

## 3.10 SUMMARY

This chapter discussed the research methodology adopted by the study to determine the challenges encountered by women who had used TOP services, and those who had wished to have TOP services but could not access TOP services and the nurses who provide TOP services in the NWP. The study design, population, sampling, research, setting, data collection and analysis were described.

Ethical considerations that could have impacted on the study namely respect for a person, beneficence, privacy and justice were addressed. Reliability and validity of the research instruments were also described.

Chapter 4 will present the analysis and discussion of data obtained from structured interviews with women in phase 1 who had used TOP services in the NWP, South Africa.

# CHAPTER 4

# Data analysis and discussion: Phase 1: Challenges encountered by women who had used TOP services

## 4.1 INTRODUCTION

This chapter presents the data analysis and discussions for phase 1, with regard to challenges encountered by women who utilised TOP services in the NWP. The data were obtained from 150 respondents who used TOP service and agreed to be interviewed at the 14 designated public health facilities providing TOP services in the NWP.

This was the first phase of the study, where the researcher and two research assistants conducted structured interviews with 150 women who had used TOP services and agreed to be interviewed at these sites from August to November 2009 in the NWP. Out of the 19 designated public health facilities providing TOP services in the NWP, only 14 were active during 2009. The structured interview schedule contains 5-point Likert scale type questions to determine the most important issues by ranking the individual answers. The mean score was first calculated out of 5 for each individual question and then the results were sorted and saved in an Excel spreadsheet. The individual statement was ranked in order of importance. Percentages were rounded off to one decimal point.

The findings will be related to the literature review and will also indicate correlations, contrasts, similarities and/or differences. The study was guided by the HBM as the conceptual framework and research questions were derived from the three major tenets of the HBM, namely:

- Modifying factors
- Likelihood of action
- Individual perceptions

The research questions relating to challenges encountered by women who had used TOP services in Phase 1 were:

- Why are TOP services not accessible to all women who request it?
- What are the obstacles experienced by women who request TOP services?
- What is the level of satisfaction of women who had used TOP services?
- Why do women still seek illegal TOP services?
- Why do women not use contraceptives provided free of charge at the public health facilities to prevent unplanned pregnancies?
- Why can women not negotiate safe sex (condom use) to prevent unwanted pregnancies?
- Do women who seek TOP service receive pre- and post-TOP counselling?
- Do women receive contraceptive counselling post-TOP services?
- What impact do women's culture, religion, values and beliefs have on their access to TOP services?
- Is confidentiality of the TOP services maintained?

## 4.2 DEMOGRAPHIC DATA

- **Modifying factors in Phase 1**

According to the HBM, modifying factors such as age, marital status and income can influence a woman's access to TOP services.

### 4.2.1 Age

The age of respondents ranged from younger than 20 years to more than 41 years. Of these respondents, 32.0% (n=48) fell within the age group of 21 – 25 years, followed by those who were 20 years and younger with 29.3% (n=44). The percentage of respondents in the age groups older than 25 years (26-30 years) decreased from 15.0% (n=23) to 5.0% (n=7) for those who were older than 41 years.

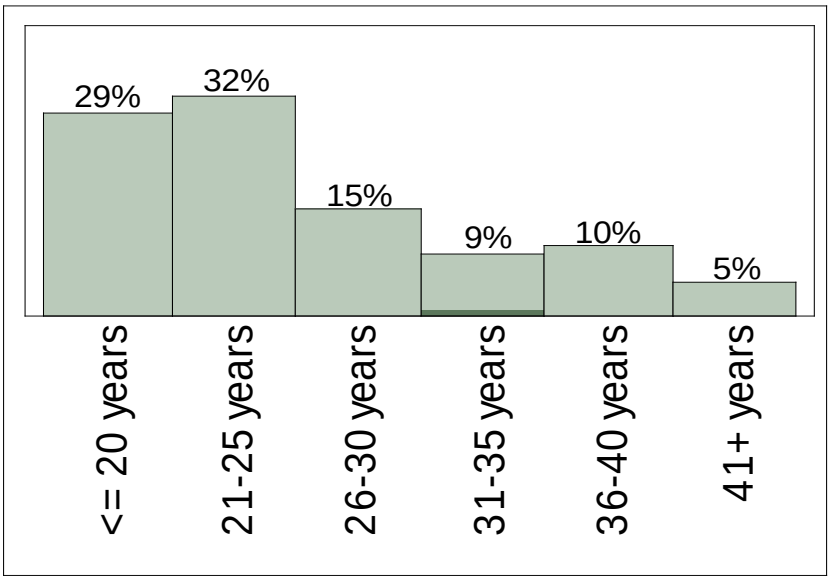



**Figure 4.1**

**Age distribution of respondents (n=150)**

The findings of this study correlate with other studies in terms of the age group category of 21-25 as being the highest percentage of women who utilised TOP services (Bowes & Macleod 2006:13; Regmi & Madison 2009:45).

### 4.2.2 Marital status

Out of 150 respondents, 71.3% (n=107) reported that they had never been married and only 15.3% (n=23) were married. These results confirm that single women constituted the highest percentage of women who requested TOP services in the NWP. The study conducted by Lang et al (2005:53) revealed that more than three quarters of South African women who had requested TOP services in their study were single. Another study conducted in the Eastern Cape also revealed that 78.0% of the respondents were single, which also supports the evidence that the TOP rates were higher among single women (Mdleleni-Bookholane 2007:250).

A study conducted in the USA, on the trends in the characteristics of women obtaining TOP services revealed that unmarried women accounted for the majority of TOP service users in 2004 (Henshaw & Kost 2008:9).

According to the HBM's modifying factors, demographic, social psychological and structural factors could influence a pregnant woman who wants to use TOP services not to access TOP services. Furthermore the modifying factors such as age, parental and marital status could have an impact on a pregnant woman who wants to utilise TOP services.

### 4.2.3 Religion

Out of 150 respondents, 94.0% (n=141) reported that they were Christians, 0.7% (n=1) Muslims, 3.3% (n=5) had no religious affiliation and 2.0% (n=3) reported "other religion" without any specifications.

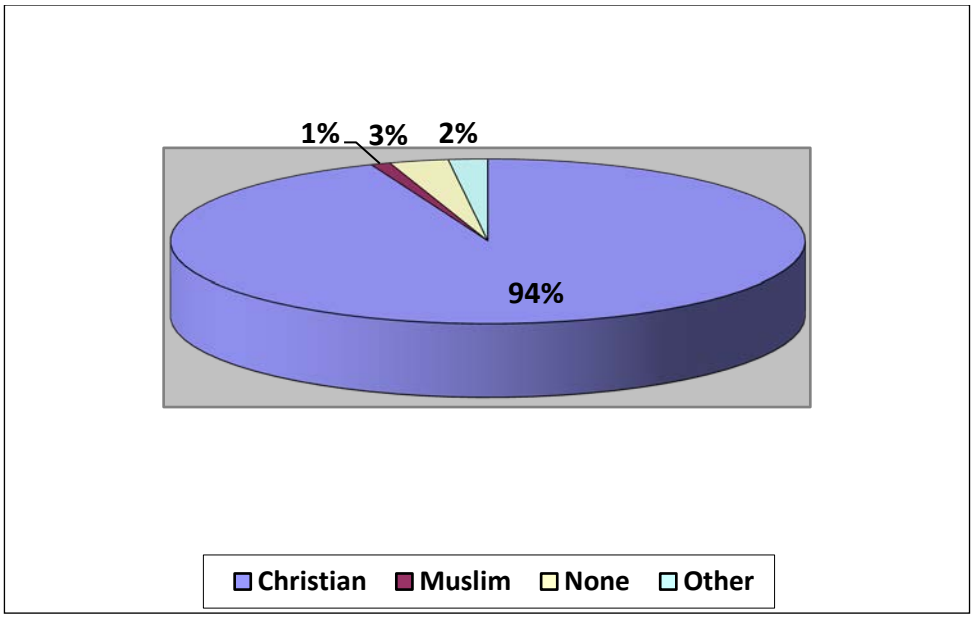



**Figure 4.2**
**Religion of respondents (n=150)**

Lebese (2009:17) argues that Christian and Islamic religious beliefs uphold the sanctity of life, shaping moral and ethical perceptions of TOP services. However, most respondents (94.0%; n=141) had used TOP services despite being self-reported Christians.

### 4.2.4 Employment

The majority of the respondents, (77.3%; n=116), indicated that they were unemployed, only 5.3% (n=8) were permanently employed and 17.3% (n=26) were temporarily employed. It should be noted that the students who participated in the study were also counted as being unemployed. The General Household Survey (GHS) done in 2005, indicated that the unemployment rate of females in the NWP was 38.9%, suggesting that females were poor in the NWP and might therefore have opted for TOP services (The NWP 2007:16).

### 4.2.5 Type of job

Of the respondents 44.0% (n=66) indicated that they were unemployed correlating with that of the GHS done in 2005 indicating that 29.3% (n=44) were students, 16.0% (n=24) did not specify their types of jobs, 5.3% (n=8) were general workers, and 5.3% (n=8) were sales persons (The NWP 2007:15).

These statistics indicate that most respondents lacked financial resources and this could be one of the reasons they opted to use TOP services, as they might have been unable to support another child financially.

### 4.2.6 Monthly incomes

Out of 149 respondents, 73.8% (n=110) indicated that they did not earn anything, which correlated with the findings reported in sections 4.2.4 and 4.2.5. Figure 4.3 indicates the earnings of respondents. Out of the 39 respondents who indicated that they were earning money, 10.0% (n=15) indicated that they earned less than R1000.00 and another 10.0% (n=15) earned between R1001 – R2000 per month. A small percentage (4.7%; n=7) earned between R2001 and R3000 per month and only two (1.3%) earned R3001 or more per month.

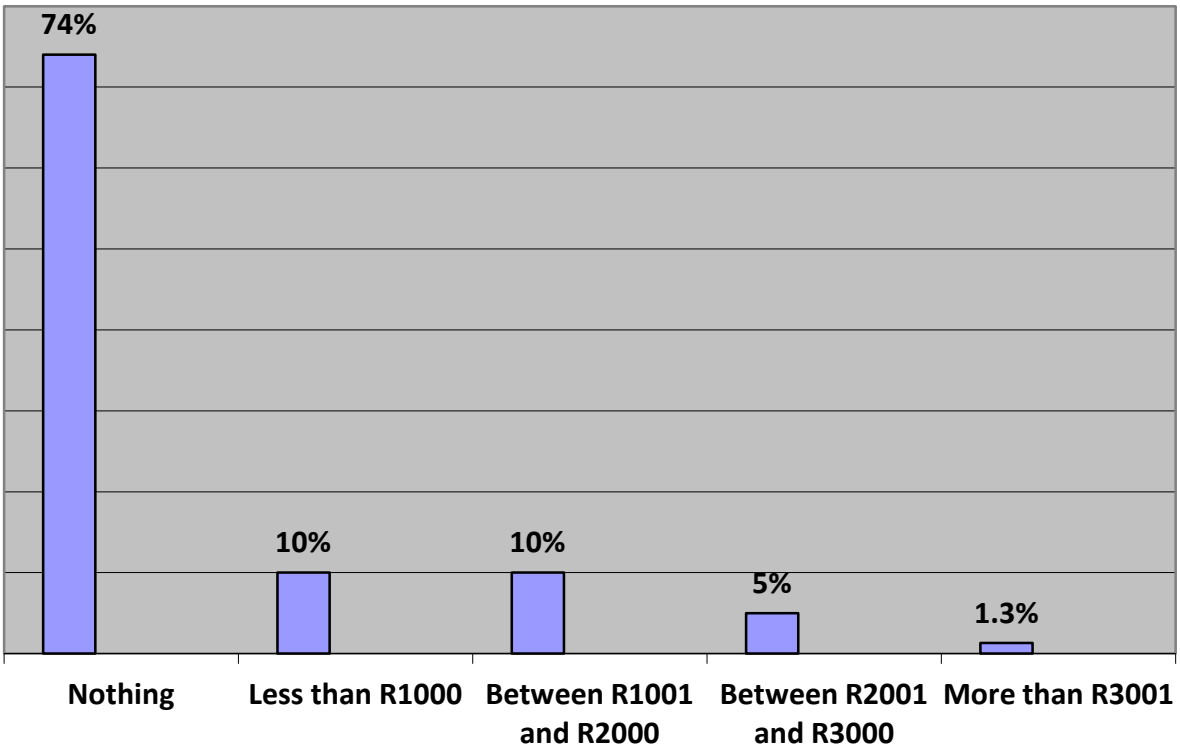



**Figure 4.3**

**Respondents' earnings per month (n=149)**

This correlates with another study's finding indicating that 68.7% of the respondents using TOPs, were either in the "no income" or "low income" category (Bowes & Macleod 2006:14).

### 4.2.7 Number of children

Of the respondents, 36.7% (n=55) indicated that they had never given birth, 25.3% (n=38) had one child, 16.7% (n=25) had two children, 20.0% (n=30) had 3-5 children and 1.3% (n=2) had 6 or more children.

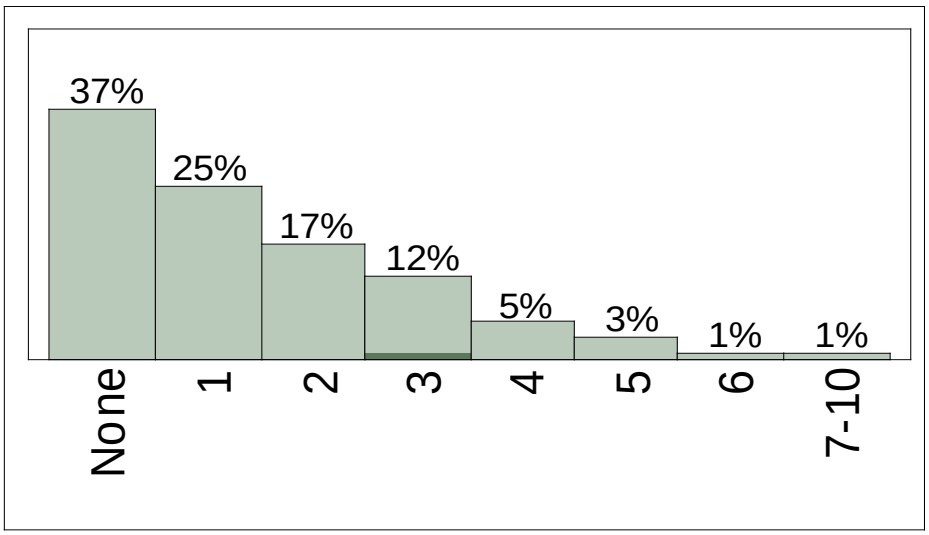



**Figure 4.4**

**Respondents' number of children (n=150)**

### 4.2.8 Number of times termination of pregnancy services had been used

Out of 150 respondents, 90.0% (n=135) indicated it was the first time and 10.0% (n=15) indicated that it was the second time that they had used TOP services. Similarly, the study conducted by Pud and Amit (2005:145), indicated that 72.5% of their respondents had used TOP for the first time. The findings of this study indicate TOP services were not used for family planning purposes.

## 4.3 ACCESSIBILITY OF TERMINATION OF PREGNANCY SERVICE

The respondents were requested to indicate their perceived accessibility to TOP services.

- **Likelihood of action in Phase 1**

### 4.3.1 Transport to access termination of pregnancy facilities

The majority of respondents (96.0%; n=144) indicated that they needed to use transport to access TOP services. According to the HBM transport might be a barrier to those

women who could not afford transport fees to access TOP service when they needed to do so (Mackey 2002:8).

### 4.3.2 Distances travelled to access termination of pregnancy services

The distance a person has to travel to a health service might influence the person's ability to use the TOP services.

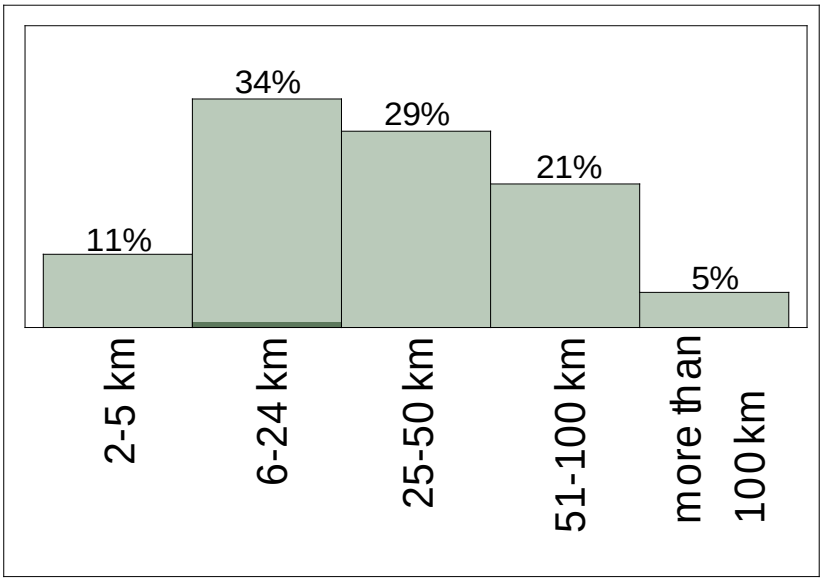



**Figure 4.5**
**Kilometres travelled by respondents to access TOP service (n=150)**

The NWP is vast province and women have to travel long distances before they can access TOP services and the accessibility poses challenges to those women who want to use TOP services in this province.

### 4.3.3 Legal right to access termination of pregnancy

In response to one of the items in the interview schedule (see annexures D-F), all 100% (n=150) indicated that a woman has a legal right to access TOP services. Thus women knew that it was their right to request and access TOP services.

### 4.3.4 Knowledge about the Choice of Termination of Pregnancy Act (no 92 of 1996), as amended by Act no 1 of 2008

Out of 148 respondents, 87.2% (n=129) indicated that they had heard about the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008. Only 12.8% (n=19) had not heard about the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008. These findings confirm the outcome of a study conducted in KwaZulu-Natal in South Africa, where 16.9% of the respondents said they were unaware of such an act, while 83.1% said they were aware of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008 (Patel & Myeni 2008:740).

### 4.3.5 Source of information about the Choice of Termination of Pregnancy Act (no 92 of 1996), as amended by Act no 1 of 2008

It is very important for women to know where to access TOP services when needed. Unless women know where to access TOP services, they would be unable to access these services.

**Table 4.1 Response on the source of information about the Choice of Termination of Pregnancy Act (no 92 of 1996), as amended by Act no 1 of 2008**

| Item | Statement | Yes | | No | | Total | | No response |
|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | n |
| 13.1 | Friends | 67.9 | 89 | 32.0 | 42 | 100 | 131 | 19 |
| 13.2 | Television | 22.4 | 22 | 77.6 | 76 | 100 | 98 | 52 |
| 13.3 | Clinic | 77.8 | 105 | 22.0 | 30 | 100 | 135 | 15 |
| 13.4 | Hospital | 53.5 | 53 | 46.5 | 46 | 100 | 99 | 51 |
| 13.5 | Magazines/news papers | 47.8 | 54 | 52.2 | 59 | 100 | 113 | 37 |
| 13.6 | Teacher | 28.6 | 28 | 71.4 | 70 | 100 | 98 | 52 |
| 13.7 | Other, specify | 34.1 | 15 | 66.0 | 29 | 100 | 44 | 106 |

Out of 131 respondents, 67.9% (n=89/131) reported that their information source about the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008 was friends. The respondents who indicated television as their source were 22.4% (n=22/98). Those who indicated the hospital as their source of information were 53.5% (n=53). It seems as if clinics, 77% (n=105/135) were the most important sources of information about the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008.

According to Lipp (2008:3 citing Goss 2004) the majority of women in her study indicated that they had received information about TOPs from magazines, books and the Internet.

The results of this study revealed that magazines and newspapers were not the most important sources of information for women as 52.2% (n=59/113) had not received information from these sources. This means that only 47.8% (n=54/113) received information through magazines/newspapers. Of the respondents, 28.6% (n=28/98) indicated teachers as being their sources of information. Clinics, friends and hospitals provided some information on TOP services.

According to the study findings most respondents (71.0%; n=106) in this study were 21+ years and out of school, that might be the reason why few respondents mentioned teachers as their TOP information sources. Relating to the HBM, lack of knowledge about the availability of TOP services on request could pose barriers to accessing TOP services (Mackey 2002:8).

### 4.3.6 Experience with nurses rendering TOP services

**Table 4.2 Experiences of respondents with nurses rendering TOP services and with the services as such**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 14.1 | Nurses refuse to render TOPs | 34.0 | 51 | 9.3 | 14 | 56.7 | 85 | 100 | 150 | 0 |
| 14.2 | Nurses who provide TOPs are generally caring people | 66.7 | 100 | 14.0 | 21 | 19.3 | 29 | 100 | 150 | 0 |
| 14.3 | Nurses who render TOPs are generally unfriendly | 21.5 | 32 | 15.4 | 23 | 63.1 | 94 | 100 | 149 | 1 |
| 14.4 | Nurses monitor all patients having TOPs hourly | 47.9 | 70 | 21.2 | 31 | 30.8 | 45 | 100 | 146 | 4 |
| 14.5 | Nurses generally leave patients to care for themselves | 19.6 | 29 | 18.9 | 28 | 62.0 | 91 | 100 | 148 | 2 |
| 14.6 | Nurses put you on a waiting list if you request TOPs | 26.2 | 39 | 0.7 | 1 | 73.2 | 109 | 100 | 149 | 1 |
| 14.7 | Nurses do not want to be involved in TOPs | 30.0 | 44 | 27.9 | 41 | 42.2 | 62 | 100 | 147 | 3 |
| 14.8 | Nurses generally leave patients to clean up their “own mess” after TOPs | 24.5 | 36 | 18.4 | 27 | 57.1 | 84 | 100 | 147 | 3 |
| 14.9 | I am satisfied with the termination of pregnancy services | 48.0 | 71 | 5.4 | 8 | 46.6 | 69 | 100 | 148 | 2 |

Of the respondents, (56.7%; n=85) agreed with the statement that nurses refused to render TOP services, only 34.0% (n=51) disagreed and 9.3% (n=14) were neutral. This was also confirmed by other studies indicating that nurses had refused to assist with TOP service because TOP services were against their personal ethics and those nurses who were willing to provide TOP services had been overworked (Mamabolo 2006:38 citing Prabhakarah 1998).

Of the respondents, 66.7% (n=100) disagreed with the statement that nurses providing TOP services were generally caring people, only 19.3% (n=29) agreed and 14.0% (n=21) were neutral. Walden (2009:33) cited Walden (2006) about the caring process in nursing, described a caring nurse as one who "encompasses the behaviours and attitudes demonstrated in the applicable actions, protected by law, and developed with competence to promote the potentialities of people that view conserving or improving the human condition in the process of living and dying."

Of the respondents, 73.2% (n=109) agreed with the statement that nurses put women on a waiting list when they request TOP services, 26.2% (n=39) disagreed and 0.7% (n=1) were neutral. Waiting lists could be a barrier for women to access TOP services and some might resort to illegal TOPs. This is the case because the CTOP Act only allows TOPs on request till 12 weeks' gestation.

Of the respondents, 57.1% (n=84) agreed with the statement that nurses left them to clean up their own mess after surgical TOPs, 24.5% (n=36) disagreed and 18.4% (n=27) were neutral. Thus it appears as if 57.1% (n=84) of the women who had accessed TOP services in the NWP, had to clean up themselves.

Some respondents, 48.0% (n=71) disagreed with the statement that they were satisfied with TOP services, while 46.6% (n=69) agreed and 5.4% (n=8) were neutral. Thus fewer than half of these women were satisfied with the TOP services they had used in the NWP.

### 4.3.7 Number of weeks' gestation when requesting TOP services

Of respondents, 64.7.0% (n=97) were 2-8 weeks pregnant when they requested TOP services, followed by 33.3% (n=50) who were 9-12 weeks pregnant and only 2.0% (n=3)

who were beyond 13-16 weeks gestation. In one of the facilities there was a doctor who was also providing TOP services to women with pregnancies exceeding 12 weeks' gestation.

The results of this study correlate with other studies conducted in other countries like Sweden, where 93.0% of TOP services were performed before 12 weeks' of gestation and 6.0% between 12 and 18 weeks (Hammarstedt et al 2006:229).

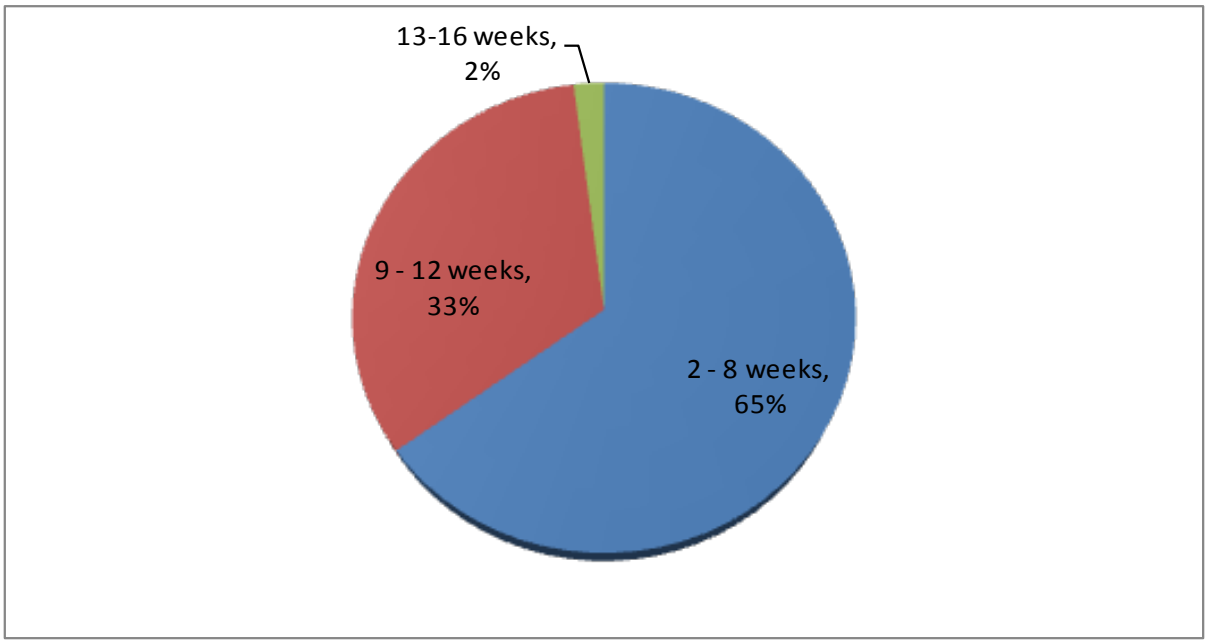



**Figure 4.6**

**Gestation time when requesting TOP service (n=150)**

### 4.3.8 Test performed

Of the respondents, 59.5% (n=88) indicated that before the nurses placed the women on the waiting list, they performed urine tests to confirm the pregnancy. Only 10.8% (n=16) indicated that the nurses did blood tests to confirm the pregnancy. Out of 148 respondents who answered this question, 88.5% (n=131) indicated that a sonar had been done to confirm the pregnancy.

## 4.4 ILLEGAL TERMINATION OF PREGNANCY SERVICES AND THE USE OF CONTRACEPTIVES

- **Individual perceptions of respondents in Phase 1**

The inaccessibility of TOP services might cause women to resort to illegal TOP services which might be costly, unsafe and dangerous.

**Table 4.3 Respondents' experiences concerning TOP services and the use of contraceptives**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 17.1 | TOP services are accessible to the public | 53.3 | 83 | 6.0 | 9 | 38.7 | 58 | 100 | 150 | 0 |
| 17.2 | TOP services are acceptable | 42.7 | 64 | 10.7 | 16 | 46.7 | 70 | 100 | 150 | 0 |
| 17.3 | TOP services are linked to reproductive health services | 75.2 | 112 | 4.7 | 7 | 20.1 | 30 | 100 | 149 | 1 |
| 17.4 | TOP services are stigmatised | 28.9 | 43 | 4.0 | 6 | 67.1 | 100 | 100 | 149 | 1 |
| 17.5 | TOP services are used as a method of contraceptives | 39.3 | 59 | 18.7 | 28 | 42.0 | 63 | 100 | 150 | 0 |
| 17.6 | It is better for women to seek illegal TOP services if they cannot be assisted in designated public health facilities, than to have an unwanted baby | 46.0 | 69 | 9.3 | 14 | 44.7 | 67 | 100 | 150 | 0 |
| 17.7 | A person providing illegal TOP services should not be punished | 50.0 | 75 | 10.7 | 16 | 39.3 | 59 | 100 | 150 | 0 |
| 17.8 | I am in the position to negotiate safe sex (condom use) with my partner | 65.8 | 98 | 3.4 | 5 | 30.9 | 46 | 100 | 149 | 1 |
| 17.9 | When I become intimate with my partner, we use a condom | 46.6 | 69 | 16.9 | 25 | 36.5 | 54 | 100 | 148 | 2 |
| 17.10 | Only unmarried people should use condoms | 42.7 | 64 | 2.7 | 4 | 54.7 | 82 | 100 | 150 | 0 |
| 17.11 | I used a condom the last time I had sex | 38.0 | 57 | 0.7 | 1 | 61.3 | 92 | 100 | 150 | 0 |
| 17.12 | I am using a female condom when having sex | 64.7 | 97 | 0.0 | 0 | 35.3 | 53 | 100 | 150 | 0 |

Of the respondents, 53.3% (n=83) disagreed with the statement that TOP services were accessible to the public, 38.7% (n=58) agreed and 6.0% (n=9) were neutral. Reportedly, 46.7% (n=70) of the respondents agreed that TOP services were

acceptable to the public, 42.7% (n=64) disagreed with the statement and 10.7% (n=16) were neutral. These findings indicate that TOP services were not easily accessible to women in the NWP.

Of the respondents 75.2% (n=112) disagreed with the statement that TOP services were linked to reproductive health services. It is not clear why TOP services were not linked to reproductive health services in some facilities in the NWP.

Of the respondents, 67.1% (n=100) agreed with the statement that TOP services were stigmatised, 28.9% (n=43) disagreed with the statement and 4.0% (n=6) were neutral. In another study a woman who chose to obtain TOP services outside her residential area was still concerned about being seen and described how she was disturbed by the anti-TOP demonstration outside the clinic. A respondent in another study compared the stigma associated with HIV and AIDS to the stigma associated with having a TOP (Harries et al 2007:[11]).

Of the respondents, 39.3% (n=59) disagreed with the statement that TOP services were used as contraceptives, 42.0% (n=63) agreed and 18.7% (n=28) were neutral. This is in line with the previous finding where 10.0% (n=15) indicated that it was the second time that they had used TOP services.

Considering the risk involved in illegal TOPs, 44.7% (n=67) of the respondents agreed with the statement that it was better for women to seek illegal TOP services if they could not be assisted in designated public health facilities, than to have unwanted babies. The Sowetan newspaper (2009b:8) reported that many teenagers continued to seek backstreet TOP services rather than legal facilities to end unwanted pregnancies. In terms of the HBM, perceived threats of illegal TOP services include complications and death (Mackey 2002:8). Furthermore, 50.0% (n=75) of the respondents disagreed with the statement that a person providing illegal TOP services should not be punished, 39.3% (n=59) agreed and 10.7% (n=16) were neutral.

Of the respondents, 65.8% (n=98) disagreed with the statement that they were in the position to negotiate safe sex (condom use) with their partners, 30.9% (n=46) agreed and 3.4% (n=5) were neutral. Another 46.6% (n=69) of the respondents disagreed with

the statement, 36.5% (n=54) agreed and only 16.9% (n=25) used condoms when they became intimate with their partners.

Reportedly, 54.7% (n=82) agreed that only unmarried people should use condoms and 42.7% (n=64) disagreed. Of the respondents, 64.7% (n=97) disagreed with the statement that they used female condoms when having sex, 35.3% (n=53) agreed.

## 4.5 COUNSELLING

According to the HBM, counselling is one of the crucial variables mentioned under the psychological variables. Therefore respondents were asked to indicate their experiences with counselling services in the NWP.

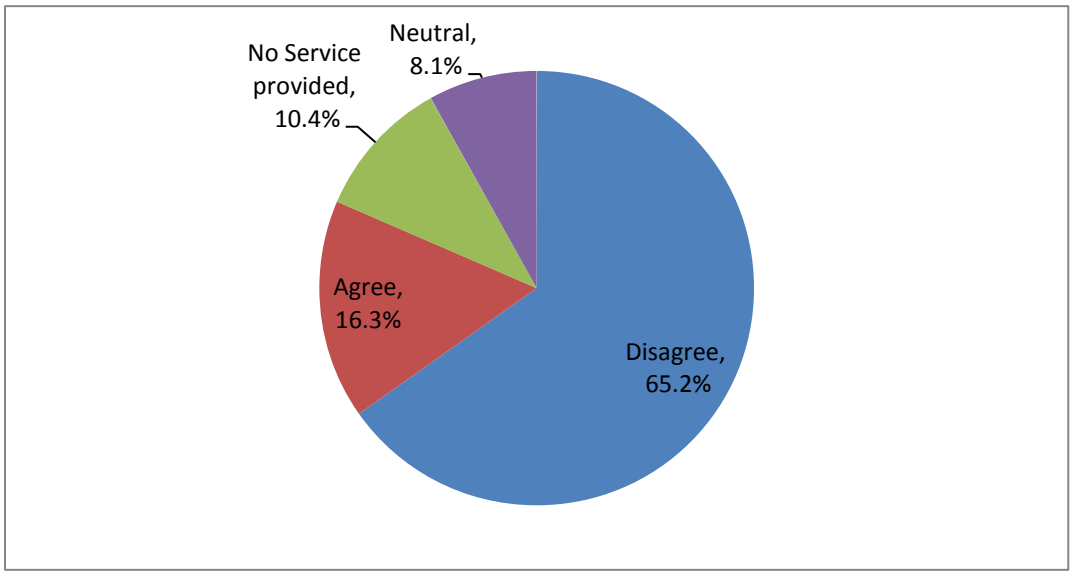



**Figure 4.7**

**Respondents' experience of counselling service (n=133)**

Of the 133 respondents who answered the question, a large percentage (65.2%; n=88) disagreed with the statement that the counselling services provided were excellent, while 10.4% (n=14) did not receive any counselling. Only 16.3% (n=20) agreed that the counselling they received was excellent while 8.1% (n=11) were neutral.

### 4.5.1 Respondents' answer to open-ended questions

Respondents also answered open-ended questions on who offered counselling services at the TOP facilities. Table 4.4 indicates the respondents' indications as to persons offering counseling services

**Table 4.4 Counselling services offered at TOP facilities**

| Item | Statement | Nurse | | Social worker | | Don't know | | Lay counsellors | | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| | | n | % | n | % | n | % | n | % | n |
| 19 | Counselling services for TOP | 80 | 53.3 | 50 | 33.3 | 20 | 13.3 | 0 | 0 | 150 |
| 20 | Counselling services for HIV and AIDS | 81 | 54.0 | 10 | 6.7 | 36 | 24.0 | 23 | 15.3 | 150 |
| 21 | Counselling services for contraceptives | 150 | 100 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 150 |

According to the responses 53.3% (n=80) of the respondents reported nurses as people who provide counselling for TOP services, 33.3% (n=50) reported social workers, and 13.3% (n=20) did not know.

Of the respondents, 54.0% (n=81) indicated nurses as people who provided counselling services for HIV and AIDS, whereas 6.7% (n=10) reported social workers, 24.0% (n=36) did not know, and 15.3% (n=23) indicated lay counsellors.

All respondents, 100% (n=150) indicated that nurses provided counselling about contraceptives. Thus nurses provided all the counselling about contraceptives while nurses and social workers provided counselling about TOPs. Nurses, social workers and lay counsellors provided counselling about HIV and AIDS.

### 4.5.2 The respondents' experiences relating to nurses and counselling about termination of pregnancy services

**Table 4.5 The respondents' experiences relating to nurses and counselling in termination of pregnancy services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 22.1 | The nurses providing TOPs provided me with the support I needed | 59.3 | 89 | 8.7 | 13 | 32 | 48 | 100 | 150 | 0 |
| 22.2 | The nurses providing TOPs understood that having a TOP was my choice | 62.7 | 94 | 8.0 | 12 | 29.3 | 44 | 100 | 150 | 0 |
| 22.3 | The nurses providing TOPs explained the procedure to me | 76.0 | 114 | 1.3 | 2 | 22.7 | 34 | 100 | 150 | 0 |
| 22.4 | The nurses providing TOPs provided pre-and post termination of pregnancy counselling to me | 63.8 | 95 | 3.4 | 5 | 32.9 | 49 | 100 | 149 | 1 |
| 22.5 | The type of support offered by nurses providing TOPs was sufficient | 61.1 | 91 | 10.1 | 15 | 28.9 | 43 | 100 | 149 | 1 |
| 22.6 | My community provided support for women who had their pregnancies terminated | 57.0 | 85 | 8.7 | 13 | 34.2 | 51 | 100 | 149 | 1 |
| 22.7 | A woman should be allowed to make her own decision to have a TOP | 38.9 | 58 | 2.0 | 3 | 59.1 | 88 | 100 | 149 | 1 |
| 22.8 | A woman should consult a counsellor before deciding to have a TOP | 56.0 | 84 | 6.0 | 9 | 38.0 | 57 | 100 | 150 | 0 |
| 22.9 | A woman should consult a nurse before deciding to have a TOP | 60.0 | 90 | 2.0 | 3 | 38.0 | 57 | 100 | 150 | 0 |
| 22.10 | A woman should consult her partner before deciding to have a TOP | 60.7 | 91 | 4.7 | 7 | 34.7 | 52 | 100 | 150 | 0 |
| 22.11 | A woman should consult her clergyman before deciding to have a TOP | 58.4 | 87 | 11.4 | 17 | 30.2 | 45 | 100 | 149 | 1 |
| 22.12 | A woman should consult her family before deciding to have a TOP | 52.0 | 78 | 11.3 | 17 | 38.0 | 57 | 100 | 150 | 0 |
| 22.13 | A woman should consult her friends before deciding to have a TOP | 58.7 | 88 | 7.3 | 11 | 34.0 | 51 | 100 | 150 | 0 |
| 22.14 | A woman should consult her mother-in-law before deciding to have a TOP | 64.0 | 96 | 1.3 | 2 | 34.7 | 52 | 100 | 150 | 0 |

Of the respondents, 59.3% (n=89) disagreed with the statement that nurses providing TOP services, provided them with the support they needed, 32.0% (n=48) agreed and 8.7% (n=13) were neutral. Lebese (2009:39) argued that the health professionals, involved in TOP services, faced the challenge of being ostracised and victimised by

their colleagues and communities. This might have influenced the nurses' support provided to women using TOP services. Of the respondents, 29.3% (n=44) felt that the nurses providing TOP services understood that having a TOP was the woman's own choice, 62.7% (n=94) disagreed, and 8.0% (n=12) were neutral.

Most respondents, 76.0% (n=114) disagreed with the statement that nurses providing TOP services explained the procedure to them, 22.7% (n=34) agreed and 1.3% (n=2) were neutral. Reportedly, 63.8% (n=95) disagreed with the statement that nurses providing TOP services provided pre- and post-TOP counselling to them, 32.9% (n=49) agreed and 3.4% (n=5) were neutral.

Of the respondents, 61.1% (n=91) disagreed with the statement that the support offered by nurses providing TOP services was sufficient, 28.9% (n=43) agreed, 10.1% (n=15) were neutral. The support provided by nurses before the TOP procedure would be most important due to the emotional experience of the respondents.

Of the respondents, 57.0% (n=85) disagreed with the statement that the community provided support to women who had their pregnancies terminated, 34.2% (n=51) agreed and 8.7% (n=13) were neutral.

Of the respondents 59.1% (n=88) agreed with the statement that women should be allowed to make their own decisions to have TOPs done, 38.9% (n=58) disagreed and 2.0% (n=3) were neutral. In accordance with this, women disagreed to consult with counsellors (56.0%; n=84), nurses (60.0%; n=90), partners (60.7%; n=91), clergymen (58.4%; n=87), families (52.0%; n=78), friends (58.9%; n=88), and their mothers-in- law (64.0%; n=96).

## 4.6 LIKELIHOOD OF INFLUENCE OF CULTURE AND RELIGIOUS BELIEFS AND MORAL VALUES ON THE UTILISATION OF TOP SERVICES

Cultural and religious beliefs and moral values could be perceived as barriers for some women to access TOP services when needed, as related to the HBM.

**Table 4.6 The impact of culture and religious beliefs and moral values on women's access to termination of pregnancy services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 23.1 | My religious beliefs prevent me from accessing TOPs | 48.0 | 72 | 4.7 | 7 | 47.3 | 71 | 100 | 150 | 0 |
| 23.2 | My cultural beliefs prevent me from accessing TOPs | 46.0 | 69 | 2.7 | 4 | 51.3 | 77 | 100 | 150 | 0 |
| 23.3 | My moral values prevent me from accessing TOPs | 50.7 | 76 | 5.3 | 8 | 44.0 | 66 | 100 | 150 | 0 |
| 23.4 | Termination of pregnancy is a sin | 38.3 | 57 | 4.7 | 7 | 57.0 | 85 | 100 | 149 | 1 |
| 23.5 | I feel guilty because I terminated a pregnancy | 45.0 | 67 | 8.1 | 12 | 47.0 | 70 | 100 | 149 | 1 |
| 23.6 | I feel I am a sinner | 41.3 | 62 | 6.7 | 10 | 52.0 | 78 | 100 | 150 | 0 |
| 23.7 | I feel I am a "baby killer" | 38.0 | 57 | 8.7 | 13 | 53.3 | 80 | 100 | 150 | 0 |
| 23.8 | I feel God will never forgive me | 52.3 | 78 | 3.4 | 5 | 44.3 | 66 | 100 | 149 | 1 |
| 23.9 | I do not have any negative feelings after the termination of my pregnancy | 55.7 | 83 | 5.4 | 8 | 38.9 | 58 | 100 | 149 | 1 |
| 23.10 | I feel relieved because the procedure is over | 30.7 | 46 | 0.0 | 0 | 69.3 | 104 | 100 | 150 | 0 |

Almost an equal number of respondents, disagreed (48.0%; n=72) and agreed (47.3%; n=71) with the statement that religious beliefs could prevent a woman from accessing TOP services, while 4.7% (n=7) were neutral.

Of the respondents, 51.3% (n=77) agreed with the statement that cultural beliefs prevented them from accessing TOP services, 46.0% (n=69) disagreed and 2.7% (n=4) were neutral.

Of the respondents, 50.7% (n=76) disagreed with the statement that moral values could prevent women from accessing TOP services, 44.0% (n=66) agreed and 5.3% (n=8)

were neutral. Relating to the HBM, moral values could also prevent a pregnant woman from accessing TOP services (Mackey 2002:8).

As many as 57.0% (n=85) of the respondents agreed with the statement that TOP is a sin, 38.3% (n=57) disagreed and 4.7% (n=7) were neutral. The thought of being a sinner could pose a barrier to a woman who wants to have a TOP done.

Fewer than half, 47.0% (n=70) agreed with the statement that they felt guilty because they had terminated a pregnancy, 45.0% (n=67) disagreed and 8.1% (n=12) were neutral.

Of the respondents, 41.3% (n=62) disagreed with the statement that they felt they were sinners, 52.0% (n=78) agreed 6.7% (n=10) were neutral. The thought of being a sinner because of using TOP services might be a barrier to access TOP services to some women.

A few respondents (38.0%; n=57) disagreed with the statement that they felt they were "baby killers'', 8.7% (n=13) were neutral and 53.3% (n=80) agreed. Of the respondents, 52.3% (n=78) disagreed with the statement that God would never forgive them, 44.3% (n=66) agreed and 3.4% (n=5) were neutral.

Of the respondents, 55.7% (n=83) disagreed with the statement that they did not have any negative feelings after the termination of their pregnancies, 38.9% (n=58) agreed and 5.4% (n=8) were neutral.

The findings revealed a sense of relief amongst respondents because the procedure was over, as 69.3% (n=104) agreed with the statement and 30.7% (n=46) disagreed.

## 4.7 CONFIDENTIALITY

TOP services are sensitive issues and women who utilised these services would like that to remain private and confidential due to the stigma attached to TOP services. The respondents were required to answer some open-ended questions concerning their feelings about TOP services and the respondents felt that the TOP services in the NWP lacks confidentiality and privacy.

### 4.7.1 Dislikes about TOP services

An open-ended question asked the respondents to indicate what they disliked about TOP services.

A number of the respondents, 59.3% (n=89) disliked the fact that they had to wait at the TOP facilities because they were afraid that someone might recognise them and that invaded their privacy. The other disliked aspect was that TOP services rooms were closely situated to other services like maternity, lacking the needed privacy and confidentiality. One respondent stated “I dislike the fact that there is no confidentiality in the sense that the waiting room for patients who request TOP is combined with one for the pregnant women who came in for checkup”.

Another respondent said they were normally labeled “those who came for TOP must go that side”, so if your sister or neighbour is there, they will hear that you came for a TOP and this was what they disliked about the TOP services. A lack of privacy was mentioned by one respondent because they all waited in one room and rested in the same room after the procedure and they disliked this.

Confidentiality may also be a problem when patients only have one file, as mentioned by a respondent “I am not sure if they are using the same files for all the illnesses when you come to the hospital because if they do, it is going to be a problem” which they also disliked.

Answering questions in front of other patients can be embarrassing as indicated by one respondent “I had been asked what I am going to do in front of the other patients and my answer was ‘I am the one from yesterday.’ I disliked that with all my heart”. A teenage respondent remarked that teenagers did not want to come to the hospital because they did not trust nurses to keep their secrets.

### 4.7.2 Aspects the respondents liked about TOP services

Only 36.7% (n=55) of the women said they liked the fact that TOP services were private and the social worker talked to them in a room individually. Sufficient rooms were available where they could rest after the TOP procedure.

Another respondent stated that she did not have issues with confidentiality because she could talk to her friends and community about it. Of the respondents, 4.0% (n=6) indicated that they did not stay in that area, making it private and secretive for them because nobody knew them in that area.

### 4.7.3 Respondents' one wish for the nurses providing TOP services

The respondents were asked if they had one wish for the nurses who provided the TOP service to them, what would that be.

Twenty (13.3%) respondents indicated that they wished that God would forgive the nurses and provide the nurses with strength and wisdom. Another respondent indicated that she wished that the nurses could keep on assisting women who needed TOP services because financial circumstances of pregnant women sometimes forced them to request TOP services.

A few respondents, (3.3%; n=5) also wished that the nurses would enjoy their work and keep up the good work, to be strong and provide support to women who requested TOP services. It was indicated by a respondent that she knew it was not the easiest job to do in the world but wished the nurses strength and will-power. Four percent (n=2) of the respondents also wished that nurses providing TOP services could keep information about TOP service confidential, and that nurses should treat them with dignity and respect.

Other wishes of respondents included that nurses could provide TOP services daily and not put them on a waiting list; should give them time to relax until the pain subsided; could give them strong pain killers because TOP service were painful; could be understanding, caring and supportive to women who requested TOP services.

### 4.7.4 Advice to other women about TOP services

Respondents were requested to indicate whether they would give other women advice on TOP services. Nearly half of the respondents, (47.3%; n=71) felt that it had to be a woman's decision alone whether to terminate her pregnancy or not.

More than half of the respondents (51.3%; n=77), indicated that if it was a student who wanted to finish her studies and women who are unemployed, they would advise them to use TOP services. One respondent indicated that she could give advice because they talked openly about TOP services in her community and that people had different reasons why they used TOP services.

Another respondent said "TOP is a tough decision to make and a woman had to have valid reasons for requesting it. It is not a choice, but due to reasons beyond one's control".

### 4.7.5 Advice for women concerning illegal TOP services

A question pertaining to illegal TOP services was put to the respondents.

The majority of the respondents (85.3%; n=128) indicated that illegal TOP services were unsafe, risky and dangerous. A woman, making use of illegal TOP services, could die. They would not advise women to go for illegal TOP services.

The same percentage of respondents, 85.3% (n=128) also indicated that they did not know exactly where these illegal TOP service providers worked because they provided you with their cell phone numbers and picked you up to go to specific places or next to shops. They give you tablets and after you paid, they leave. They also tell you that when you bleed excessively you should go to the hospital.

One respondent remarked that "it is risky but better than having an unplanned baby". If the hospital refuses to give a TOP to a woman she will advise a woman to use illegal TOP services. Another respondent felt that when it is a student who is prepared to pay and willing to take the risk, she would advise her to go for illegal TOP service because

the students said the nurses abused them emotionally. It was indicated by a respondent that “a lot of people/women have died because of illegal TOPs and government made TOP services safe and accessible. There is no need to advise a woman on illegal TOP services”.

### 4.7.6 Changes in TOP services facilities

A question asking the respondents what they will change in their TOP facilities was asked.

Some respondents, 58.7% (n=88) indicated that they would change the facilities to make them bigger, more private and separated from other wards like maternity, gynaecology wards and antenatal clinics, because it makes them feel guilty and uneasy. The fact that other women were caring for or delivering their babies while they opted for TOP services, was traumatic.

Of the respondents, 20.7% (n=31) indicated that they would change the waiting list at the TOP facilities, 8.0% (n=12) would change the nurses’ attitudes, 9.3% (n=14) felt nothing must be changed as they experienced the TOP services to be fine and 3.3% (n=5) would change the number of nurses as they felt there was a shortage of staff.

### 4.7.7 Respondents’ views on the effectiveness of TOP counselling services

In response to a question relating to the effectiveness of the TOP services, 76.0% (n=114) felt the TOP counselling services were ineffective. However, almost a quarter 24.0% (n=36) felt the TOP counselling services were effective and the nurse and the social workers told them about TOP services, including the options of adoption and counselling on contraceptive usage.

### 4.7.8 Respondents’ feelings about nurses’ attitudes providing TOP services

The respondents were asked how they felt about the nurses’ refusal to provide TOP services. Of the respondents, 32.7% (n=49) felt that the nurses were overworked, did not get support from other nurses as only one nurse was responsible for TOP services

and when the nurse was on study leave or sick, nobody provided the TOP services. Other respondents (5.3%; n=8), felt nurses were good people, supportive and caring.

Almost two thirds (62.0%; n=93) had negative feelings indicating that nurses had no patience, were rude and did not like to work with TOP clients. One respondent remarked that “They don’t understand teenagers and that is why we don’t talk to our parents about TOP”.

### 4.7.9 Major challenges encountered by women who had used TOP services in the NWP

*Respondents* had to indicate the major challenges women faced who had used TOP services in the NWP and stated:

Women who requested TOPs were fearful of the nurses, as indicated by 16.0% (n=24) of the respondents.

Just more than a fifth (21.3%; n=32) found the lack of privacy and confidentiality; health care providers treating people without dignity and respect and fear of bumping into people who knew them, challenging.

Socio-economic challenges such as travelling, transport problems, distance from the TOP facility, unemployment, poverty and lack of finances were mentioned by 49.3% (n=74) of the respondents. There were those respondents who indicated waiting lists or booking systems as major challenges for accessing TOP services (6.7%; n=10).

Pregnancy that was too advanced was also a major challenge mentioned by 6.7% (n=10) respondents who indicated this challenge because there were no facilities to do TOPs when the pregnancy was beyond 12 weeks’ gestation. Hence some women went to other provinces for TOP services.

### 4.7.10 Circumstances under which nurses may refuse to provide TOP services to a woman

A question was asked if there were circumstances under which nurses may refuse to provide TOP services. Most respondents (68.7%; n=103) indicated that nurses may refuse TOP services if the pregnancy is beyond 12 weeks' gestation. Other respondents (31.3%; n=47) indicated that it is a woman's right and nurses don't have the right to refuse a woman TOP services when she needs it.

### 4.7.11 Reasons why women seek TOP services in other provinces

An open-ended question asked the respondents why they would seek TOP services in other provinces. Some respondents, 8.7% (n=13) indicated that if there are no TOP services in their areas, women may seek these services in other provinces. Judgemental attitudes of the community towards TOP service in their areas will be a reason for 9.3% (n=14) of the respondents to seek TOP services in another province.

Some respondents (15.3%; n=23) said "may be the services are quicker, no waiting lists in other provinces" and better services, support and understanding of nurses providing TOP services in other provinces.

Privacy and confidentiality and the belief that their secrets would be kept safe forever because nobody knows them in the other provinces seems to be the reasons proposed by most women (67.0%; n=100).

### 4.7.12 The influence of religious beliefs on accessing TOP services

Another open-ended question asked the respondents whether the religion of a woman could prevent her from accessing TOP services. Nearly half (48.7%; n=73), indicated that the church could not prevent a woman from accessing TOP services as one respondent remarked "I know it is not right to do it but the church cannot prevent me, it is my choice".

However, some respondents (51.3%; n=77), indicated that a woman can be prevented by religion because TOP is a sin. This is portrayed by the remark of one of the respondents who said “Yes, Christians view TOP as murder”.

Another respondent believed it is a big sin, stating “although one is doing it you will always have that guilty feeling that you have sinned”.

### 4.7.13 Major obstacles encountered to access TOP services in the NWP

Respondents indicated the following major obstacles in accessing TOP services in the NWP.

The waiting list before accessing TOP services was indicated by 18% (n=27) as an obstacle. Similarly, according to the study conducted by Kane (2009:909), the factors contributing to inequality to access TOP services in their study were variations in waiting times and cost where women were not referred to public health facilities.

Some respondents, 36.7% (n=55) indicated transport, travelling long distances due to the lack of nearby TOP facilities or closure of TOP facilities as many of these facilities were closed in their areas, to be major obstacles. As one woman said “I travelled a long distance with a bus to come here. I started at the clinic and they have referred me to the hospital and I don’t think I will be able to get the bus as it is already late”.

Another identified obstacle was nurses’ attitudes towards women requesting TOP services, especially those who did not work in TOP services (25.3%; n=38). A respondent described it as the “judgemental attitudes of nurses especially when you are raped, fell pregnant and opted for TOP”.

Of the respondents, 5.3% (n=8) indicated community attitudes towards women who used TOP services, they called them “murderers”, “baby killers” and “witches”. Of the respondents, 14.7% (n=22) felt TOP services were still stigmatised hence some of the women could not use TOP services, even if they wanted to do so.

### 4.7.14 Respondents' comments about TOP services in their areas

The respondents were requested to comment on TOP services in their areas.

The respondents (53.3%; n=83) suggested that TOP services should be made more acceptable to the community so that those who want TOP services should be free to do so in their own areas.

Some respondents, 13.3% (n=20) indicated that all the health facilities should provide TOP services because unemployed women cannot access TOP services because of the finances required for travelling.

Privacy was a concern for one respondent because if a clerk just calls us and says "Those who want TOP services must go to that room", it breaks the privacy because people start saying "Oooh, they are going to kill babies". Of the respondents, 26.7% (n=40) indicated that space must be increased and more rooms should be added. Daily TOP services were suggested by 4.7% (n=7) of the respondents to accommodate people who come from far since there are no TOP services in some areas of the NWP.

## 4.8 TYPE OF SERVICE PROVIDED

In this section the respondents were requested to indicate the type of services provided before and during the TOP procedure at the TOP facilities in the NWP.

### 4.8.1 The procedure followed to terminate the pregnancy

In response to the question how their pregnancies were terminated, most respondents, 93.3% (n=140) reported that they used a pill to induce abortion, 2.0% (n=3) did not use a pill and 4.7% (n=7) respondents did not answer this question. Similarly, according to Essilfie-Appiah et al (2005:10), South African women use misoprostol, which is obtained on doctor's prescription to induce TOPs. Furthermore, all the respondents (100.0%; n=150) agreed that the vacuum extraction was used to ensure that products of conception had been removed, preventing infections after the procedure.

### 4.8.2 Weeks of gestation when TOPs were performed

Of the respondents, 63.0% (n=92) indicated that they were 2-8 weeks, 34.2% (n=50) indicated they were 9-12 weeks and 2.7% (n=4) were 13-16 weeks pregnant when their pregnancies had been terminated. Four respondents did not answer the question. The results correlate with provisions of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, which indicate that in South Africa, TOP services are available, on request during the first 12 weeks of gestation without giving any reason for requesting TOP services.

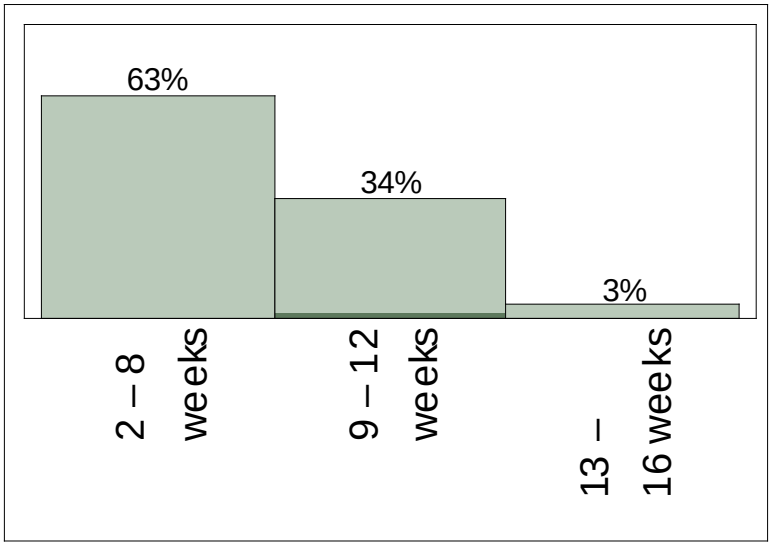



**Figure 4.8**
**Gestation period when TOP were done (n=146)**

### 4.8.3 Pain experienced during TOP procedure

Of the respondents, 64.6% (n=95) indicated that they experienced almost unbearable pain, 28.6% (n=42) experienced moderate pain, 6.1% (n=9) experienced only a little bit of pain and 0.7% (n=1) reported that there was no pain during the TOP procedure.

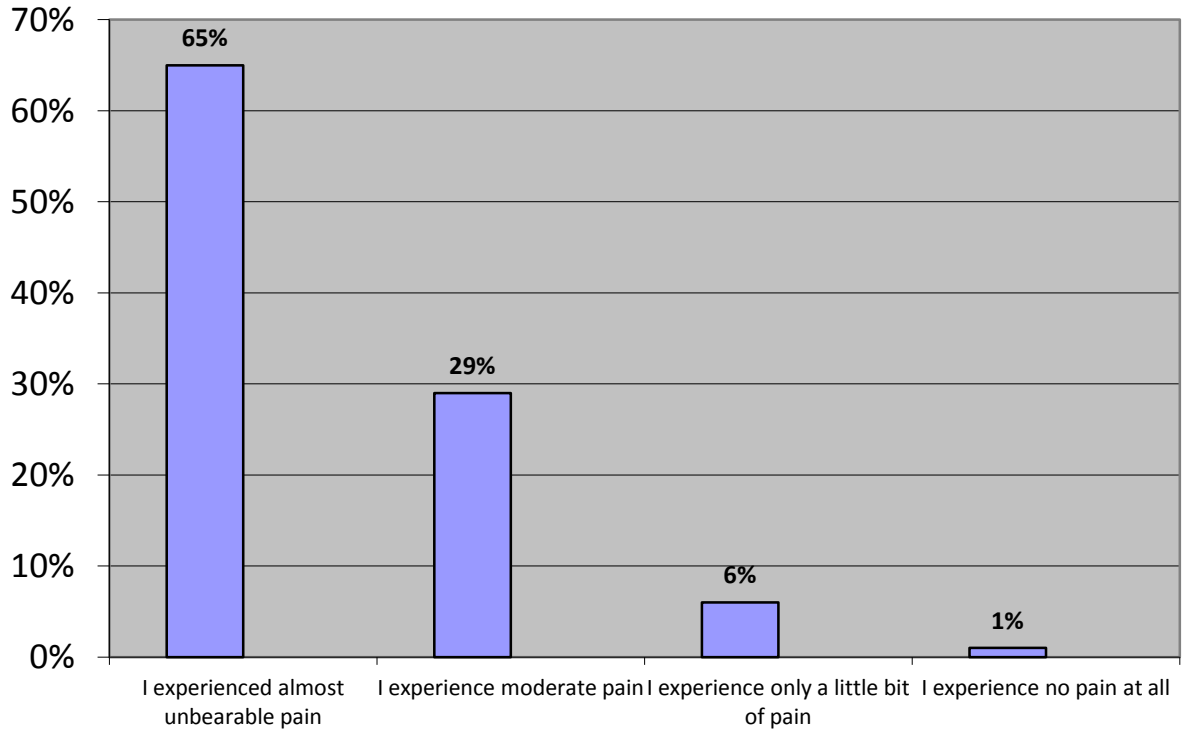



**Figure 4.9**

**Level of pain experienced by respondents during TOP procedure (n=147)**

A high percentage of the respondents (95.4%; n=125) did not experience any infection and only 4.6% (n=6) reported infections and 19 respondents did not respond to this question. However, the majority of the respondents (83.0%; n=117) reported bleeding after the TOP procedures and 17.0% (n=24) did not experience any bleeding.

Sixty six percent (n=94) of the respondents indicated that they experienced discomfort after the procedure, and 27.3% (n=39) did not experience any discomfort after the procedure.

## 4.9 SUMMARY

Of the respondents in this study, 71.3% (n=92) were younger than thirty, 71.3% (n=107) were unmarried and 94.0% (n=141) were Christians. Unemployment ranged high under the respondents (77.3%; n=116) leaving them without any income. Therefore, these findings correlate with the findings reported in sections 4.2.4 and 4.2.5 figure 4.3 which indicates the earnings of the respondents.

Of the respondents, 90.0% (n=135) indicated that they had never terminated a pregnancy previously.

The TOP services seem not to be easily accessible, as 96.0% (n=144) indicated that they had to use transport to access TOP services. More than a quarter of the respondents had to travel more than 50km to access these services as indicated in figure 4.4.

Apparently all (100%; n=150) respondents were knowledgeable about the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, and their legal rights with the main source of their information being the clinics, as indicated by 77.8% (n=105) respondents and friends (67.9%; n=89).

The respondents, 63.1% (n=94) and 66.7% (n=100) regarded the nurses to be uncaring and unfriendly (see table 4.2). Although the majority of the respondents (98.0%; n=147) requested TOP services early, there were those who requested these services late in their gestation period (see figure 4.6).

The study also revealed that before the nurses put a pregnant woman on the waiting list, a sonar was performed to confirm a pregnancy as indicated by 88.5% (n=131). A few of the respondents (10.8%; n=16) indicated blood and 59.5% (n=88) urine tests. A number of respondents, 65.2% (n=88) disagreed with the statement that the counselling services were excellent (see figure 4.7). Of the respondents, 53.3% (n=80) reported that nurses provided counselling for TOP services.

Almost half of the respondents, 47.3% (n=71) indicated that religion could prevent a pregnant woman from accessing TOP services. Those women who agreed that TOP is sinful, were more than half (57.0%; n=80) and a high percentage of the respondents, 69.3% (n=104) indicated that they felt relieved after the procedure was over.

Of the respondents, 67.0% (n=100) reported that privacy and confidentiality were their greatest concerns at the facilities providing TOP services in the NWP. Furthermore some respondents (25.3%; n=38) also mentioned the judgemental attitudes of the nurses and the community (5.3%; n=8) as the main reasons for seeking TOPs in other provinces.

A number of respondents (93.3%; n=140) indicated that the nurses used a pill to induce TOP and all the respondents (100%; n=150) agreed that vacuum extraction was used to ensure that products of conception had been properly removed. Of the respondents, 63.0% (n=92) were between 2-8 and 34.2% (n=50) were 9-12 weeks pregnant when they requested TOP services (see figure 4.8). This correlates with figure 4.6, indicating that most women requested for TOPs between 2-12 weeks gestation. Some respondents (64.6%; n=95) also indicated that they had experienced unbearable pain during the procedure.

Chapter 5 of the study will discuss data obtained from women who wished to have TOPs but could not manage to access these services in phase 2 of this study.

# CHAPTER 5

# Analysis and discussion of research findings: Phase 2 Women who wished to use TOP services but did not manage to access these services

## 5.1 INTRODUCTION

This chapter discusses the research results received from data collected in phase 2. Data were collected from a sample of 50 women who wished to use TOP services but who did not manage to access TOP services in the NWP. This was a difficult sample to access, especially accessing those women who had been admitted to gynaecological wards after TOPs.

Since TOP is a sensitive matter most women who had been admitted with incomplete TOPs did not want to participate in the study, even though the doctors and nurses confirmed that they had been admitted with incomplete TOPs. Most of them feared that the illegal TOP providers might get into trouble if they disclosed any information about their TOPs.

The researcher, assisted by two research assistants, visited all the public health facilities, gynaecological wards where these women were treated for incomplete TOPs in the NWP from August to November 2009.

The purpose of data collection was to identify the barriers women encountered to access TOPs in the NWP, and to identify and describe the opinions and feelings of these women about TOP services in the NWP.

Answers to the questions were summarised in graphs, frequencies and percentages. The research findings will also be related to the theoretical framework (HBM) of the study. The objectives of this study, focusing on the challenges encountered by women who wanted to use TOP services, and requested TOP services, but could not access these services, in phase II were to:

- establish the contributory factors for inaccessibility of TOP services to women who requested
- identify the opinions and feelings of these women about TOPs
- describe the perceived barriers they encountered to access TOP services in the NWP

It should be noted that the respondents were requested to indicate their experiences with nurses, providing TOP services in the public health facilities in the NWP. None of these respondents actually used the TOP services in the public facilities of the NWP. Consequently the answers portrayed their perceptions in sections 5.3.4-5.4, 5.11.1 - 5.11.2 and 5.15 are probably based on “hearsay” from other patients and not based on their authentic experiences.

## 5.2 DEMOGRAPHIC DATA

- **Modifying factors in phase 2**

According to the HBM, the modifying factors could influence pregnant women’s utilisation of TOP services. The modifying factors discussed in this section involve age, marital status, religion and employment status.

### 5.2.1 Age

Of the respondents, 38.0% (n=19) fell into the 21-25 year age group followed by 20 and younger representing 28.0% (n=14) while 26-30 years was 14.0% (n=7), 31-35 years 12.0% (n=6), 36-40 years 6.0% (n=3) and only 2.0% (n=1) were 41 years and older. All 50 respondents answered this question. These findings concur with the findings of phase I where the majority of the respondents fell within the age group of 21-25 years. Similarly the study conducted by Jones, Finer and Singh (2008:1) in the USA, revealed that 58.0% of women who obtained TOPs, were in their twenties.

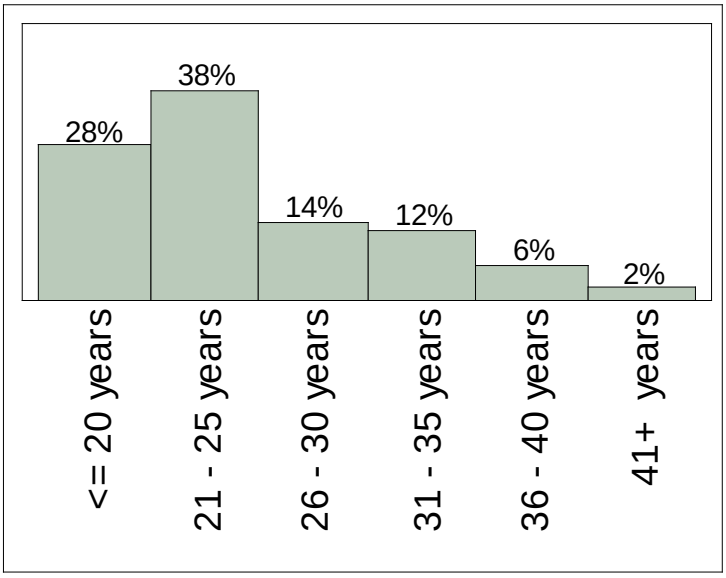



**Figure 5.1**

**Age of respondents (n=50)**

### 5.2.2 Marital status

Of the respondents 82.0% (n=41) indicated that they had never been married, 6.0% (n=3), were married, 8.0% (n=4) were divorced and 4.0% (n=2) were widowed. All 50 respondents answered this question. Similarly, a study conducted in South Africa by Morroni et al (2006:3) revealed that 53.1% of women in their study indicated that they were single and 35.4% where married. Therefore, these findings correlate with other studies where most women, who requested TOP services, were single.

### 5.2.3 Religion

The respondents were also requested to indicate their religious affiliations. Ninety percent (n=45) indicated that they were Christians, while 4.0% (n=2) indicated that they were Muslims. One respondent (2.0%) indicated that she did not belong to any religion and 4.0 % (n=2) indicated ‘other’ without specifying what they implied.

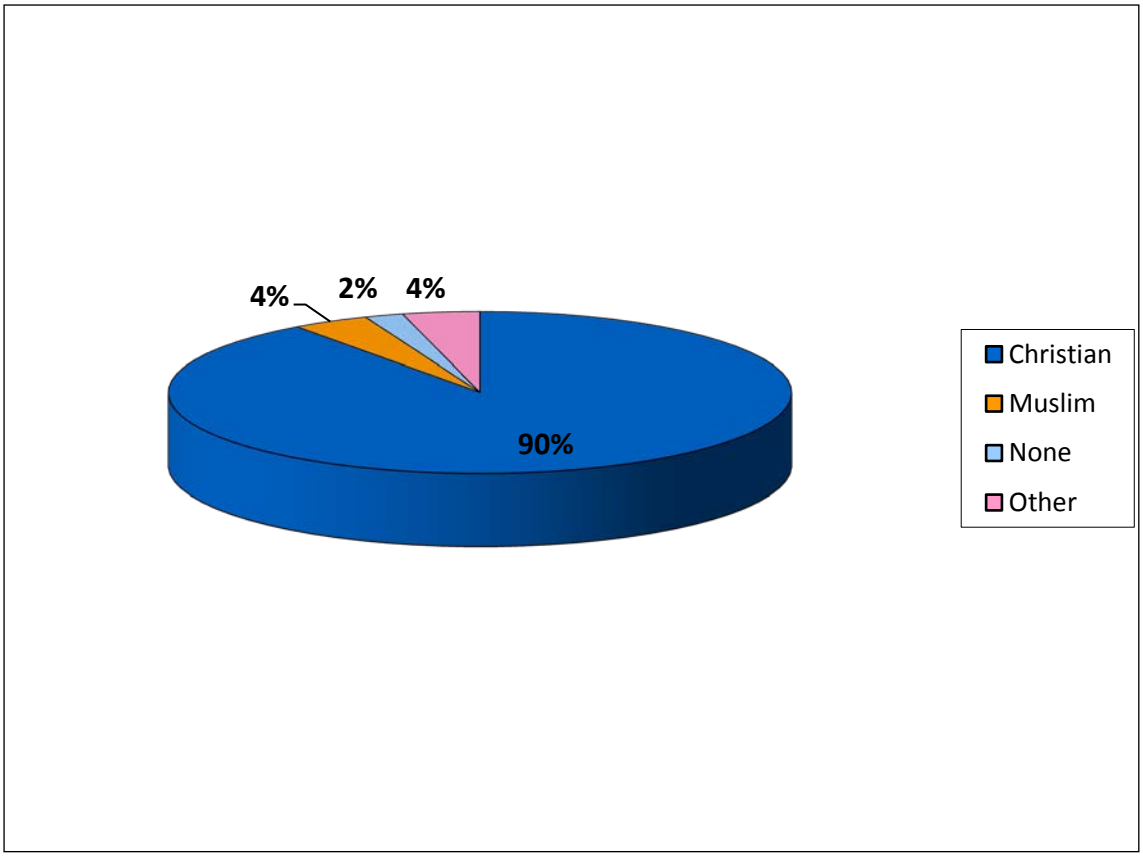



**Figure 5.2**
**Respondents' religious affiliations (n=50)**

The research results correlate with the findings of phase 1 where most women (94.0%; n=141) who requested TOP services in the public health facilities in the NWP, were also Christians.

### 5.2.4 Population groups

Of the women who requested TOP services, but could not access these services, blacks were in majority (88.0%; n=44), followed by whites with 8.0% (n=4) and only 4.0% (n=2) were coloureds. Figure 5.3 indicates the population groups of women who requested TOP services but could not access such services.

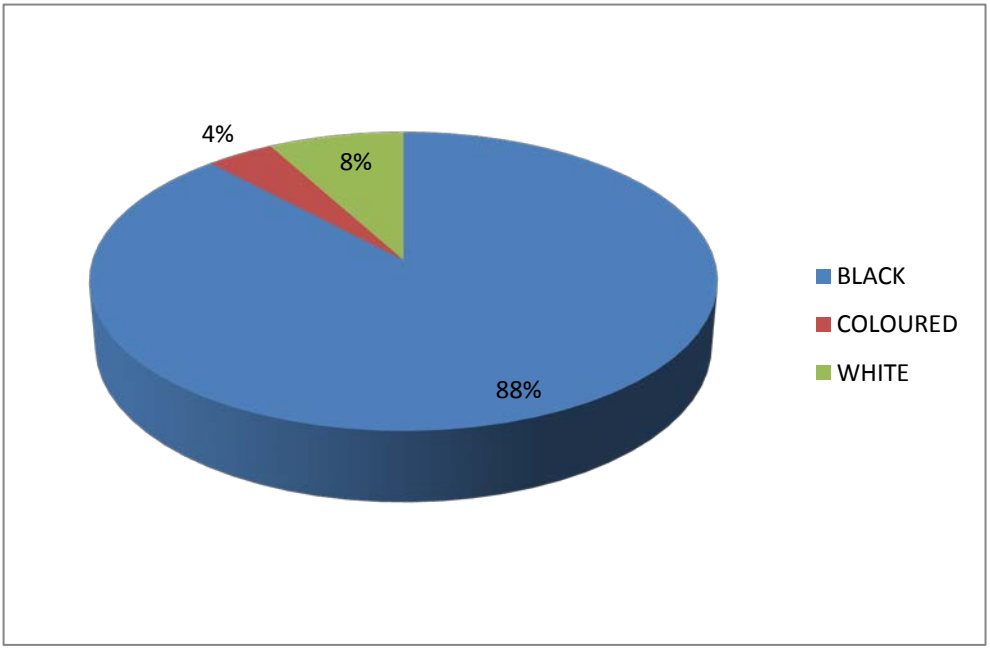



**Figure 5.3**

**Respondents' population groups (n=50)**

### 5.2.5 Number of children

An equal number of respondents 36.0% (n=18), reported that they either had no children or one child. Those who had 2 children were 12.0% (n=6), 3 children, 14.0% (n=7) and 4 children 2.0% (n=1). The reason why 72.0% (n=36) reportedly had no or only one child, might be due to the fact that many respondents (66.0%; n=33) were 25 years or younger.

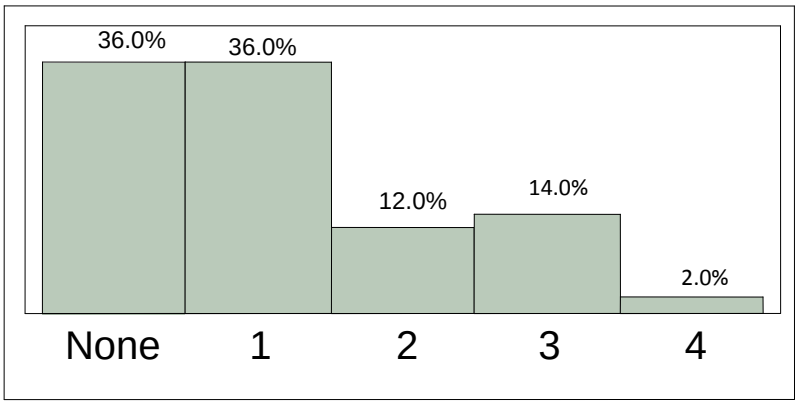



**Figure 5.4**

**Respondents' number of children (n=50)**

### 5.2.6 Number of times termination of pregnancy was requested

Almost all respondents (92.0%; n=46) reported that they requested TOP services once and only 8.0% (n=4) had done so twice. All 50 respondents answered this question. Women who participated in this study did not use TOPs for contraceptive purposes. Similarly, a study done by Jones, Singh, Finer and Frohwirth (2006:18) in the USA, indicated that just more than a half of the women in their study requested TOPs once, while nearly 10% requested it more than four times.

### 5.2.7 Employment

The majority of the respondents (80.0%; n=40), indicated that they were unemployed and only 20.0% (n=10) were employed. A study conducted by Lebese (2009:14) indicated that a relationship exists between maternal mortality and morbidity and poverty and inequality. Women and children usually experience more vulnerability of being poor globally and regionally.

The GHS in 2005 (The NWP 2007:16) indicated that the unemployment rate of females in the NWP was 40.0% and the results of the study revealed that 80.0% of women who participated in this study were unemployed. Consequently the findings of this study correlated with the GHS done in 2005, indicating that many women in the NWP were unemployed.

## 5.3 ACCESSIBILITY OF TOP SERVICES

- **Likelihood of action in phase 2**

There is a likelihood that women can still not access TOP services in the facilities designated to provide TOP services as stipulated in the provisions of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, according to the HBM. Accessibility of TOP services might remain a challenge despite the fact that women should be able to access TOP services legally free of charge.

### 5.3.1 Use of transport to access TOP

Almost all respondents (96.0%; n=48) reported that they had to use transport to access TOP services and only 4.0% (n=2) indicated that they did not need transport. In terms of the HBM, transport could be seen as a barrier to access TOP services. These findings also confirmed the results of other studies done in South Africa, where women reported that they had to travel more than 100 kilometers to access TOP services (Mackey 2002:8).

### 5.3.2 Distances to be travelled to access TOP services

The respondents indicated that they had to travel long distances before they could access TOP services. Forty percent (n=20) indicated that they had to travel 25–50 kilometers, followed by those (30.0%; n=15) who travelled 6-24 kilometers, 18.0% (n=9) travelled 51-100 kilometers. A small percentage 6.0% (n=3) had to travel more than 100 kilometers or 2-5 kilometers. Figure 5.4 indicates the kilometers travelled by women, to access TOP services in the NWP.

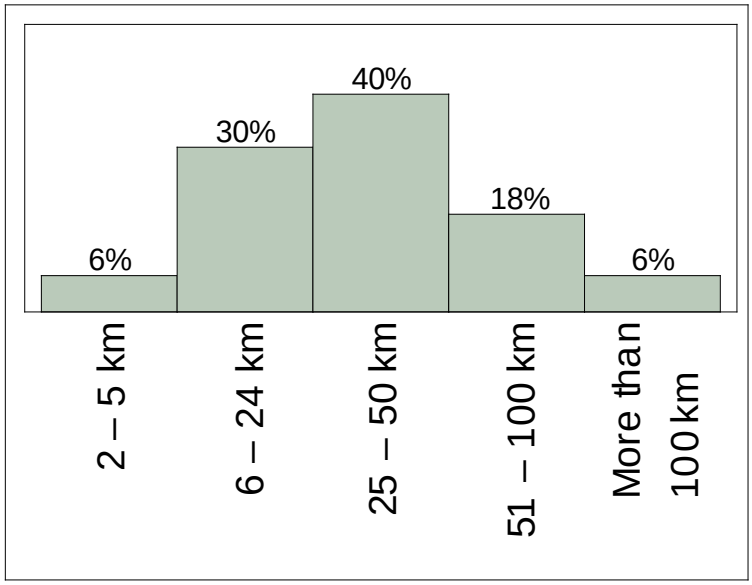



**Figure 5.5**
**Distances travelled by respondents to access TOP services in the NWP (n=50)**

### 5.3.3 Fees for TOP services

All the respondents (100%; n=50) indicated that they did not have to pay for TOP services at public health facilities in the NWP. According to the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, women in South Africa can access TOP services at the designated public health facilities free of charge during the first 12 weeks of gestation.

Although the women who requested TOP services did not have to pay for these services, 96.0% (n=48) had to pay for transport to access TOP services.

### 5.3.4 Experience of respondents with nurses in TOP services

The respondents were requested to indicate their experiences with nurses, providing TOP services in the public health facilities in the NWP.

**Table 5.1 Opinions of the respondents towards nurses providing TOP services**

| Item | Statements | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 11.1 | Nurses should be punished for refusing to provide TOP services | 64.0 | 32 | 2.0 | 1 | 34.0 | 17 | 100 | 50 | 0 |
| 11.2 | Nurses should be fired for refusing to render TOP services | 62.5 | 30 | 12.5 | 6 | 27.1 | 13 | 100 | 48 | 2 |
| 11.3 | Nurses should be allowed to choose whether to provide TOP services or not | 32.0 | 16 | 10.0 | 5 | 58.0 | 29 | 100 | 50 | 0 |
| 11.4 | Nurses should be forced to provide TOP services | 64.0 | 32 | 8.0 | 4 | 28.0 | 14 | 100 | 50 | 0 |

Of the respondents, 64.0% (n=32) disagreed with the statement that nurses should be punished for refusing to provide TOP services. Only 34.0% (n=17) agreed and 2.0% (n=1) were neutral. However, relating to the CTOP Act (no 92 of 1996), section 10(1)c, as amended by Act no 1 of 2008, it is stated that any person who 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.

Reportedly 62.5% (n=30) of the respondents disagreed with the statement that nurses should be fired for refusing to render TOP services, 27.1% (n=13) agreed, 12.5% (n=6) were neutral. Two respondents did not answer this question.

A number of respondents (58.0%; n=29), agreed with the statement that nurses should be allowed to choose whether to provide TOP services or not, and 32.0% (n=16) disagreed with the statement, 10.0% (n=5) were neutral. Reportedly, 64.0% (n=32) of the respondents disagreed with the statement that nurses should be forced to provide TOP services. Only 28.0% (n=14) agreed and 8.0% (n=4) were neutral. All 50 respondents answered this question.

### 5.3.5 Respondents' perceptions about nurses providing TOP services

More than half of the respondents, 52.0% (n=26) agreed with the statement that nurses refused to render TOP services, 38.0% (n=19) disagreed and 10.0% (n=5) were neutral about this question.

**Table 5.2 Respondents' perceptions about nurses providing TOP services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 11.1 | Nurses refuse to render TOP services | 38.0 | 19 | 10.0 | 5 | 52.0 | 26 | 100 | 50 | 0 |
| 11.2 | Nurses who provide TOP services are generally caring people | 36.0 | 18 | 26.0 | 13 | 38.0 | 19 | 100 | 50 | 0 |
| 11.3 | Nurses who render TOP services are generally unfriendly | 50.0 | 25 | 26.0 | 13 | 24.0 | 12 | 100 | 50 | 0 |
| 11.4 | Nurses monitor all TOP patients hourly | 27.7 | 13 | 51.1 | 24 | 21.3 | 10 | 100 | 47 | 3 |
| 11.5 | Nurses generally leave TOP patients to care for themselves | 37.5 | 18 | 50.0 | 24 | 12.5 | 6 | 100 | 48 | 2 |
| 11.6 | Nurses put you on a waiting list if you request a TOP | 4.0 | 2 | 2.0 | 1 | 94.0 | 47 | 100 | 50 | 0 |
| 11.7 | Nurses do not want to be involved with TOP services | 30.6 | 15 | 12.2 | 6 | 57.1 | 28 | 100 | 49 | 1 |
| 11.8 | Nurses generally leave patients to clean up their "own mess" after TOPs | 49.0 | 24 | 44.9 | 22 | 6.1 | 3 | 100 | 49 | 1 |

Of the respondents, 36.0% (n=18) disagreed with the statement that nurses who provided TOP service were generally caring people, 26.0% (n=13) were neutral and 38.0% (n=19) agreed with the statement.

Half of the respondents (50.0%; n=25) disagreed with the statement that nurses who rendered TOP services were generally unfriendly, 26.0% (n=13) were neutral and 24.0% (n=12) agreed. Reportedly, 27.7% (n=13) of the respondents disagreed with the statement that nurses monitored all patients undergoing TOP hourly, 51.1% (n=24) were neutral and 21.3% (n=10) agreed with the statement.

Some respondents (37.5%; n=18) disagreed with the statement that nurses generally leave patients to care for themselves, 12.5% (n=6) agreed with the statement and 50.0% (n=24) were neutral. Two respondents did not answer this question.

Most respondents (94.0%; n=47) agreed with the statement that nurses put them on a waiting list when requesting TOP services, whereas 4.0% (n=2) disagreed and only 2.0% (n=1) were neutral. Similarly, the study conducted by Coleman, Coyle and Rue (2010:2) revealed that the most frequently endorsed reason for late TOPs was difficulty in making arrangements for TOPs according to 48.0% of women in that study.

Some respondents (57.1%; n=28) agreed with the statement that nurses did not want to be involved in TOP services, 30.6% (n=15) disagreed with the statement and 12.2% (n=6) were neutral. One respondent did not answer this question.

Reportedly, 49.0% (n=24) of the respondents disagreed with the statement that nurses left patients to clean up their “own mess” after the TOP, 6.1% (n=3) agreed and 44.9% (n=22) were neutral. One respondent did not answer this question.

The data portrayed in table 5.2 indicate that the respondents considered nurses to be unwilling to provide TOP services, were not generally caring persons, were unfriendly, did not monitor TOP patients hourly, left TOP patients to care for themselves, put patients’ names on waiting lists, did not want to be involved with TOP services and left patients to clean up their “own mess” after TOPs.

### 5.3.6 Respondents' satisfaction with TOP services

The respondents were requested to indicate their level of satisfaction with the TOP services. Responses revealed that out of 48 respondents, there was an equal number of respondents 40.0% (n=19) who were satisfied and who were dissatisfied. Several respondents (15.1%; n=7) were very dissatisfied and 6.2% (n=3) were very satisfied. Two respondents did not respond to this question. Please refer to figure 5.6

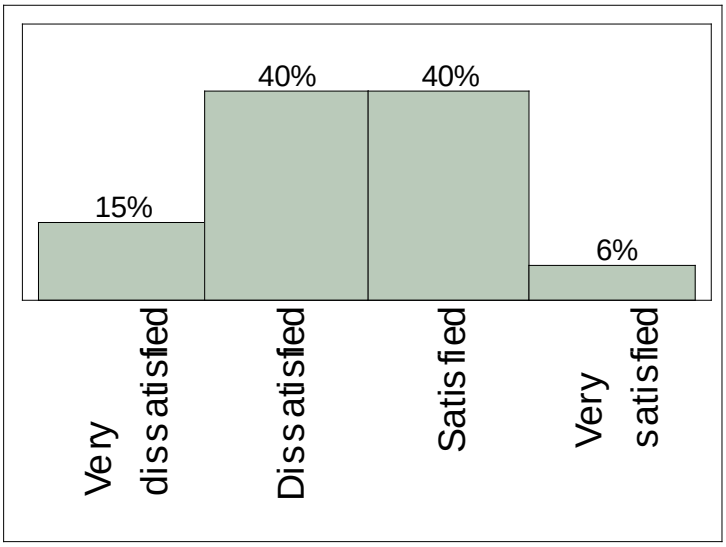



**Figure 5.6**

**Respondents' level of satisfaction with TOP services (n=48)**

### 5.3.7 The quality of TOP services and the role of policy makers

In reference to the question as to whether the poor quality of TOP services should be addressed by policy makers, the majority of the respondents (80.0%; n=40) agreed and only 13.0% (n=6) disagreed. Four respondents did not answer this question.

### 5.3.8 The quality of pregnancy-related services provided by traditional healers

Some respondents (66.7%; n=32), disagreed with the statement that traditional healers provided the best TOP services, 33.3% (n=16) agreed and two respondents failed to answer this question. In South Africa the CTOP Act (no 92 of 1996: section 2(1)(a)), as amended by Act no 1 of 2008, prohibits any person who is not a medical practitioner or a registered midwife (who has completed the prescribed training course) to perform

TOPs. A study conducted among traditional healers in the NWP indicated that almost all the traditional healers, with the exception of one, were against TOP services because of moral and religious beliefs. However, these traditional healers were of the opinion that TOPs should be done in cases of rape and incest (Rakhudu et al 2006:58).

## 5.4 TESTS PERFORMED TO CONFIRM PREGNANCY BEFORE PLACING WOMEN'S NAMES ON TOP WAITING LISTS

- **Individual perceptions in phase 2**

The respondents were requested to indicate the types of tests the nurses performed to confirm their pregnancies, before placing women's names on waiting lists for TOPs.

**Table 5.3 Tests performed to confirm pregnancy**

| Test performed | Yes | | No | | Total | | No response |
|---|---|---|---|---|---|---|---|
| | % | n | % | n | % | n | n |
| Urine sample | 32.0 | 16 | 34.0 | 17 | 100 | 33 | 17 |
| Blood sample | 6.0 | 3 | 56.0 | 28 | 100 | 31 | 19 |
| Sonar | 88.0 | 44 | 8.0 | 4 | 100 | 48 | 2 |
| Abdominal palpation | 26.0 | 13 | 38.0 | 19 | 100 | 32 | 18 |

The majority of the respondents (88.0%; n=44) indicated that the nurses performed a sonar before placing a woman on a waiting list. According to the NWP policy the woman requesting TOP services must have a urine test done, abdominal palpation to determine uterine size and these woman would be sent for ultrasound examinations. The policy accommodates all these but indicates that ultrasound is available, but not essential although it can be useful if available on site. According the data portrayed in table 5.3, the nurses failed to do urine tests and abdominal palpations for some women before placing their names on TOP waiting lists.

## 5.5 THE MOST COMMON REASONS FOR WOMEN'S REQUESTS FOR TOPs

The research results revealed that women in the NWP indicated various reasons for requesting TOPs.

### Table 5.4 Most common reasons for requesting TOPs

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 15.1 | Poverty | 4.2 | 2 | 0.0 | 0 | 95.8 | 46 | 100 | 48 | 2 |
| 15.2 | Pregnant woman is a teenager | 6.3 | 3 | 8.3 | 4 | 85.4 | 41 | 100 | 48 | 2 |
| 15.3 | Pregnant woman has a health problem | 4.2 | 2 | 8.3 | 4 | 87.5 | 42 | 100 | 48 | 2 |
| 15.4 | The foetus has a health problem | 0.0 | 0 | 10.4 | 5 | 89.6 | 43 | 100 | 48 | 2 |
| 15.5 | The pregnant woman is a survivor of rape | 0.0 | 0 | 8.3 | 4 | 91.7 | 44 | 100 | 48 | 2 |
| 15.6 | The pregnant woman is a survivor of incest | 0.0 | 0 | 0.0 | 0 | 100 | 45 | 100 | 45 | 5 |
| 15.7 | The pregnant woman uses TOP service for family planning | 82.6 | 38 | 8.7 | 4 | 8.7 | 4 | 100 | 46 | 4 |

The majority of the respondents (95.8%; n=46) agreed with the statement that poverty was one of the reasons why women requested TOP services and only 4.2% (n=2) disagreed and two respondents did not answer this question. Similarly, according to the CTOP Act (no 92 1996), as amended by Act no 1 of 2008, a pregnancy may be terminated if the continued pregnancy could significantly affect the social or economic circumstances of the woman.

Of the respondents, 85.4% (n=41) agreed that the reason for terminating a pregnancy is commonly because it is a teenage pregnancy but 6.3% (n=3) disagreed while 8.3% (n=4) were neutral. The study revealed that 87.5% (n=42) of the respondents agreed that the most common reason for a women to request TOPs was when she had a health problem, 4.2% (n=2) disagreed and 8.3% (n=4) were neutral.

Most respondents 89.6% (n=43) agreed with the statement that the most common reason for a woman to request a TOP was when the foetus had a health problem and 10.4% (n=5) were neutral. None of the respondents disagreed with the statement. The

CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, allows a woman to have a TOP done after 20 weeks' gestation period if a medical practitioner, after consultation with another medical practitioner, or a registered midwife, is of the opinion that the continued pregnancy would result in severe malformation of the foetus.

Of the respondents, 91.7% (n=44) agreed with the statement that when a pregnant woman was a survivor of rape, TOP services should be available, and 8.3% (n=4) were neutral. These findings correlate with the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, which allows TOP services when the pregnancy resulted from rape or incest.

All respondents (100%; n=45) agreed with the statement that if a woman was a survivor of incest, it was a reason for a woman to request a TOP. No respondent disagreed with the statement or were neutral. Five respondents did not answer this question.

The majority of the respondents (82.6%; n=38) disagreed with the statement that TOP services were used for family planning, only 8.7% (n=4) agreed, 8.7% (n=4) were neutral. Four respondents did not answer this question. Similarly, the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, also affirms that TOP services are not a form of contraception or population control.

## 5.6 ILLEGAL TERMINATION OF PREGNANCY SERVICES AND THE USE OF CONTRACEPTIVES

The analysis of the findings of this section of the study revealed the respondents' experiences with illegal TOP services and their use of contraceptives.

**Table 5.5 Experiences of respondents concerning legal and illegal TOP services and condom use**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 16.1 | TOP services are accessible to the public | 53.1 | 26 | 0.0 | 0 | 46.9 | 23 | 100 | 49 | 1 |
| 16.2 | TOP services are acceptable | 67.3 | 33 | 8.2 | 4 | 24.5 | 12 | 100 | 49 | 1 |
| 16.3 | TOP services are linked to reproductive health services | 12.5 | 6 | 16.7 | 8 | 70.8 | 34 | 100 | 48 | 2 |
| 16.4 | TOP services are stigmatised | 18.4 | 9 | 2.0 | 1 | 79.6 | 39 | 100 | 49 | 1 |
| 16.5 | TOP services are used as a contraceptive method | 75.5 | 37 | 10.2 | 5 | 14.3 | 7 | 100 | 49 | 1 |
| 16.6 | Women prefer illegal TOPs to having unwanted babies | 26.5 | 13 | 12.2 | 6 | 61.2 | 30 | 100 | 49 | 1 |
| 16.7 | It is better for women to seek an illegal TOP than to have an unwanted baby | 34.7 | 17 | 14.3 | 7 | 51.0 | 25 | 100 | 49 | 1 |
| 16.8 | A person providing illegal TOP services should not be punished | 26.5 | 13 | 18.4 | 9 | 55.1 | 27 | 100 | 49 | 1 |
| 16.9 | Illegal TOPs are acceptable to the public | 57.1 | 28 | 32.7 | 16 | 10.2 | 5 | 100 | 49 | 1 |

Of the respondents, 53.1% (n=26) disagreed with the statement that TOP services are accessible to the public, 46.9% (n=23) agreed with the statement. No respondents were neutral and one respondent did not answer this question. None of these women could access legal TOP services in the NWP, consequently it could not be explained why 46.9% (n=23) said these services were accessible to the public.

A number of the respondents (67.3%; n=33) disagreed with the statement that TOP services are acceptable to the public, 8.2% (n=4) were neutral and 24.5% (n=12) agreed with the statement. One respondent did not answer this question. This finding indicates that 67.3% (n=33) women regarded TOPs as being publicly unacceptable.

The research findings revealed that 70.8% (n=34) of the respondents agreed with the statement that TOP is linked to reproductive health services, 12.5% (n=6) disagreed and 16.7% (n=8) were neutral. Two respondents did not answer this question.

Of the respondents, 75.5% (n=37) disagreed with the statement that TOPs were used as a method of contraception and 14.3% (n=7) agreed and 10.2% (n=5) were neutral. One respondent did not answer this question.

Of the respondents, 18.4% (n=9) disagreed with the statement that TOPs were stigmatised. The majority of the respondents 79.6% (n=39) agreed and only one (2.0%) respondent was neutral. One respondent did not answer this question. These findings concur with the HBM, which indicates that stigma can be seen as a barrier to accessing TOP services (Mackey 2002:8).

Reportedly, 61.2% (n=30) of the respondents agreed that women prefer illegal TOP services to having unwanted babies, 26.5% (n=13) disagreed and 12.2% (n=6) were neutral. One respondent did not answer this question. Some respondents, 51.0% (n=25) agreed with the statement that it would be better for a woman to seek illegal TOP services rather than to have an unwanted baby, 34.7% (n=17) disagreed and 14.3% (n=7) were neutral. One respondent did not answer this question. Illegal TOP services are dangerous and unsafe. In South Africa, illegal TOP services are still rife and women can access illegal TOP services up to eight months' gestation for just R400.00. No physical address was provided in this advertisement and it only stated "one day abortions, safe and pain free" (The Sunday Sun 2007:7; Mackey 2002:8).

Despite the risk of complications and death, reportedly, 55.1% (n=27) of the respondents agreed with the statement that a person providing illegal TOP services should not be punished, 26.5% (n=13) disagreed with the statement and 18.4% (n=9) were neutral. One did not answer this question.

## 5.7 BARRIERS ENCOUNTERED BY WOMEN TO ACCESSING LEGAL TOP SERVICES

The women who requested TOPs faced different challenges which prevented them from accessing these services in the NWP. Table 5.6 indicates the barriers women reportedly encountered in their efforts to access legal TOP services

**Table 5.6 Perceived barriers experienced by women when accessing legal TOP services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 17.1 | Fear of clinic nurses | 10.0 | 5 | 2.0 | 1 | 88.0 | 44 | 100 | 50 | 0 |
| 17.2 | Gossiping by nurses | 18.0 | 9 | 6.0 | 3 | 76.0 | 38 | 100 | 50 | 0 |
| 17.3 | Lack of privacy | 6.0 | 3 | 6.0 | 3 | 88.0 | 44 | 100 | 50 | 0 |
| 17.4 | Clinics fully booked | 4.0 | 2 | 0.0 | 0 | 96.0 | 48 | 100 | 50 | 0 |

Of the respondents, 88.0% (n=44) agreed with the statement that fear of clinic nurses would prevent them from accessing legal TOP services, 2.0% (n=1) were neutral and 10.0% (n=5) disagreed. The majority of the respondents (76.0%; n=38), agreed that gossiping by nurses could be a barrier to women requesting TOP services, while 18.0% (n=9) disagreed and 6.0% (n=3) were neutral. Thus perceived attitudes of nurses posed challenges to women seeking legal TOPs in the NWP.

The study findings revealed that 88.0% (n=44) of the respondents agreed with the statement that lack of privacy could be a barrier for women requesting TOP services, 6.0% (n=3) disagreed and 6.0% (n=3) were neutral. The majority of the respondents, 96.0% (n=48) agreed with the statement that if the clinic is fully booked, it posed a barrier to women requesting TOP services and only 4.0% (n=2) disagreed with the statement. No respondents were neutral.

## 5.8 THE GREATEST BARRIERS FOR WOMEN TO ACCESS TOP SERVICE

The analysis of the research findings revealed barriers for women in the NWP to access TOP services. Relating to the HBM, perceptions about nurses might limit women's access to TOP services in the NWP.

**Table 5.7 The greatest barriers for women to access TOP services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 18.1 | Ignorance | 53.1 | 26 | 6.1 | 3 | 40.8 | 20 | 100 | 49 | 1 |
| 18.2 | Lack of knowledge about the CTOP Act | 38.8 | 19 | 12.2 | 6 | 49.0 | 24 | 100 | 49 | 1 |
| 18.3 | Pregnancy too advanced | 10.2 | 5 | 6.1 | 3 | 83.7 | 41 | 100 | 49 | 1 |
| 18.4 | Delays before appointment for TOPs | 12.2 | 6 | 2.0 | 1 | 85.7 | 42 | 100 | 49 | 1 |
| 18.5 | Lack of TOP service provision | 6.1 | 3 | 4.1 | 2 | 89.8 | 44 | 100 | 49 | 1 |
| 18.6 | Poor quality of service | 24.5 | 12 | 12.2 | 6 | 63.3 | 31 | 100 | 49 | 1 |
| 18.7 | Negative attitudes of nurses | 18.4 | 9 | 6.1 | 3 | 75.5 | 37 | 100 | 49 | 1 |
| 18.8 | Judgemental attitudes of nurses | 14.3 | 7 | 4.1 | 2 | 81.6 | 40 | 100 | 49 | 1 |

A number of the respondents (53.1%; n=26) disagreed with the statement that the greatest barrier for accessing TOP services was ignorance, while 6.1% (n=3) were neutral and 40.8% (n=20) agreed with the statement. Of the respondents, 49.0% (n=24) agreed with the statement that lack of knowledge about the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, was the greatest barrier to accessing TOP services, 38.8% (n=19), disagreed and 12.2% (n=6) were neutral. Similar responses to these two questions indicated that about half of the respondents considered ignorance and lack of knowledge as barriers for accessing TOP services.

The majority of the respondents (83.7%;n=41) agreed that if a pregnancy was too advanced it could be the greatest barrier for women to access TOP services, 10.2% (n=5) disagreed and 6.1% (n=3) were neutral. According to the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, TOPs should be done before 12 weeks' gestation. Women should thus know that they need to undergo TOPs as soon as possible.

Of the respondents 85.7% (n=42) agreed with the statement that delays preceding appointments with TOP services could also be the greatest barrier for women to access TOP services, 12.2% (n=6) disagreed and 2.0% (n=1) was neutral. Of the respondents, 89.8% (n=44) agreed with the statement that lack of service provision could be the greatest barrier to access TOP services, 6.1% (n=3) disagreed and 4.1% (n=2) were

neutral. Most of the respondents 63.3% (n=31) agreed with the statement that poor quality service could be the greatest barrier for women to access TOP services, 24.5% (n=12) disagreed and 12.2% (n=6) were neutral. Thus the perceived quality of TOP services in the NWP did not encourage the respondents to seek TOP services.

The majority of the respondents (75.5%;n=37) agreed that the negative attitudes of the nurses could be the greatest barrier for women to access TOP services, 18.4% (n=9) disagreed and 6.1% (n=3) were neutral. Of the respondents, 81.6% (n=40) agreed that the judgemental attitudes of the nurses could be the greatest barrier for women to access TOP services, 14.3% (n=7) disagreed and 4.1% (n=2) were neutral. One did not answer this question. These findings concur with those reported in section 5.6, indicating the nurses' attitudes deterred women from seeking TOP services in the NWP.

## 5.9 OPINIONS ABOUT THE GENERAL PRACTITIONERS (GPS) PROVIDING TOP SERVICES IN THE NORTH WEST PROVINCE

The respondents were requested to indicate their opinions about the general practitioners (medical doctors) providing TOP services.

**Table 5.8 Opinions of the respondents about the general practitioners providing TOP services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 19.1 | The service of the general practitioners providing TOPs is accessible. | 12.2 | 6 | 18.4 | 9 | 69.4 | 34 | 100 | 49 | 1 |
| 19.2 | The general practitioners providing TOPs are helpful. | 4.1 | 2 | 16.3 | 8 | 79.6 | 39 | 100 | 49 | 1 |
| 19.3 | The services of the general practitioners providing TOP services are private. | 4.1 | 2 | 10.2 | 5 | 85.7 | 42 | 100 | 49 | 1 |
| 19.4 | There is no waiting period for services of the general practitioners providing TOP services. | 8.2 | 4 | 10.2 | 5 | 81.6 | 40 | 100 | 49 | 1 |

Of the respondents 69.4% (34) agreed with the statement that the services of the general practitioners (doctors) providing TOP services were accessible, 18.4% (n=9) were neutral and 12.2% (n=6) disagreed. One did not answer this question. The majority of the respondents, 79.6% (n=39) agreed that the general practitioners providing TOP services were helpful, 16.3% (n=8) were neutral and 4.1% (n=2) disagreed with the statement.

Similarly, 85.7% (n=42) of the respondents agreed with the statement that the TOP services provided by the GPs were private, 4.1% (n=2) disagreed and 10.2% (n=5) were neutral. Reportedly, 81.6% (n=40) of the respondents agreed with the statement that there was no waiting period for TOP service provided by GPs, 10.2% (n=5) were neutral, and 8.2% (n=4) disagreed.

According to the respondents' replies TOP services provided by general practitioners were accessible, offered privacy, did not have long waiting periods and the doctors were helpful. These responses indicated more positive perceptions of TOP services provided by general practitioners than by public health facilities (hospitals and clinics). However, no respondent indicated the estimated cost of TOP services provided by general practitioners.

## 5.10 RESPONDENTS' OPINIONS ABOUT TOP SERVICES AND THE USE OF CONTRACEPTIVES

Despite the legal access of TOP services in South Africa, illegal TOP services are still rife.

**Table 5.9 The respondents' opinions about TOP services and the use of contraceptives**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 21.1 | Unsafe TOP is dangerous | 0.0 | 0 | 0.0 | 0 | 100 | 50 | 100 | 50 | 0 |
| 21.2 | Non government organisations rather than public health care facilities should provide TOP service. | 58.0 | 29 | 6.0 | 3 | 36.0 | 18 | 100 | 50 | 0 |
| 21.3 | I am in a position to negotiate safe sex (condom use) with my partner. | 36.0 | 18 | 2.0 | 1 | 62.0 | 31 | 100 | 50 | 0 |
| 21.4 | When I become intimate with my partner, we use a condom. | 46.0 | 23 | 12.0 | 6 | 42.0 | 21 | 100 | 50 | 0 |
| 21.5 | It is better for unemployed women to have TOP services in order to avoid starvation of their babies. | 22.0 | 11 | 8.0 | 4 | 70.0 | 35 | 100 | 50 | 0 |
| 21.6 | It is better for a teenager to have TOP in order to further her studies. | 16.0 | 8 | 10.0 | 5 | 74.0 | 37 | 100 | 50 | 0 |
| 21.7 | A woman can die as a result of an unsafe TOP. | 8.0 | 4 | 0.0 | 0 | 92.0 | 46 | 100 | 50 | 0 |
| 21.8 | Only unmarried people should use condoms. | 94.0 | 47 | 0.0 | 0 | 6.0 | 3 | 100 | 50 | 0 |

All respondents (100%; n=50) agreed with the statement that unsafe TOPs are dangerous and 92% (n=46) indicated that women could die as a result of an unsafe TOP. Of the respondents, 58.0% (n=29) disagreed with the statement that non government rather than public health care facilities should provide TOP services, 36.0% (n=18) agreed and 6.0% (n=3) were neutral.

Some of the respondents (62.0%; n=31) agreed with the statement that they could negotiate safe sex with their partners, 36.0% (n=18) disagreed with the statement and 2.0% (n=1) were neutral. All respondents answered this question. Relating to the HBM, factors that prevent women from practicing safe sex to prevent unplanned pregnancies, were viewed as barriers to contraceptive use (Mackey 2002:8).

Some respondents, 46.0% (n=23) disagreed with the statement that they used condoms with their partners, 42.0% (n=21) agreed and 12.0% (n=6) were neutral. The majority of the respondents, 94.0% (n=47) disagreed with the statement that only unmarried people should use condoms, and only 6.0% (n=3) agreed with the statement.

Of the respondents 70.0% (n=35) agreed with the statement that it was better for an unemployed women to have a TOP in order to avoid starvation of the baby, 22.0% (n=11) disagreed with the statement, 8.0% (n=4) were neutral.

Some respondents, 74.0% (n=37) agreed with the statement that it was better for a teenager to have a TOP in order for her to further her studies, 16.0% (n=8) disagreed and 10.0 % (n=5) were neutral.

## 5.11 COUNSELLING

The CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008 makes provision for non-mandatory and non-directive counselling to be given to a woman who chooses to terminate a pregnancy.

Out of 29 respondents who replied to this question, 37.9% (n=11) indicated that no counselling services were provided to them when they requested TOP services, only 34.5% (n=10) agreed that counselling had been provided to them and 10.3% (n=3) disagreed, whereas 17.2% (n=5) were neutral. According to this finding, more than a third of the women requesting TOPs did not receive any counseling, contrary to the stipulations of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008.

### 5.11.1 Who offers counselling service in TOP facilities?

The respondents indicated who offered counselling services to them in the TOP facilities:

- Psychologist: (64.9%; n=24) indicated “no” and (35.1%; n=13) don’t know (37 responses.
- Psychiatrist: (67.6%; n=23) indicated “no” and (32.3%; n=11) don’t know (34 responses).

- Social worker: (37.8%; n=17) indicated “yes’’ and 33.3%; n=15) “no’’ while (28.9%; n=13) don’t know (45 responses).
- Counsellors: (24.3%; n=9) “yes’’ and (43.2%; n=16) “no” (32.4%; n=12) don’t know (37 responses).
- “Other”: (23.1%; n=9) indicated “yes’’ (41.0%; n=16) “no’’ and (35.9%; n=14) don’t know (39 responses).

Social workers and counsellors offered most counselling at TOP facilities. Unfortunately, no probing questions were asked about the apparent absence of nurses and/or whether “nurses” were included in the “other” category.

The respondents further indicated who offered counselling services for voluntary HIV counselling and testing:

- Psychologist: 61.5% (n=24) “no” and 38.5% (n=15) don’t know (39 responses).
- Psychiatrist: 60.5% (n=23) “no” 39.5% (n=15) don’t know (38 responses).
- Social worker: 2.6% (n=1) “yes” 61.5% (n=24) “no” and 35.9% (n=14) don’t know (39 responses).
- Counsellors: 52.2% (n=42) indicated “yes” 19.6% (n=9) “no” 28.3% (n=13) don’t know (46 responses).
- “Other”: 17.9% (n=7) indicated “yes” 41.0% (n=16) “no” and 41.0% (n=16) don’t know (39 responses).

Consequently, HIV counsellors provided HIV counselling to approximately half of the respondents. Nurses were not mentioned as providing HIV counselling.

Respondents indicated who offered counselling services about contraceptives:

- Psychologists: 88.2% (n=30) “no” and 11.8% (n=4) don’t know (34 responses).
- Psychiatrists: 88.2% (n=30) “no” and 11.8% (n=4) don’t know (34 responses).
- Social workers: 2.9% (n=1) “yes”, 82.4% (n=28) “no” and 14.7% (n=5) don’t know (34 responses).
- Counsellors: 30.3% (n=10) “yes”, 57.6% (n=19) “no” 12.1% (n=4) don’t know (33 responses).

- Nurses: 74.0% (n=37) “yes”, 22.0% (n=11) “no” and 4.0% (n=2) don’t know (50 responses).

According to these findings, nurses offered most counselling about contraceptives.

### 5.11.2 The support received from the nurses providing TOP services

Nurses’ support to women who received TOPs might differ depending on the attitudes of nurses towards TOPs.

**Table 5.10 Support respondents received from the nurses providing TOP services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 26.1 | The nurses understood that having TOP is my choice | 18.0 | 9 | 2.0 | 1 | 80.0 | 40 | 100 | 50 | 0 |
| 26.2 | The nurses explained the TOP procedure to me | 50.0 | 25 | 6.0 | 3 | 44.0 | 22 | 100 | 50 | 0 |
| 26.3 | The nurses provided counselling services pre and post – TOP procedure to me | 66.0 | 33 | 12.0 | 6 | 22.0 | 11 | 100 | 50 | 0 |
| 26.4 | The support provided by nurses rendering TOP services to me, was sufficient | 56.0 | 28 | 18.0 | 9 | 26.0 | 13 | 100 | 50 | 0 |

Most respondents, 80.0% (n=40) agreed with the statement that the nurses understood that having a TOP was the woman’s choice, one (2.0%) was neutral and 18.0% (n=9) disagreed with the statement. These responses indicate that nurses respected women’s decisions to have TOPs.

Of the respondents, 50.0% (n=25) disagreed with the statement that nurses explained TOP procedures to them, 44.0% (n=22) agreed with the statement and 6.0% (n=3) were neutral. Reportedly nurses explained the TOP procedure to only 44.0% of the respondents, implying that 56.0% did not receive such counselling. However, it should be emphasised that none of these respondents utilised TOP services at the public health care facilities in the NWP. Possibly nurses might have time to explain the procedure only to women who were actually using the TOP services.

Reportedly, 66.0% (n=33) of the respondents disagreed with the statement that the nurses provide pre- and post-TOP counselling TOP service, 22.0% (n=11) agreed with the statement, 12.0% (n=6) were neutral. Of the respondents 56.0% (n=28) disagreed with the statement that the support provided by nurses providing TOP services was sufficient, 26.0% (n=13) agreed with the statement and 18.0% (n=9) were neutral. All 50 respondents answered the question. However, none of these respondents used TOP services in the public facilities of the NWP. Consequently these answers merely portrayed their perceptions (probably based on “hearsay” from other patients) and not on their actual experiences.

## 5.12 RESPONDENTS’ VIEWS ON COMMUNITY SUPPORT FOR WOMEN WHO HAD USED TOP SERVICES

The majority of the respondents, (88.0%; n=44) disagreed with the statement that the community provided support for women who had their pregnancies terminated, 12.0% (n=6) agreed. Thus 88.0% of the respondents expected community disapproval because they had used TOP services.

## 5.13 RESPONDENTS’ OPINIONS AS TO WHO A WOMAN SHOULD CONSULT BEFORE TOP SERVICES

Respondents were requested to state who a woman should consult before considering using TOP services.

**Table 5.11 Respondents' opinion on who a woman should consult before deciding to have TOP services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 28.1 | A woman should make a decision on her own | 8.0 | 4 | 0.0 | 0 | 92.0 | 46 | 100 | 50 | 0 |
| 28.2 | A woman should consult a counsellor | 32.0 | 16 | 10.0 | 5 | 58.0 | 29 | 100 | 50 | 0 |
| 28.3 | A woman should consult her partner | 62.0 | 31 | 6.0 | 3 | 32.0 | 16 | 100 | 50 | 0 |
| 28.4 | A woman should consult a nurse | 12.0 | 6 | 2.0 | 1 | 86.0 | 43 | 100 | 50 | 0 |
| 28.5 | A woman should consult her clergy man | 82.0 | 41 | 16.0 | 8 | 2.0 | 1 | 100 | 50 | 0 |
| 28.6 | A woman should consult her family | 76.0 | 38 | 8. 0 | 4 | 16 .0 | 8 | 100 | 50 | 0 |
| 28.7 | A woman should consult her friends | 91.8 | 45 | 4.1 | 2 | 4.1 | 2 | 100 | 49 | 1 |
| 28.8 | A woman should consult her mother-in-law | 87.8 | 43 | 2.0 | 1 | 10.2 | 5 | 100 | 49 | 1 |
| 28.9 | A woman should consult "others" (please specify) | 54.8 | 17 | 3.2 | 1 | 41.9 | 13 | 100 | 31 | 19 |

Most respondents, (92.0%; n=46) agreed with the statement that a woman should make her own decision before using TOP services, and only 8.0% (n=4) disagreed with the statement. Similarly, 54.8% (n=68) of the respondents, in the study conducted by Patel and Myeni (2008:744), also agreed that it should be a woman's decision to have TOP services.

Reportedly, 58.0% (n=29) of respondents agreed with the statement that women should consult a counsellor before deciding to use TOP services, 10.0% (n=5) were neutral and 32.0% (n=16) disagreed with the statement.

Reportedly, 62.0% (n=31) of respondents disagreed with the statement that a woman should consult her partner before deciding to use TOP services, 6.0% (n=3) were neutral and 32.0% (n=16) agreed. According to the study conducted by Patel and Myeni (2008:744), 72.5% (n=90) of their respondents agreed that a pregnant woman should consult her partner before deciding to use TOP services. In terms of the CTOP

Act (no 92 of 1996), as amended by Act no 1 of 2008, the woman is the sole decision-maker about using TOP services, and need not consult anyone.

Of the respondents, 86.0% (n=43) agreed that a woman should consult a nurse before deciding to use TOP services, 2.0% (n=1) were neutral and 12.0% (n=6) disagreed with the statement. Thus most respondents (86.0%; n=43) wanted to be counselled by nurses. However, nurses were not mentioned in response to a question about persons providing counselling at TOP facilities (see first paragraph of section 5.11.1).

Reportedly, 82.0% (n=41) of respondents disagreed that women should consult a clergyman before deciding to use TOP services, 16.0% (n=8) were neutral and 2.0% (n=1) agreed with the statement. Of the respondents 76.0% (n=38) disagreed that a woman should consult her family before deciding to use TOP services, 8.0% (n=4) were neutral and 16.0% (n=8) agreed with the statement. The majority of the respondents (91.8%; n=45) disagreed that a woman should consult friends before deciding to use TOP services, 4.1% (n=2) were neutral and 4.1% (n=2) agreed with the statement. Most respondents (87.8%; n=43) disagreed that a woman should consult her mother-in-law before deciding to use TOP services, one (2%) was neutral and 10.0% (n=5) agreed with the statement. Most respondents, 54.8% (n=17) disagreed with the statement that a woman should consult “others” before deciding to use TOP services, one (3.2% ) was neutral and 41.9% (n=13) agreed. It should be mentioned that the respondents were requested to specify “other’’ but they did not do so.

Based on these findings, most respondents (86.0%; n=43) agreed that nurses should be consulted before deciding to use TOP services. Only 32.0% (n=16) of these women agreed that their partners should be consulted, while a few women would consult their friends, ministers of religion, families, or mothers-in-law.

## 5.14 IMPACT OF CULTURE AND RELIGIOUS BELIEFS AND MORAL VALUES

**Table 5.12 The impact of respondents' culture and religious beliefs and moral values on using TOP services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 29.1 | My religious beliefs prevent me from accessing TOPs | 30.6 | 15 | 4.1 | 2 | 65.3 | 32 | 100 | 49 | 1 |
| 29.2 | My cultural beliefs prevent me from accessing termination of pregnancy services | 45.0 | 22 | 6.1 | 3 | 49.0 | 24 | 100 | 49 | 1 |
| 29.3 | My moral values prevent me from accessing TOP service | 42.9 | 21 | 10.2 | 5 | 46.9 | 23 | 100 | 49 | 1 |
| 29.4 | Termination of pregnancy is a sin | 35.4 | 17 | 4.2 | 2 | 60.4 | 29 | 100 | 48 | 2 |
| 29.5 | I feel guilty because I terminated a pregnancy | 30.6 | 15 | 2.1 | 1 | 67.3 | 33 | 100 | 49 | 1 |
| 29.6 | I feel I am a sinner | 32.7 | 16 | 2.1 | 1 | 65.3 | 32 | 100 | 49 | 1 |
| 29.7 | I feel I am a "baby killer" | 55.1 | 27 | 2.1 | 1 | 42.9 | 21 | 100 | 49 | 1 |
| 29.8 | I feel God will never forgive me | 70.0 | 35 | 8.0 | 4 | 22.0 | 11 | 100 | 50 | 0 |
| 29.9 | I do not have any negative feelings about TOP services | 68.0 | 34 | 8.0 | 4 | 24.0 | 12 | 100 | 50 | 0 |
| 29.10 | I feel relieved because the procedure is over | 10.2 | 5 | 4.1 | 2 | 85.7 | 42 | 100 | 49 | 1 |

Reportedly, 65.3% (n=32) of the respondents agreed that their religious beliefs prevented them from accessing TOP services, whereas, 30.6% (n=15) disagreed and 4.1% (n=2) were neutral. Relating to the HBM, religious beliefs could be a barrier for women to access TOP services (Mackey 2002:8). However, only one respondent (2.0%) agreed that a clergyman should be consulted prior to deciding about a TOP. This might indicate that almost all the women decided to use TOP services without consulting their ministers of religion.

The study findings revealed that 49.0% (n=24) of the respondents agreed that their cultural beliefs prevented them from accessing TOP services, 45.0% (n=22) disagreed and 6.1% (n=3) were neutral. According to the HBM, cultural beliefs could be a barrier for women to access TOP services (Mackey 2002:8). These cultural beliefs were not specified.

The analysis of the study findings revealed that moral values could prevent a woman from accessing TOP services as indicated by 46.9% (n=23) of the respondents who agreed, 42.9 % (n=21) disagreed and 10.2% (n=5) were neutral. However, all these women did not undergo TOPs.

Some respondents, 60.4% (n=29) perceived TOPs to be sinful, whereas 35.4% (n=17) disagreed and 4.2% (n=2) were neutral. Similarly, the findings in the study conducted by Patel and Myeni (2008:745) revealed that 66.1% (n=82) of their respondents agreed that TOP was a sin against God. Some respondents, 65.3% (n=32) agreed with the statement that they felt they were sinners because they wanted to use TOP services, 32.7% (n=16) disagreed and 2.1% (n=1) was neutral. This perception could impact on a woman's choice to use TOP services, or to delay her decision while the pregnancy progresses. Of the respondents, 70.0% (n=35) disagreed with the statement that they felt that God would not forgive them, whereas, 22.0% (n=11) agreed with the statement and 8.0% (n=4) were neutral.

Of the respondents, 67.3% (n=33) agreed with the statement that they felt guilty because they wanted to terminate their pregnancies, 30.6% (n=15) disagreed with the statement and one (2.1%) was neutral.

## 5.15 CONFIDENTIALITY

Open-ended questions were asked about various aspects of TOP services. Respondents were asked to indicate what they liked/disliked most about the confidentiality of the TOP services.

Of the respondents (64%; n=32) felt that there was no privacy in the TOP facilities. To illustrate this one respondent said: "Nurses discuss conditions of clients amongst themselves". Another respondent indicated that privacy was inadequate and that the rooms were too few. Of the respondents, 24.0% (n=12) indicated that the place was not big enough; therefore there was no privacy in the facility. People who came for TOP service shared rooms with people who came for general illnesses.

Another respondent stated: "No, there is no confidentiality because TOP is recorded in your file and anyone can open your file and read it while you are asleep". A remark by one respondent was as follows: "When the sister who provides TOP is on leave, the sister in maternity would say "The TOP sister is not here and anybody could hear that we are here for TOP, so what's the point about confidentiality".

**Respondents' positive remarks about confidentiality**

One respondent indicated that "the sister talked to me alone, that is what I liked about confidentiality". Thirteen (26%) respondents liked the fact that the social worker talked to them privately. One respondent said "Nobody knows me here, I am just free".

Although a few respondents appreciated privacy at the TOP facilities, most perceived these services to lack confidentiality. This might deter women from using the public TOP services in the NWP.

**Respondents' wishes for nurses providing TOP services**

Of the respondents 88.0% (n=44) indicated that they wished nurses could change their attitudes towards women requesting TOP services and provide TOP services when needed.

In response to this open-ended question, one respondent replied it as "I wish the nurse can understand that it is my choice to have TOP and my decision needs to be respected". Another respondent remarked "that nurses should be patient, women have reasons why they need TOP services".

Another respondent said "not to judge us to come when the pregnancy is advanced. They put you on a waiting list, when you come they are not there, then you have to come, and they tell you: No!!! they can't do it".

One respondent said she wished that the nurse could understand that "I take full responsibility for my action and there should be providers of TOP services because I need it".

Twelve (24.0%) respondents indicated that they wished nurses should be more understanding, friendly and more caring towards women requesting TOP services.

**Respondents' TOP advice to other women**

Some of the respondents (34.0%; n=17), indicated that they would support a pregnant woman who does not have any other choice, whereas (64.0%; n=32) indicated that they would not advise a pregnant woman to use TOP services. To illustrate this one respondent said: "I am not comfortable talking to others about it", while another respondent said: "I don't think it is the right thing to do".

Seventeen (34.0%) respondents indicated that they would advise pregnant students, who wished to complete their studies, to use TOP services.

**Respondents' advice on illegal TOPs**

In response to an open-ended question, most respondents (82.0%; n=41), indicated that if they could not be assisted at either the clinic or hospital they would advise a woman to use illegal TOP services but would also tell them about the dangers, whereas 18.0%( n=9) indicated that they would not do so.

**One aspect of TOP services respondents would change**

Of the respondents, 54.0% (n=27) indicated that booking systems or waiting lists for TOP clients should be more systematic and transparent.

Privacy was indicated as a problem by 31.3% (n=15) who suggested the provision of extra rooms, separated from those used for other conditions or illnesses.

Of the respondents, 8.0% (n=4) indicated that TOP services should be provided daily, including counselling services.

Another respondent indicated "enough resources" without specifying and three respondents indicated that they wanted more TOP nurses. One respondent said

“Nurses to understand that for an unemployed woman to have a child it is not a nice thing”.

**Respondents’ reports about counselling services provided at TOP facilities**

Of the respondents, 56.0% (n=28) indicated that allegedly no counselling was done and 38.0% (n=19) indicated that it was done effectively. Few respondents, 6.0% (n=3) indicated that only pre TOP counselling was done by the social worker.

Consequently, pre- and post-TOP counselling appeared to be inadequate, as reported by women who could not access TOP services.

**Feelings of respondents concerning nurses who provided TOP services**

One respondent remarked that “they think we are prostitutes”. A high percentage of respondents (76.0%; n=38) felt that nurses did not give women who requested TOPs support and 12.0% (n=6) indicated that nurses were stressed, overworked, frustrated and could not cope.

One respondent said “I feel we are inconveniencing them and they end up being aggressive and short tempered”.

**Major challenges encountered by women requesting TOP services in the NWP but who could not access theses services**

The waiting list was the major obstacle as indicated by 36.0% (n=18). Of the respondents, 22.0% (n=11) indicated lack of TOP facilities in the NWP as a major obstacle. One said “The facilities providing TOP services are few in the province. Some women who wanted TOPs, ended up with babies because there were no facilities for TOPs in their areas”.

Some respondents (42.0%; n=21) indicated that attitudes of nurses, transport and financial constraints were major obstacles. Others (8.0%; n=4) indicated that there were no facilities providing TOPs beyond 12 weeks’ gestation in the NWP, the people ended up opting for illegal TOPs.

**Respondents' views about circumstances under which nurses might refuse to provide TOP services**

Most respondents, 52.0% (n=22) indicated that a nurse could refuse to provide TOP services if the pregnancy is beyond 12 weeks' gestation. Some respondents (46.0%; n=23) indicated that the woman has a right to access TOP services if she wants it.

**Reasons why women might seek TOP services in other provinces**

Some respondents (20.0%; n=10) indicated that better services were provided in other provinces. Of the respondents, 32.0% (n=16) indicated that nobody knew them in other provinces and that it would be private and confidential. To illustrate this, one respondent said that she was afraid of nurses who were gossiping and the scandals that could go around, if the information about her TOP should become public knowledge.

The unavailability of nurses was indicated by 16.0% (n=8) of the respondents as a reason to seek TOP services in other provinces. Of the respondents, 14.0% (n=7) indicated that the TOP services beyond 12 weeks' gestation were reasons why women in the NWP sought TOP services in other provinces. Thus the TOP services provided in the NWP seemed to lack confidentiality, resources and nurses.

**Respondents' perceptions about the religion of a woman relating to the TOP services**

One respondent indicated that it depended on how strong a woman felt about her religion. Some respondents (46.0%; n=23), indicated that the choice of a woman had to be respected.

Of the respondents, 48.0% (n=23) indicated that if TOP was against one's religion, one needed to respect one's religion and values. One respondent indicated "No, a woman can ask for forgiveness in private, only God and she will know about the TOP". Of the respondents, 8.0% (n=4) indicated that because TOP is a sin, religion could prevent women from accessing TOP services. However, the influence of religion might be

limited because only one woman indicated that a clergyman should be consulted prior to using TOP services.

**The major obstacles in accessing TOP services in the NWP**

Transport was mentioned by 10.0% (n=5) of the respondents to be a major obstacle and also TOP clinics were not easily accessible. Too few facilities providing TOP services were indicated by 30.0% (n=15) of the respondents as obstacles to using TOP services in the NWP.

Of the respondents, 26.0% (n=13) indicated “waiting lists” implying that this delay might cause a women to exceed the 12 weeks’ gestation as stipulated in the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008. More nurses providing TOP services, would presumably help to limit the waiting lists for TOPs, and enable more women to use these public services in the NWP.

One (2.0%) respondent indicated that some doctors don’t want to do TOPs in their surgeries. However, table 5.8 indicates that most women were satisfied with TOP services provided by general practitioners.

Some of the respondents, 34.0% (n=17) indicated that the nurses’ attitudes were the major obstacles to TOP services. This finding agrees with those portrayed in table 5.7 where more than 75% of the respondents agreed that nurses’ attitudes posed barriers to their utilisation of TOP services in the NWP.

**Respondents’ other comments about TOP services in their areas**

Some respondents, 50.0% (n=25) indicated that TOP services should be provided at clinics to ensure accessibility to all women, also those who are unemployed. Of the respondents, 20.0% (n=10) indicated that TOP services should be provided daily. One (2.0%) respondent said: “some of the nurses should be employed and trained to do TOP service”.

One (2.0%) respondent suggested “Government to ask private doctors to do TOP for free for people who come to them”. Privacy and bigger rooms were proposed by 26.0% (n=13) respondents.

Others (22.0%; n=11) indicated that nurses should be more understanding, caring and treat patients with positive attitudes, dignity and respect. These “other” comments confirmed findings reported earlier in this chapter.

## 5.16 SUMMARY

According to the findings 66.0% (n=33) of respondents in phase 2 were younger than 30 years as portrayed in figure 5.1. The findings also revealed that respondents (82.0%; n=41) in phase 2 of the study were single. Similarly like in phase I, the majority of the respondents (90.0%; n=45) were Christians. An equal number of respondents (36.0%; n=18) reported that they either had no children or one child as portrayed in figure 5.4.

The findings of phase 2 of this study also revealed that almost all respondents (92.0%; n=46) reported that they had requested TOP services only once. A high percentage of respondents (80.0%; n=40) indicated that they were unemployed and 96.0% (n=48) indicated that they used transport to access TOP services.

The findings in phase 2 of this study revealed that 94.0% (n=47) of the respondents indicated that the booking system or waiting lists were challenges for women who requested TOP services in the NWP (see table 5.2). Furthermore, a high percentage (88.0%; n=44) of the respondents in this study felt that there was no privacy in the TOP facilities (see table 5.6). Most respondents (88.0%; n=44) wished that nurses, providing TOP services, could change their attitudes towards women requesting TOP services. Furthermore, 58.0% (n=29) felt that nurses should work at TOP service only if the nurses choose to do so.

The findings in this phase of the study revealed that most respondents (80.0%; n=40) recommended that the policy makers should address the poor quality of TOP services. The findings of this study also revealed that 88.0% (n=44) of respondents reported that sonar tests were performed to confirm the pregnancy which also concurs with findings in phase 1 (see table 5.3). However, 88.0% (n=44) of respondents reported that fear of

clinic nurses would prevent them from accessing TOP services as portrayed in table 5.6. Another barrier that would prevent women from accessing TOP services was a fully booked clinic reported by 96.0% (n=48) women. According to respondents, 85.7% (n=42) felt that the general practitioners providing TOP services were helpful and 81.6% (n=40) indicated that there is no waiting period for TOP services at the general practitioners. However, no respondent indicated what general practitioners charged for providing TOP services.

The findings revealed that 37.9% (n=11) respondents indicated that no counselling services were provided to them. The findings also revealed that 65.3% (n=32) of respondents indicated that religious beliefs can prevent them from accessing TOP services. More than half of the respondents (60.4%; n=29) indicated that TOP is a sin.

The findings of this chapter were discussed according to the components of the HBM, namely, modifying factors, individual perceptions and likelihood of action. The study's findings revealed that woman who requested TOP services in the NWP, but who did not access these services, faced barriers including transport costs, TOP waiting lists, unfriendly nurses, lack of privacy and confidentiality at the public services providing TOPs in the NWP.

Chapter 6 will discuss the findings on phase 3, which focused on the challenges faced by registered nurses providing TOP services in the public health facilities in the NWP.

# CHAPTER 6

# Analysis and discussion of research results: Phase 3: Challenges encountered by nurses providing TOP services

## 6.1 INTRODUCTION

Data collected from nurses, working in facilities providing TOP services in the NWP, in phase 3 were analysed. The study population included all nurses who provided TOP services in the NWP at the time of data collection during October to November 2009.

The main focus of phase 3 of this study was to address the challenges encountered by nurses providing TOP services in the NWP of South Africa.

The research results will be presented in tables, graphs and percentages. A 5 point Likert scale was used to determine the most important issues by ranking the individual questions' responses. The mean score was also used and the individual questions were also ranked in order of importance. The relation of the results with the theoretical framework (HBM) will also be considered.

The research questions of this study were:

- Do public health facilities providing TOP services have a sufficient number of trained nurses to provide TOP services in the NWP?
- What are the perceptions and opinions of nurses regarding TOP services?
- What impact do nurses' religious values, morals and beliefs have on providing TOP services?
- What are the attitudes of nurses towards women who requested TOP services?
- What are the obstacles encountered in the implementation of the CTOP Act?
- How were nurses' personal lives influenced by the fact that they were rendering TOP services?

- What kind of support do nurses, providing TOP services, receive from their families, colleagues, managers and their communities?
- What are the circumstances of nurses working in TOP services?
- How do nurses, who provide TOP services, view the TOP service guidelines?
- Do nurses provide pre and post-counselling to women who request TOP services?

Section A of the structured interview schedule attempted to obtain biographical data, which included age, gender, population, marital status, religion, number of children and number of years of working in TOP services. Nurses also had to indicate whether or not they were registered midwives and considered their TOP training to be adequate.

## 6.2 BIOGRAPHICAL DATA

- **Modifying factors in phase III**

The modifying factors are outlined by the HBM as concepts including demographic, socio-psychological and structural variables which are factors that could prevent the nurses from providing TOP services.

### 6.2.1 Age

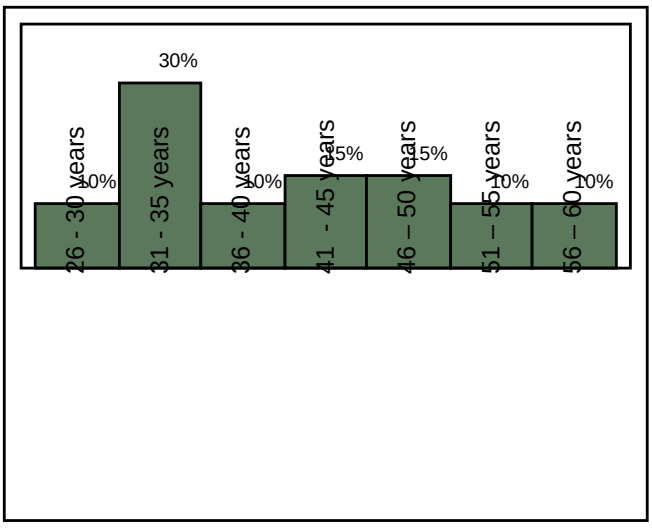



**Figure 6.1**

**Age distribution of the respondents (n=20)**

Ages of the respondents ranged from 26-60 years. Of the respondents, 30.0% (n=6) fell within the age group of 31-35 years, followed by 15.0% (n=3), 15.0%(n=3) who fell

within 41-45 and 46-50 years respectively,10.0% (n=2) fell within 26-30, 10.0% (n=2) fell within 36-40, those who were 51-55 were 10.0% (n=2) and another 10.0% (n=2) were between 56-60 years. Figure 6.1 outlines the age distribution of the respondents, indicating that the largest age group was 31-35 years.

The modifying factors identified in this study include age, gender, marital status, religion and number of children. These modifying factors can influence the attitude of nurses towards providing TOP services.

### 6.2.2 Gender

Both male and female nurses provided TOP services in the public health facilities in the NWP. Reportedly, the majority of the nurses, 85.0% (n=17) were females and 15.0% (n=3) were males.

### 6.2.3 Population

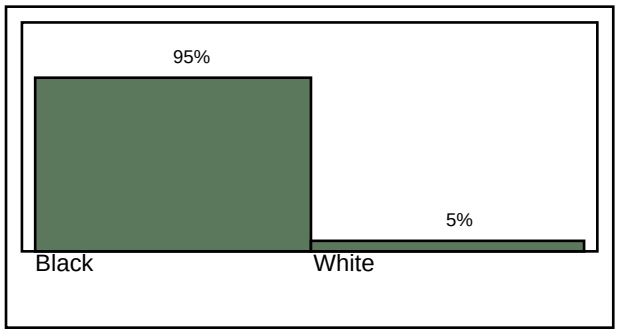



**Figure 6.2**

**Respondents' population group in phase III (n=20)**

As portrayed in figure 6.2, the majority of the research respondents were from the black population, 95.0% (n=19), only 5.0% (n=1) were white. All the respondents answered this question.

### 6.2.4 Marital status

Of the respondents, 25.0% (n=5) indicated that they were married, 40.0% (n=8) had never been married, 30.0% (n=6) were divorced and one (5.0%) was a widow.

### 6.2.5 Religious affiliation

The majority of the respondents (90.0%;n=18), reported that they were Christians, only 10.0% (n=2) reported “other” religion without any specification. Religion can influence the attitude of nurses working in TOP services as reported by Harries et al (2009:6).

### 6.2.6 Registered midwives

All respondents (100%; n=20) were registered midwives.

### 6.2.7 Number of grandchildren

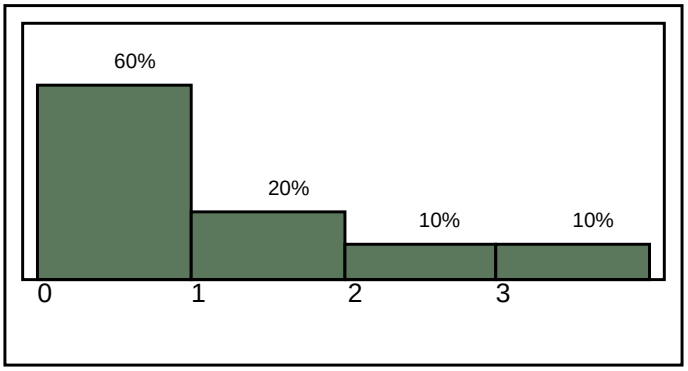



**Figure 6.3**
**Respondents’ number of grandchildren (n=20)**

The majority of the respondents, 60.0% (n=12) indicated that they had none, 20.0% (n=4) indicated one, 10.0% (n=2) indicated two, 10.0% (n=2) indicated three children.

### 6.2.8 Working in TOP services

All respondents (100%; n=20) indicated that they worked in TOP services, thus meeting the inclusive criterium to be a respondent for phase 3 of this study.

### 6.2.9 Training received to perform TOP

Of the respondents, 75.0% (n=15) indicated that their TOP training was adequate, 20.0% (n=4) felt their TOP training was inadequate. Only 5.0% (n=1) indicated that they did not receive any TOP training. The findings of this study revealed that most of the nurses 95.0% (n=19) were trained as TOP service providers in the NWP. However, the limited number of nurses providing TOP services in the NWP could pose challenges to women requesting TOP services in this province. In terms of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, all nurses providing TOP services should receive training to do so.

### 6.2.10 Period of time of working in TOP services

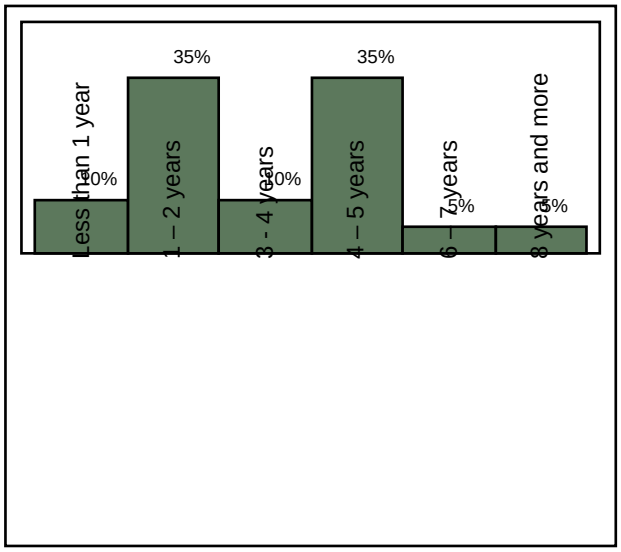



**Figure 6.4**
**Number of years that respondents had worked in TOP services (n=20)**

Of the respondents (10.0%; n=2) indicated that they had worked less than one year in TOP services, 35.0% (n=7) 1-2 years, 10.0% (n=2) 3-4 years, 35.0% (n=7) 4-5 years and only 5.0% (n=1) indicated 6-7 years. Another 5.0% (n=1) indicated 8 years and

longer. Thus 90% (n=18) of the nurses had worked in TOP services for more than one year.

## 6.3 FEELINGS AND RELIGION

### Respondents' individual perceptions about TOP services

Respondents were requested to indicate their feelings about their involvement with TOP services. Table 6.1 indicates the highlights of the respondents' feelings reflected by the mean scores (based on a 5-point Likert scale).

**Table 6.1 Respondents' feelings reflected by mean scores**

| Item | Statement | Mean score |
|---|---|---|
| 11.1 | I often feel sad | 3.4 |
| 11.2 | I often feel frustrated | 3.3 |
| 11.3 | I often feel worthless | 3.0 |
| 11.4 | I often feel denial | 2.1 |
| 11.5 | I often feel relieved | 3.3 |
| 11.6 | I often feel stressed | 4.0 |
| 11.7 | I often feel anxious | 3.0 |
| 11.8 | I often feel aggressive | 3.0 |
| 11.9 | I often feel hopeless | 3.0 |
| 11.10 | I often have a feeling of fulfillment | 3.2 |
| 11.11 | I often feel depressed | 3.3 |
| 11.12 | I often have a feeling of bluntness | 2.4 |
| 11.13 | I often have a feeling of achievement | 4.0 |
| 11.14 | I often feel happy | 4.0 |
| 11.15 | I often have a feeling of desperation | 3.0 |
| 11.16 | I often feel satisfied with a job well done | 4.1 |
| 11.17 | I often feel confused | 2.2 |
| 11.18 | I often feel exhausted | 4.0 |

The research findings in table 6.1 reveal that the respondents agreed most with the statement "I often feel satisfied with a job well done" with a mean score of 4.1 and a mean score of 4.0 for "I often have a feeling of achievement" as well as for "I often feel happy". The statement with which most respondents disagreed (I often feel denial) had a mean score of 2.1. Similarly, they also disagreed with the statement (I often feel confused) with a mean score of 2.2.

These findings seem to portray that the nurses providing TOP services in the NWP managed to maintain positive attitudes towards their work. However, both statements "I often feel stressed" and "I often feel exhausted" had mean scores of 4.0. Both these responses indicate that nurses providing TOP services in the NWP, experienced stress and exhaustion.

### 6.3.1 Respondents' sleeping patterns

Table 6.2 indicates the sleeping patterns of the respondents.

**Table 6.2 Respondents' sleeping patterns**

| Item | Statement | Definitely no | | No | | Yes | | Definitely yes | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | % | n | n |
| 12.1 | I cannot fall asleep at night | 15.8 | 3 | 68.4 | 13 | 10.5 | 2 | 5.3 | 1 | 100 | 19 | 1 |
| 12.2 | I wake up very early in the morning and cannot sleep again | 11.1 | 2 | 50.0 | 9 | 27.8 | 5 | 11.1 | 2 | 100 | 18 | 2 |
| 12.3 | I have nightmares. | 15.8 | 3 | 47.4 | 9 | 31.6 | 6 | 5.3 | 1 | 100 | 19 | 1 |
| 12.4 | I cannot sleep at all | 26.3 | 5 | 73.7 | 14 | 0.0 | 0 | 0.0 | 0 | 100 | 19 | 1 |

Only 10.5% (n=2) of the respondents indicated that they had problems to fall asleep at night; 50.0% (n=9) did not wake up very early in the morning without falling asleep again; 47.4% (n=9) did not have nightmares and 73.7% (n=14) could sleep.

These findings do not portray undue sleeping problems among the respondents.

## 6.4 RESPONDENTS' FEELINGS ABOUT THEIR INVOLVEMENT IN TOP SERVICES

Respondents had to indicate their feelings about their involvement in TOP services.

**Table 6.3 Respondents' feelings about their involvement with TOP services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 13.1 | I do not like to go out because of my involvement with TOPs | 90.0 | 18 | 5.0 | 1 | 5.0 | 1 | 100 | 20 | 0 |
| 13.2 | I feel guilty because of my involvement with TOP services | 70.0 | 14 | 10.0 | 2 | 20.0 | 4 | 100 | 20 | 0 |
| 13.3 | I enjoy my work | 25.0 | 5 | 25.0 | 5 | 50.0 | 10 | 100 | 20 | 0 |
| 13.4 | I feel I am a sinner because of my involvement with TOPs | 60.0 | 12 | 15.0 | 3 | 25.0 | 5 | 100 | 20 | 0 |
| 13.5 | I feel that God will never forgive me because of my involvement with TOPs | 65.0 | 13 | 20.0 | 4 | 15.0 | 3 | 100 | 20 | 0 |
| 13.6 | I do not have any negative feelings because of my involvement with TOPs | 55.0 | 11 | 20.0 | 4 | 25.0 | 5 | 100 | 20 | 0 |
| 13.7 | People gossip about me because of my involvement with TOPs | 30.0 | 6 | 15.0 | 3 | 55.0 | 11 | 100 | 20 | 0 |
| 13.8 | I have been assaulted because of my involvement with TOPs | 95.0 | 19 | 5.0 | 1 | 0.0 | 0 | 100 | 20 | 0 |
| 13.9 | I live in fear of being attacked by members of the community because of my involvement with TOPs | 85.0 | 17 | 10.0 | 2 | 5.5 | 1 | 100 | 20 | 0 |
| 13.10I | I live in fear for the safety of my family because of my involvement with TOPs | 90.0 | 18 | 5.0 | 1 | 5.0 | 1 | 100 | 20 | 0 |

Reportedly, 90.0% (n=18) of the respondents disagreed with the statement that they did not like to go out because of their involvement with TOP services. This implied that almost all nurses managed to go out despite their involvement with TOPs. This was the case despite the finding that 55.0% (n=11) indicated that people gossiped about their involvement with TOP services.

Only 10.0% (n=2) of the respondents felt guilty and 25.0% (n=5) regarded themselves to be sinners because of their involvement with TOP services. Of the respondents, 65.0% (n=13) disagreed with the statement that they felt that God would never forgive them because of their involvement with TOP services, 15.0% (n=3) agreed and 20.0% (n=4) were neutral.

Reportedly 55.0% (n=11) of the nurses had negative feelings because of their involvement with TOP services. However, no nurse had been assaulted and only one nurse (5.0%) feared being attacked by members of the community because of her involvement with TOP services. Most respondents (90.0%; n=18) did not fear for the safety of their families because of their involvement with TOP services.

## 6.5 RESPONDENTS' PERCEPTIONS AND OPINIONS ABOUT TOP SERVICES

### 6.5.1 Number of monthly TOPs performed at special clinics

Figure 6.5 portrays the number of TOPs managed per month in public health facilities in the NWP.

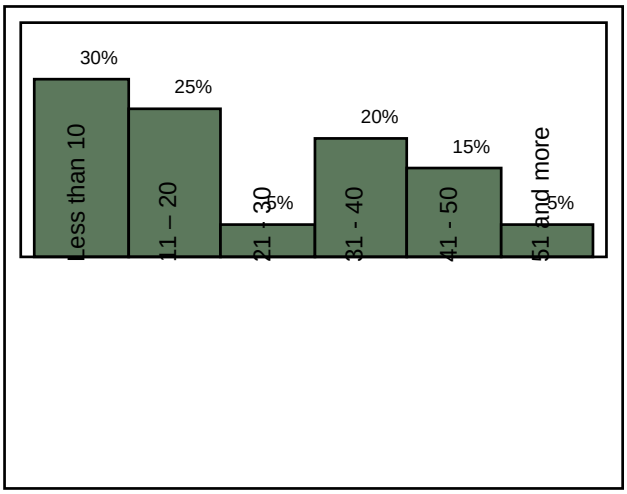



**Figure 6.5**
**Number of TOPs performed monthly at special clinics (n=20)**

Of the respondents, 30.0% (n=6) reported fewer than 10 TOPs per month, followed by 25.0% (n=5) who indicated 11-20 TOPs were performed monthly. Only one (5.0%)

indicated that 51 and more TOPs were performed per month in one public facility. Even in facilities where 50 TOPs were performed per month, this would amount to 2.5 TOPs per working day. However, if TOPs were provided on one day per week it would amount to 12.5 TOPs per day.

The study findings revealed that 25.0% (n=5) of the respondents reported that it was realistic for the department to manage fewer than 10 TOPs per month, 30.0% (n=6) reported 11-20, 15.0% (n=3) reported 21-30, 10.0% (n=2) reported 31-40, 15.0% (n=3) reported 41-50 and only 5.0% (n=1) reported 51 and more. No reasons were given for these indications.

## 6.6 RESPONDENTS' PERCEPTIONS ABOUT WHO SHOULD RECEIVE TOP SERVICES

The respondents had different feelings about who should receive TOP services.

**Table 6.4 Respondents' opinions about who should receive TOP services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 16.1 | Women who had a previous TOP | 65.0 | 13 | 10.0 | 2 | 25.0 | 5 | 100 | 20 | 0 |
| 16.2 | Women who are expecting a child with congenital abnormalities | 10.0 | 2 | 5.0 | 1 | 85.0 | 17 | 100 | 20 | 0 |
| 16.3 | Women who have been raped | 0.0 | 0 | 10.0 | 2 | 90.0 | 18 | 100 | 20 | 0 |
| 16.4 | Women who are at risk of committing suicide | 5.0 | 1 | 15.0 | 3 | 80.0 | 16 | 100 | 20 | 0 |
| 16.5 | Women who are suffering from mental illness | 0.0 | 0 | 10.0 | 2 | 90.0 | 18 | 100 | 20 | 0 |
| 16.6 | Women who never had children | 60.0 | 12 | 15.0 | 3 | 25.0 | 5 | 100 | 20 | 0 |
| 16.7 | Women who are mentally retarded | 5.3 | 1 | 5.3 | 1 | 90.0 | 17 | 100 | 19 | 1 |
| 16.8 | Women with HIV/Aids | 30.0 | 6 | 35.0 | 7 | 35.0 | 7 | 100 | 20 | 0 |
| 16.9 | Women who are victims of incest | 0.0 | 0 | 20.0 | 4 | 80.0 | 16 | 100 | 20 | 0 |
| 16.10 | Women who have three and more children | 42.1 | 8 | 11.0 | 2 | 47.4 | 9 | 100 | 19 | 1 |
| 16.11 | Women who are poor and cannot care financially for their children | 30.0 | 6 | 10.0 | 2 | 60.0 | 12 | 100 | 20 | 0 |
| 16.12 | A woman who has an unplanned pregnancy | 25.0 | 5 | 20.0 | 4 | 55.0 | 11 | 100 | 20 | 0 |

Reportedly, 65.0% (n=13) of the respondents disagreed with the statement that a woman who had a previous TOP should receive subsequent TOP services, 25.0% (n=5) agreed and only 10.0% (n=2) were neutral. Consequently 65.0% (n=13) of the nurses might not have had positive attitudes towards providing TOP services to women who had undergone previous TOPs.

Most respondents (85.0%; n=17) agreed with the statement that a woman expecting a child with congenital abnormalities, should have a TOP and 90.0% (n=18) agreed that women who had been raped should access TOP services. Most respondents (90.0%; n=17) agreed with the statement that women who are mentally retarded could use TOP services.

Most respondents (80.0%; n=16) agreed that women at risk of committing suicide and 90.0% (n=18) agreed that women suffering from mental illness should access TOP services. Thus most nurses agreed that TOPs should be provided to women at risk of committing suicide and/or suffering from mental illness.

Reportedly, 60.0% (n=12) of the nurses disagreed that women who never had children could use TOP services and 30.0% (n=6) disagreed with the statement that women with HIV/AIDS should be provided with TOP services. It could not be ascertained why some nurses considered that women without children and HIV positive women should not access TOPs. In terms of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, all these women should have access to TOP services.

Most respondents (80.0%; n=16) agreed that women who are victims of incest should be provided with TOP services but 42.1% (n=8) disagreed that women who have three and more children should be provided with TOP services.

Of the respondents, 30.0% (n=6) disagreed with the statement that women who are poor and cannot care financially for their children can be provided with TOP services, and 25.0% (n=5) disagreed that women who have unplanned pregnancies should be provided with TOP services.

Almost all nurses agreed that women who had been raped, expected a child with congenital abnormalities, suffering from mental illnesses, with mental retardation, or who are victims of incest should have access to TOPs.

However, at least one third of the nurses, providing TOP services in the NWP, were not in favour of providing such services to women who

- had used TOP services previously
- never had children
- were poor
- had unplanned pregnancies
- had HIV/AIDS

In terms of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, every woman has the right to use TOP services. The nurses' alleged exclusions of some women from TOP services, might be regarded as being illegal.

## 6.7 RESPONDENTS' VIEWS ON WOMEN'S APPROPRIATE AGES TO BE ALLOWED TO DECIDE ABOUT TOPS

Figure 6.6 indicates the views of respondents on how old a woman should be before being allowed to make a decision to have a TOP.

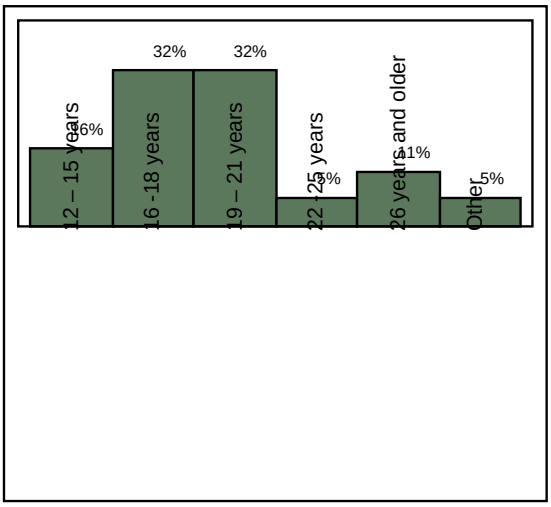



**Figure 6.6**
**Respondents' views on the age at which woman could decide about using TOP services (n=20)**

The findings revealed that 32,0% (n=6) respondents felt women should be aged 16-18, 32.0% (n=6) the same number of the respondents felt that women should be between 19-21 years, 32.0% (n=6) before they should be allowed to decide to have TOPs, only 16.0% (n=3) felt women should be between 12-15 years. These findings differ from the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, which indicates that a girl at the age of 12 years can make this decision on her own.

## 6.8 RESPONDENTS' OPINIONS ON WHO SHOULD BE CONSULTED PRIOR TO USING TOP SERVICES

The respondents had to indicate their views on who should be consulted before deciding to use TOP services.

**Table 6.5 Who should women consult before deciding to have TOP services**

| Item | Statement | Mean |
|---|---|---|
| 18.1 | A woman should make a decision on her own | 4.0 |
| 18.2 | A woman should consult a counselor | 4.2 |
| 18.3 | A woman should consult her partner | 3.4 |
| 18.4 | A woman should consult a nurse | 4.3 |
| 18.5 | A woman should consult a clergyman | 2.0 |
| 18.6 | A woman should consult her family | 3.0 |
| 18.7 | A woman should consult her friends | 2.0 |

The respondents disagreed with item 18.5 "women should consult a clergyman" with a mean score of 2.0 and item 18.7 "women should consult her friends" with a mean score of 2.0. The statement with which most respondents agreed was that "women should consult a nurse" with a mean score of 4.3.

## 6.9 RESPONDENTS' KNOWLEDGE ABOUT THE CTOP ACT (NO 92 OF 1996), AS AMENDED BY ACT NO 1 OF 2008

Respondents where requested to indicate their knowledge about the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, and their needs to revise the Act.

**Table 6.6 Respondents' knowledge about the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008**

| Item | Statement | No | | Yes | | Total | | No response |
|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | n |
| 20.1 | It is not necessary to read the CTOP Act as I know it well enough | 74.0 | 14 | 26.3 | 5 | 100 | 19 | 1 |
| 20.2 | I read the CTOP Act at least once a month | 42.1 | 8 | 58.0 | 11 | 100 | 19 | 1 |
| 20.3 | I read the CTOP Act at least once in three months | 63.2 | 12 | 37.0 | 7 | 100 | 19 | 1 |
| 20.4 | I read the CTOP Act at least twice a year | 74.0 | 14 | 26.3 | 5 | 100 | 19 | 1 |
| 20.5 | I read the CTOP Act at least once a year | 89.0 | 17 | 11.0 | 2 | 100 | 19 | 1 |
| 20.6 | I have never read the CTOP Act | 95.0 | 18 | 5.3 | 1 | 100 | 19 | 1 |
| 20.7 | I feel the CTOP Act is not good enough and needs to be revised | 26.3 | 5 | 74.0 | 14 | 100 | 19 | 1 |
| 20.8 | I feel the CTOP Act is good enough and needs no revision | 88.2 | 15 | 12.0 | 2 | 100 | 17 | 3 |
| 20.9 | I feel that nurses should have a choice as to whether or not to work in TOP services | 22.2 | 4 | 78.0 | 14 | 100 | 18 | 2 |
| 20.10 | I feel that nurses should be penalised for refusing to provide TOP services | 78.0 | 14 | 22.2 | 4 | 100 | 18 | 2 |

Of the respondents, 95.0% (n=18) indicated that they had copies of the CTOP Act no 92 of 1996), as amended by Act no 1 of 2008, in their respective institutions, only 5.3% (n=1) did not have this act.

Of the respondents, 74.0% (n=14) indicated "no" to the statement that it was not necessary to read the CTOP Act no 92 of 1996), as amended by Act no 1 of 2008, as they knew it well enough while 26.3% (n=5) agreed. Consequently 74.0% (n=14) agreed that it was necessary to read the Act (no 92 of 1996) repeatedly even though they were familiar with its contents.

Reportedly, 42.1% (n=8) of the respondents answered "no" to the statement that they read the CTOP Act no 92 of 1996), as amended by Act no 1 of 2008, at least once a

month, 58.0% (n=11) answered “yes” to the statement, while 63.2% (n=12) reportedly read this Act once every three months.

Of the respondents, 63.2% (n=12) indicated “no” to the statement that they read the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, at least once every three months, only 37.0% (n=7) answered “yes” that they read the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008 at least once in three months.

Few respondents (26.3%; n=5) read the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, at least twice a year and only 11.0% (n=2) did so at least once a year. Only 5.3% (n=1) indicated that they never read the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008.

.

Some respondents (74.0%; n=14) indicated that they felt the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, was not good enough and needed to be revised. Of the respondents, 88.2% (n=15) indicated that they felt the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008 was good enough and needed no revision. The responses to these two questions seem to indicate the nurses’ perception that the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, should be revised.

Of the respondents 78.0% (n=14) indicated that nurses should have a choice as to whether or not to work in TOP services and 78.0% (n=14) indicated that nurses should not be penalised for refusing to provide TOP services.

## 6.10 THE PERCENTAGES OF TOPs DONE AT DIFFERENT GESTATION PERIODS

The respondents indicated that TOPs were conducted if the gestation period was

- up to 15 weeks (20.0%; n=5)
- 16-18 weeks (45.0%; n=9)
- 19-20 weeks (60.0%; n=12)
- 21+ weeks (70.0%; n=14)

Unfortunately no reasons were provided for these answers. However, each respondent could provide more than one answer, explaining why the total exceeds 100% (n=20). According to the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, TOPs can be performed on demand up till 12 weeks' gestation. The fact that 70% of the nurses indicated that TOPs are done at 21+ weeks' gestation appears to be contradictory to the provisions of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008.

## 6.11 RESPONDENTS' PERCEPTIONS ABOUT NURSES PROVIDING TOP SERVICES

Most of the nurses wanted to work in TOP services out of choice as indicated by the mean score of 4.1 in table 6.7.

**Table 6.7 Experiences with nurses providing TOP services**

| Item | Statement | Mean |
|---|---|---|
| 22.1 | Nurses generally refuse to render TOP services | 3.5 |
| 22.2 | Nurses should be punished if they refuse to render TOP services | 1.8 |
| 22.3 | Nurses who provide TOP services are generally caring people | 4.0 |
| 22.4 | Nurses who provide TOP services are generally unfriendly | 2.0 |
| 22.5 | Nurses monitor all patients having TOP services hourly | 3.2 |
| 22.6 | Nurses generally leave TOP services patients to care for themselves | 1.9 |
| 22.7 | Nurses do not want to be involved in TOP services | 3.5 |
| 22.8 | Nurses generally leave patients to clean up their "own mess" after TOP services | 1.8 |
| 22.9 | Nurses generally work in these services out of choice | 4.1 |

These findings revealed that most of the nurses, rendering TOP services, agreed with items 22.9 (nurses generally work in these services out of choice) with a mean score of 4.1. Item 22.8 (the nurses generally leave patients to clean up their "own mess" after TOP services) with a mean score of 1.8, scored the lowest.

## 6.12 RESPONDENTS' PERCEPTIONS ABOUT THE FOETUS

The nurses might face ethical and moral dilemmas when providing TOP services.

**Table 6.8 Respondents' perceptions about the foetus**

| Item | Statement | Mean |
|---|---|---|
| 23.1 | The foetus younger than 16 weeks is not yet a human being | 3.1 |
| 23.2 | The foetus younger than 16 weeks does not have a soul | 3.1 |
| 23.3 | Every person has the right to choose whether she wants to use TOP services | 4.3 |
| 23.4 | I would like to influence the clients not to have TOPs | 2.8 |
| 23.5 | The foetus at conception has the right to life | 3.6 |
| 23.6 | I have refused to be part of a TOP at least once | 2.1 |
| 23.7 | TOP services are often rendered on pregnancies that progressed beyond 16 weeks | 2.6 |

A number of the respondents agreed with statement 23.3 (every person has the right to choose whether she wants a TOP) with a mean score of 4.3 and disagreed most with 23.6 (I have refused to be part of TOP at least once) with a mean score of 2.1. This indicates that most nurses agreed that women have the right to access TOP services and that few nurses have refused to provide TOP services.

## 6.13 RESPONDENTS' TOP EXPERIENCES

Despite the legalisation of TOP services in South Africa, nurses in the NWP have different views about TOP services. Table 6.9 indicates the nurses' perceptions about TOP services as portrayed by mean scores, calculated from responses to items with 5-point Likert scales.

**Table 6.9 Respondents' perceptions of TOP services**

| Item | Statement | Mean score |
|---|---|---|
| 24.1 | TOP services are accessible to all women who want to make use of them | 3.5 |
| 24.2 | TOP services are acceptable to all women who want to make use of it | 3.4 |
| 24.3 | TOP services are linked to reproductive health services | 3.5 |
| 24.4 | TOP services are stigmatised | 3.7 |
| 24.5 | TOP services are used as a method of contraception | 2.4 |
| 24.6 | TOP services has reduced illegal abortions | 2.5 |
| 24.7 | TOP services are rendered professionally | 3.8 |

The respondents agreed with the following statements:

- TOP services are accessible to all women who want to use them with a mean score of 3.5.
- TOP services are acceptable to all women who want to use them with a mean score of 3.4.
- TOP services are linked to reproductive health services with a mean score of 3.5.
- TOP services are stigmatised with a mean score of 3.7.
- TOP services are rendered professionally with a mean score of 3.8.

Although all these aspects' mean scores exceeded the mean of 3, the nurses did not agree unanimously on any aspect.

Respondents' disagreed that TOP services have reduced illegal abortions with a mean score of 2.5, and that TOP services are used as a method of contraception with a mean score of 2.4.

## 6.14 RESPONDENTS' PERCEPTIONS ABOUT COUNSELLING SERVICES

The nurses who are involved in TOP services might require emotional and psychological support.

**Table 6.10 Indicate respondents' perceptions about counselling services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 25.1 | There are no official counselling services available | 84.2 | 16 | 0.0 | 0 | 16.0 | 3 | 100 | 19 | 1 |
| 25.2 | The counselling services are excellent | 25.0 | 5 | 10.0 | 2 | 65.0 | 13 | 100 | 20 | 0 |
| 25.3 | The counselling services are accessible | 20.0 | 4 | 5.0 | 1 | 75.0 | 15 | 100 | 20 | 0 |
| 25.4 | The counselling services are good | 20.0 | 4 | 10.0 | 2 | 70.0 | 14 | 100 | 20 | 0 |
| 25.5 | The counselling services are reasonable | 10.0 | 2 | 15.0 | 3 | 75.0 | 15 | 100 | 20 | 0 |
| 25.6 | The counselling services need to improve | 35.0 | 7 | 10.0 | 2 | 55.0 | 11 | 100 | 20 | 0 |
| 25.7 | The counselling services are very poor | 80.0 | 16 | 10.0 | 2 | 10.0 | 2 | 100 | 20 | 0 |

The majority of the respondents (84.2%; n=16) disagreed with the statement that there were no counselling services available at the TOP facilities and 16.0% (n=3) agreed. Most respondents (80.0%; n=16) disagreed with the statement, that the counselling services were very poor, 10.0% (n=2) were neutral and 10.0% (n=2) agreed. These responses indicate a dire need to improve the existing counselling services.

## 6.15 RESPONDENTS' VIEWS ON PROVIDING COUNSELLING SERVICES AT TOP FACILITIES IN THE NWP

Counselling services is one of the key services in TOP to ensure that the emotional needs of women had been catered for before and after the TOP procedure. Table 6.11 indicates the highlights of the respondents' views on who provided counselling services at the TOP facilities in the NWP.

**Table 6.11 Respondents' views on providers of counselling services at the TOP services in the NWP**

| Item | Statement | No | | Yes | | Do not know | |
|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n |
| 26.1 | Psychologist | 57.9 | 11 | 42.1 | 8 | 0.0 | 0 |
| 26.2 | Psychiatrist | 89.5 | 17 | 0.0 | 0 | 10.5 | 2 |
| 26.3 | Social workers | 73.6 | 14 | 26.3 | 5 | 0.0 | 0 |
| 26.4 | Members of Management | 79.0 | 15 | 11.0 | 2 | 11.0 | 2 |
| 26.5 | Lay counsellors | 89.5 | 17 | 11.0 | 2 | 0.0 | 0 |
| 26.6 | Colleagues also working in TOPs | 78.9 | 15 | 21.1 | 4 | 0.0 | 0 |

The respondents' views on who provided counselling services at TOP facilities:

- Psychologist: (42.1%; n=8) "yes'' and "no''( 58.0%; n=11)
- Psychiatrist: (89.5%; n=17) "no" and (11.0%; n=2) don't know
- Social worker: (73.6%; n=14) "no'' and (26.3%; n=5) "yes"
- Members of management: (78.9%; n=15/) "no'' (11.0%; n=2) and (11.0%; n=2) don't know
- Lay counselors: (89.5%; n=17) "no" and (11.0%; n=2)
- Colleagues also working in TOP services: (78.9%; n=15) "no" and (21.1%; n=4) "yes"

## 6.16 RESPONDENTS' PERCEPTIONS ABOUT TOP SERVICES

Respondents were asked to indicate their perceptions about TOP services. Table 6.12 portrays these perceptions of the respondents as indicated by mean scores.

**Table 6.12 Respondents' perceptions about providing TOP services as indicated by mean scores**

| ITEM | STATEMENT | MEAN SCORE |
|---|---|---|
| 27.1 | I feel good about myself | 4.3 |
| 27.2 | TOP services changed me in a negative way | 2.2 |
| 27.3 | I have been penalised because I refused to render TOP service | 1.8 |
| 27.4 | I am a caring person | 4.0 |
| 27.5 | TOP services changed me in a positive way | 3.7 |
| 27.6 | I am always friendly | 4.0 |
| 27.7 | I monitor all patients having TOP services hourly or more often if necessary | 3.9 |
| 27.8 | I generally leave a TOP patient to take care of herself while aborting the foetus | 1.9 |
| 27.9 | I cannot do more for the TOP patients because there are too many of them | 2.3 |
| 27.10 | I want to be involved with TOPs | 4.3 |
| 27.11 | I wish I could do more for the patients receiving TOPs | 3.9 |
| 27.12 | I generally leave TOP patients to clean up their own mess | 1.7 |
| 27.13 | I work in TOP services out of my own choice | 4.2 |
| 27.14 | I always do what is expected of me | 4.2 |
| 27.15 | I feel guilty about the way I treat the TOP patients | 2.3 |
| 27.16 | I have no feelings for the TOP patients | 1.8 |
| 27.17 | I like myself | 4.5 |

The majority of the respondents appeared to be satisfied with themselves and their jobs as indicated by the following responses:

- I like myself with a mean score of 4.5.
- I feel good about myself with a mean score of 4.3.
- I always do what is expected of me with a mean score of 4.2.

Only a minority of nurses reported negative perceptions, as portrayed in the following responses:

- I have been penalised because I refused to render TOP services with a mean score of 1.8.
- I generally leave a TOP patient to take care of herself while aborting the foetus with a mean score of 1.9.

- I generally leave TOP patients to clean up their own mess with a mean score of 1.7.
- I have no feelings for the TOP patients with a mean score of 1.8.

## 6.17 RESPONDENTS' ATTITUDES TOWARDS THE PROVISION OF TOP SERVICES

Respondents were requested to indicate their perceptions about the provision of TOP services. Table 6.13 indicates the influence of others on TOP services.

**Table 6.13 Influence of others on TOP services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 28.1 | The attitudes of the community towards me influence my attitude towards TOPs | 75.0 | 15 | 10.0 | 2 | 15.0 | 3 | 100 | 20 | 0 |
| 28.2 | The attitudes of my family members influence my attitude towards TOP | 65.0 | 13 | 15.0 | 3 | 20.0 | 4 | 100 | 20 | 0 |
| 28.3 | The attitudes of my friends/colleagues influence my attitude towards TOP | 65.0 | 13 | 15.0 | 3 | 20.0 | 4 | 100 | 20 | 0 |
| 28.4 | My religion influences my attitude towards TOP | 40.0 | 8 | 5.0 | 1 | 55.0 | 11 | 100 | 20 | 0 |

A number of the respondents 75.0% (n=15) disagreed with the statement that the attitudes of the community influenced their attitudes towards TOPs, 10.0% (n=2) were neutral and 15.0% (n=3) agreed.

Of the respondents, 65.0% (n=13) disagreed with the statement that the attitudes of their families influence their attitudes towards TOPs, 15.0% (n=3) were neutral and 20.0% (n=4) agreed.

Reportedly, 65.0% (n=13) of the respondents disagreed with the statement that the attitude of their friends/colleagues influence their attitude towards TOP, 15.0% (n=3) were neutral and 20.0% (n=4) disagree.

These findings indicate that the attitudes of the community, family members and friends had limited impacts on nurses' perceptions about TOPs. However, religion had some impact on more than half of the nurses' TOP attitudes.

## 6.18 WHAT RESPONDENTS LIKED MOST ABOUT TOP SERVICES

Of the respondents, 70.0% (n=14) were positive about TOP services and one respondent remarked "I like to help women who request TOP services to deal with their unplanned pregnancies and to advise them to use contraceptives until they are ready to have children".

One respondent said "What I like most about TOP services is to assist women especially those who had been raped to prevent them from using illegal TOP services".

.

Reportedly, 15.0% (n=3) indicated that they liked the counselling part most, because they assisted women to make informed decisions about TOP services.

Of the respondents, 10.0% (n=2) indicated that what they liked most about TOP services was to relieve stress from women who requested TOP services, one said "I feel I am valuable to TOP clients".

## 6.19 RESPONDENTS' DISLIKES ABOUT TOP SERVICES

Of the respondents, 30.0% (n=6) indicated that they disliked the fact that some women abused TOP services using it as contraception and requested TOP services more than once. However, one respondent said "zero! I hate it! It's murder".

Another respondent remarked "What I dislike is killing an innocent soul" and one indicated that she sometimes felt guilty after providing TOP services.

One respondent said “I dislike the fact that there is no counselling services or support in TOP services”.

Another respondent remarked “I hate it when I perform TOP procedure and find that the foetal parts are seen on the abortions”.

One said “TOP is bloody messy! It’s draining your emotions and the procedure is sometimes difficult”.

## 6.20 RESPONDENTS’ WISHES FOR WOMEN UNDERGOING TOPs

One respondent indicated that she wished that women would go for TOP services as early as possible before the foetus becomes viable. Of the respondents, 35.0% (n=7) indicated that they wished women would take accountability for their actions, to go for TOPs as early as possible, not to induce themselves, to learn from their mistakes and to be more careful in future.

A number of respondents (60.0%; n=12) indicated that one wish for women undergoing TOP services would be to use condoms to prevent unwanted pregnancies, HIV and AIDS.

## 6.21 RESPONDENTS’ WISHES FOR NURSES PROVIDING TOP SERVICES

Some respondents (65.0%; n=13) indicated that they wished nurses providing TOP services could have debriefings and counselling at least more than once per month or once every three months.

Of the respondents, 25.0% (n=5) indicated that they wished the nurses could get support from management, to provide resources and give incentives to those who provided TOP services because some of these nurses did not want to be involved in TOP services.

Ten percent (n=2) of the respondents indicated that if it was possible, nurses providing TOP services should distance themselves from their emotions involved with TOP services.

## 6.22 ADVICE TO BE GIVEN TO TOP CLIENTS ABOUT CONTRACEPTIVES

Almost all respondents (95.0%; n=19) indicated that “yes” they would give advice to women who had TOP services to use contraceptives correctly to avoid future unplanned and unwanted pregnancies. Only one respondent, (5.0%) indicated “no” she would not give advice to women who had TOPs about contraceptives and did not give any reason for her attitude..

## 6.23 THE DEPARTMENT/CARE FIELD WHERE RESPONDENTS WOULD CHOOSE TO WORK

When asked where they wanted to work, 20.0% (n=4) of the respondents indicated TOP services, 35.0% (n=7) maternity, another 20.0% (n=4) indicated gynaecological wards, 15.0% (n=3) indicated casualty, medical and antenatal departments/wards. Another 10.0% (n=2) indicated that they could work in any department. Thus only four (20.0%) would work in TOP services if they have a choice as to their work allocation.

## 6.24 RESPONDENTS’ CHOICES OF PREFERRED TOP METHODS

Some respondents (60.0%; n=12) indicated that they preferred the pill and remarked “A pill because vacuum aspiration is bad and cruel”.

Thirty percent (n=6) indicated combination of pill and vacuum because it is easy to use and after the procedure they could be sure that the women were clean and would not present with infections a few days later.

Only 10.0% (n=2) indicated vacuum as their preferred method of performing TOPs.

## 6.25 RESPONDENTS' VIEWS ON THE SUPPORT RECEIVED FROM OTHERS FOR BEING INVOLVED IN TOP SERVICES

The respondents had to indicate (not applicable, very poor, poor, acceptable, good and excellent) on the support they received from other individuals for working in TOP services.

The findings revealed that 21.1% (n=4) respondents indicated that the support they received from nursing colleagues, who also worked in TOP services, was acceptable and 16.0% (n=3) indicated this to be very poor, 26.1% (n=5) indicated good, 16.0% (n=3) indicated very poor, 16.1% (n=3) indicated excellent, 11.0% (n=2) indicated not applicable and one did not respond.

Out of 18 respondents, 28.0% (n=5) indicated acceptable, 50.0% (n=9) poor, and 22.0% (n=4) very poor in response to the support of nursing colleagues who had never worked in TOP services.

Of the respondents, 42.1% (n=8) felt that the support received from members of management of the health service was very poor and only 11.0% (n=2) indicated this to be good.

Reportedly 22.2 % (n=4) of the respondents felt the support they received from their partners/spouses was acceptable and similarly, the same number of the respondents, 22.2 % (n=4) indicated this support to be excellent.

Of the respondents, 32.0% (n=6) reported the support they received from their children was good and only 11.0% (n=2) reported this to be poor.

Of the respondents 47.3% (n=9) felt the support they received from friends, who were not nurses, was acceptable and 5.3% (n=1) reported this to be very poor.

Reportedly, 53.0% (n=10) of the respondents indicated acceptable and only 5.3% (n=1) reported the support they received from members of the community to be good.

## 6.26 COMPREHENSION OF THE NUCLEAR FAMILY

The respondents had to indicate (very good understanding, good understanding, vaguely understand, do not know what they are doing) on the comprehension of their nuclear family about their work in a TOP facility.

Only 40.0% (n=16) indicated that their nuclear families vaguely understood their work in TOP services and 4.0% (n=14) reported good understanding.

## 6.27 FEELINGS ABOUT THE SUPPORT RECEIVED FROM NUCLEAR FAMILIES

**Table 6.14 Respondents' experiences about the support received from their nuclear families**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 38.1 | They allow me to vent my feelings | 15.8 | 3 | 15.8 | 3 | 68.4 | 13 | 100 | 19 | 1 |
| 38.2 | They allow me enough time to rest | 15.8 | 3 | 10.5 | 2 | 73.7 | 14 | 100 | 19 | 1 |
| 38.3 | They think that what I am doing is important | 21.1 | 4 | 31.6 | 6 | 47.4 | 9 | 100 | 19 | 1 |
| 38.4 | They are proud of me | 10.5 | 2 | 21.1 | 4 | 68.4 | 13 | 100 | 19 | 1 |
| 38.5 | They respect me for what I am doing | 21.1 | 4 | 21.1 | 4 | 57.9 | 11 | 100 | 19 | 1 |
| 38.6 | They will defend my work in conversations with other people | 21.1 | 4 | 10.5 | 2 | 68.4 | 13 | 100 | 19 | 1 |
| 38.7 | They feel that TOP services are necessary | 10.5 | 2 | 26.5 | 5 | 63.2 | 12 | 100 | 19 | 1 |
| 38.8 | They judge me | 78.9 | 15 | 10.5 | 2 | 10.5 | 2 | 100 | 19 | 1 |
| 38.9 | They do not care about my job | 63.2 | 12 | 15.8 | 3 | 21.1 | 4 | 100 | 19 | 1 |

More than half of the respondents (68.4%; n=13) agreed with the statement that their nuclear families allowed them to vent their feelings, 15.8% (n=3) were neutral and 15.8% (n=3) disagreed. Reportedly, 73.7% (n=14) of the respondents agreed with the statement that their nuclear families allowed them enough time to rest. However, 15.8%

(n=3) disagreed and 10.5% (n=2) were neutral. Thus most nurses' nuclear families enabled them to vent their feelings and to rest.

The study revealed that 47.4% (n=9) of the respondents agreed with the statement that their nuclear families thought that they were doing important jobs, 31.6% (n=6) were neutral and 21.1% (n=3) disagreed.

As many as 68.4% (n=13) of the respondents felt their nuclear families were proud of them, but 21.1% (n=4) were neutral and 10.5% (n=2) disagreed. More than half of the respondents (57.9%; n=11) agreed with the statement that their nuclear families respected them for what they were doing, 21.1% (n=4), were neutral and another 21.1% (n=4) disagreed.

Some respondents (68.4%; n=13) agreed with the statement that their nuclear families defended their work in conversations with other people. However, 21.1% (n=4) disagreed and 10.5% (n=2) were neutral. The study results revealed that 63.2% (n=12) agreed with the statement that their nuclear family felt that TOP services were necessary, 10.5%% (n=2) disagreed and 26.3% (n=5) were neutral.

The majority of the respondents (78.9%; n=15) disagreed with the statement that their nuclear families judged them, 10.5% (n=2) were neutral and 10.5% (n=2) agreed.

According to the analysis of the results of this study, more than half, 63.2% (n=12) of the respondents disagreed with the statement that their nuclear families did not care about the jobs of the respondents, 15.8% (n=3) were neutral and 21.1% (n=4) agreed.

Reportedly most nurses enjoyed their families' support for rendering TOP services.

## 6.28 COMPREHENSION OF THE EXTENDED FAMILY

The respondents had to indicate the comprehension of their extended family members about their jobs (very good understanding, good understanding, vague understanding, do not knowing what they were doing).

Reportedly, 42.1% (n=8) of the respondents indicated that their extended families vaguely understood their work in TOP services, 21.1% (n=4) indicated good understanding and only 26.8% (n=7) reported that they did not know what their extended family members were thinking.

## 6.29 FEELINGS ABOUT THE SUPPORT RECEIVED FROM THEIR EXTENDED FAMILY MEMBERS

Table 6.15 indicates the respondents' experiences about the support received from their extended family members.

**Table 6.15 Respondents' experiences about the support received from their extended family members**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 38.1 | They allow me to vent my feelings | 38.9 | 7 | 27.8 | 5 | 33.3 | 6 | 100 | 18 | 2 |
| 38.2 | They allow me enough time to rest | 27.8 | 5 | 44.4 | 8 | 27.8 | 5 | 100 | 18 | 2 |
| 38.3 | They think that what I am doing is important | 33.3 | 6 | 33.3 | 6 | 33.3 | 6 | 100 | 18 | 2 |
| 38.4 | They are proud of me | 22.2 | 4 | 33.3 | 6 | 44.4 | 8 | 100 | 18 | 2 |
| 38.5 | They respect me for what I am doing | 38.9 | 7 | 27.8 | 5 | 33.3 | 6 | 100 | 18 | 2 |
| 38.6 | They will defend my work in conversations with other people | 38.9 | 7 | 33.3 | 6 | 27.8 | 5 | 100 | 18 | 2 |
| 38.7 | They feel that TOP services are necessary | 38.9 | 7 | 38.9 | 7 | 22.2 | 4 | 100 | 18 | 2 |
| 38.8 | They judge me | 66.7 | 12 | 33.3 | 6 | 0.0 | 0 | 100 | 18 | 2 |
| 38.9 | They do not care about my job | 61.1 | 11 | 33.3 | 5 | 11.1 | 2 | 100 | 18 | 2 |

Reportedly 33.3% (n=6) of the respondents agreed with the statement that their extended family members allowed them to vent their feelings, 27.8% (n=5) were neutral and 38.9% (n=7) disagreed. Of the respondents, 44.4% (n=8) were neutral about the statement that their extended family members allowed them enough time to rest, 27.8% (n=5) disagreed and 27.8% (n=5) agreed.

The study revealed that 33.3% (n=6) of the respondents disagreed with the statement that their extended family members thought what they were doing was important, 33.3% (n=6) were neutral and 33.3% (n=6) agreed. The findings revealed that 22.2% (n=4) of the respondents disagreed that they felt that their extended family members were proud of them, 33.3% (n=6) were neutral and 44.4% (n=8) agreed.

Reportedly 38.9% (n=7) of the respondents disagreed with the statement that their extended family members respected them for what they were doing, 27.8% (n=5) were neutral and 33.3% (n=6) agreed. Some of the respondents, 38.9% (n=7) disagreed with the statement that their extended family members would defend their work in conversations with other people. However, 27.8% (n=5) agreed and 33.3% (n=6) were neutral.

The study results revealed that 38.9% (n=7) disagreed with the statement that their extended family members felt that TOP services were necessary, 22.2% (n=4) agreed with the statement and 38.9% (n=7) were neutral. A number of the respondents, 66.7% (n=12) disagreed with the statement that their extended family members judged them, 33.3% (n=6) were neutral.

Reportedly, 61.1% (n=11) of the respondents disagreed with the statement that their extended family members did not care about the respondents' jobs, 33.3% (n=5) were neutral and 11.1% (n=2) agreed.

Consequently, it appears as if the nurses' extended family members offered less support than their nuclear family members.

## 6.30 THE COMMUNITY'S COMPREHENSION ABOUT THE RESPONDENTS' TYPE OF WORK

The respondents had to indicate the level of understanding that the community had about their work (very good understanding, good understanding, vague understanding, not knowing what they were doing).

Some of the respondents (52.9%; n=11) indicated that their community vaguely understood their work in TOP services, 21.1% (n=4) indicated good understanding, 5.3% (n=1) indicated very good understanding and 15.8% (n=3) indicated that their community did not know what they were doing.

## 6.31 RESPONDENTS' FEELINGS ABOUT THE SUPPORT RECEIVED FROM COMMUNITIES

Table 6.16 indicates the nurses' experiences about the support received from their communities.

**Table 6.16 Respondents' experiences about the support received from their communities**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 38.1 | They allow me to vent my feelings | 42.1 | 8 | 47.4 | 9 | 10.5 | 2 | 100 | 19 | 1 |
| 38.2 | They allow me enough time to rest | 36.8 | 7 | 57.9 | 11 | 5.3 | 1 | 100 | 19 | 1 |
| 38.3 | They think that what I am doing is important | 36.8 | 7 | 47.4 | 9 | 15.8 | 3 | 100 | 19 | 1 |
| 38.4 | They are proud of me | 36.8 | 7 | 47.4 | 9 | 15.8 | 3 | 100 | 19 | 1 |
| 38.5 | They respect me for what I am doing | 31.6 | 6 | 52.6 | 10 | 15.8 | 3 | 100 | 19 | 1 |
| 38.6 | They will defend my work in conversations with other people | 31.6 | 6 | 57.9 | 11 | 10.5 | 2 | 100 | 19 | 1 |
| 38.7 | They feel that TOP services are necessary | 31.6 | 6 | 57.9 | 11 | 10.5 | 2 | 100 | 19 | 1 |
| 38.8 | They judge me | 47.4 | 9 | 47.4 | 9 | 5.3 | 1 | 100 | 19 | 1 |
| 38.9 | They do not care about my job | 36.8 | 7 | 0.0 | 0 | 63.2 | 12 | 100 | 19 | 1 |

Reportedly 42.1% (n=8) of the respondents disagreed with the statement that their communities allowed them to vent their feelings, 47.4% (n=9) were neutral and 10.5% (n=2) agreed.

More than half, 57.9% (n=11) of the respondents were neutral about the statement that their communities allowed them enough time to rest, 36.8% (n=7) disagreed with the statement and 5.3% (n=1) agreed.

The study revealed that 15.8% (n=3) of the respondents agreed with the statement that their communities thought what they were doing was important, 36.8% (n=7) disagreed and 47.4% (n=9) were neutral. The findings revealed that 36.8% (n=7) of respondents disagreed that they felt that their communities were proud of them, 47.4% (n=9) were neutral and 15.8% (n=3) agreed.

Reportedly 31.6% (n=6) of the respondents disagreed with the statement that their communities respected them for what they were doing, 52.6% (n=10), were neutral and 15.8% (n=3) agreed. Of the respondents 31.6% (n=6) disagreed with the statement that their communities would defend their work in conversations with other people, 10.5 % (n=2) agreed and 57.9% (n=11) were neutral.

The study results revealed that 31.6% (n=6) of the respondents disagreed with the statement that their communities felt that TOP services were necessary, 57.9% (n=11) were neutral and 10.5% (n=2) agreed. More respondents (47.4%; n=9) disagreed with the statement that their communities judged them, 5.3% (n=1) agreed and 47.4 (n=8) were neutral. Some respondents (63.2%; n=12) agreed with the statement that their communities did not care about their jobs and 36.8% (n=7) disagreed.

Based on these findings, nurses did not perceive their communities to value TOP services.

## 6.32 RESPONDENTS' VIEWS ON OFFICIAL WORKPLACE COUNSELLING SERVICES AVAILABLE FOR NURSES RENDERING TOP SERVICES

- **Likelihood of action**

Table 6.17 indicates the official counselling services available at nurses' workplaces for those rendering TOP services.

**Table 6.17 Official counselling services available in workplaces for nurses rendering TOP services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 43.1 | There are no official counselling services available | 35.0 | 7 | 5.0 | 1 | 60.0 | 12 | 100 | 20 | 0 |
| 43.2 | The counselling services are excellent | 57.9 | 11 | 21.1 | 4 | 21.1 | 4 | 100 | 19 | 1 |
| 43.3 | The counselling services are accessible | 52.6 | 10 | 21.1 | 4 | 26.3 | 5 | 100 | 20 | 0 |

Of the respondents, 35.0% (n=7) disagreed with the statement that there were no official counselling services available in their workplaces for nurses rendering TOP services, 60.0% (n=12) agreed and 5.3% (n=1) were neutral. More than half of the respondents, 57.9% (n=11) disagreed with the statement that the counselling services were excellent, 21.1% (n=4) were neutral and 21.1% (n=4) agreed. Reportedly, 52.6% (n=10) disagreed with the statement that the counselling services were accessible, 21.1% (n=4) were neutral and 26.3% (n=5) agreed.

As many as 60.0% (n=12) of the nurses agreed that counselling services were available for nurses providing TOP services. However, more than half of the nurses did not regard these services as being accessible and/or excellent.

## 6.33 RESPONDENTS' VIEWS ON TYPES OF SUPPORT RECEIVED FROM MANAGEMENT

A number of the respondents (65.0%; n=13) indicated they did not get any support from management and one respondent remarked "They are only interested in the statistics for TOP services, not the personnel providing TOP services".

Another respondent said: "No support from management. I once had a complication and lost a patient, they did not even check if I went to the psychologist".

Of the respondents, 35.0% (n=7) indicated that they received support from management, one respondent said: “They allowed me to attend debriefing sessions and support groups”.

Another respondent remarked: “They sometimes arrange debriefing but it has been a while now since they arranged debriefing or counselling”.

Support, in the form of counseling services, received from management, appeared to be inadequate.

## 6.34 SUPPORT RESPONDENTS EXPECTED FROM THEIR EMPLOYERS

Table 6.18 indicates the types of support respondents expected from their employers.

**Table 6.18 Support respondents expected from their employers**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 45.1 | To understand the stress involved in rendering TOP services | 5.3 | 1 | 5.3 | 1 | 89.5 | 17 | 100 | 19 | 1 |
| 45.2 | To provide more manpower | 0.0 | 0 | 5.3 | 1 | 94.7 | 18 | 100 | 19 | 1 |
| 45.3 | To provide enough resources | 0.0 | 0 | 10.5 | 2 | 89.5 | 17 | 100 | 19 | 1 |
| 45.4 | To provide more days off to rest | 5.3 | 1 | 5.3 | 1 | 89.5 | 17 | 100 | 19 | 1 |
| 45.5 | To provide better remuneration | 0.0 | 0 | 10.5 | 1 | 89.5 | 17 | 100 | 19 | 1 |
| 45.6 | To provide counselling services | 0.0 | 0 | 5.3 | 1 | 94.7 | 18 | 100 | 19 | 1 |
| 45.7 | To provide a more acceptable working environment | 0.0 | 0 | 5.3 | 1 | 94.7 | 18 | 100 | 19 | 1 |
| 45.8 | Other, specify | 0.0 | 0 | 9.1 | 1 | 90.9 | 10 | 100 | 11 | 9 |

The majority of the respondents (89.5%; n=17) agreed with the statement that they expected the employers to understand the stress involved in providing TOP services, 5.3% (n=1) disagreed and 5.3% (n=1) were neutral.

The majority of the respondents (94.7%; n=18) agreed with the statement that the employer should provide more manpower, very few respondents (5.3%; n=1) were neutral and no one disagreed.

Most respondents (89.5%; n=17) agreed with the statement that the employer needed to provide more days off to rest, only one (5.3%) disagreed and one (5.3%) was neutral.

Most respondents (89.5%; n=17) agreed with the statement that they expected their employers to provide better remuneration for providing TOP services, only 10.5% (n=2) were neutral.

Reportedly, 94.7% (n=18) of the respondents agreed with the statement that they expected the employer to provide counselling services and that employers needed to provide a more acceptable working environment, only 5.3% (n=1) were neutral and none disagreed.

Most respondents (90.9%; n=10) agreed with the statement that the employer should provide other support (without further specifications), 9.1% (n=1) were neutral and none disagreed.

## 6.35 RESPONDENTS' STRESS RELIEVE MEASURES WITH OTHER COLLEAGUES

Some respondents 68.4% (n=13) reported that they never had meetings to vent their feelings with other colleagues. Some respondents indicated that they had regular meetings with their colleagues to vent their feelings less than once a month, 21.1% (n=4) at least 1-3 times a month, 5.3% (n=1) and another 5.3% (n=1) reported once a week.

Some respondents (68.4%; n=13) reported that they never had social events to forget about their work, those who indicated that they had such social events, indicated that these occurred less than once a month (31.6%; n=6).

More than half of the respondents 57.9% (n=11) reported that they never worked together as a team, 10.5% (n=2) indicated less than once a month and 5.3% (n=1) at least 1-3 times a month, 15.8% (n=3) once a week and 10.5% (n=2) reported 2 times a week.

Of the respondents, 55.6% (n=10) reported never making jokes with colleagues to relieve stress, 16.7% (n=3) less than once a month, 16.7% (n=3) at least 1-3 times a week and two times a week 11.1% (n=2).

## 6.36 RESPONDENTS' OPINIONS ABOUT UNDERSTANDING THE STRAIN EXPERIENCED BY RENDERING TOP SERVICES

**Table 6.19 Rate of support received by the users of TOP services**

| Item | Statement | Disagree | | Neutral | | Agree | | Total | | No response |
|---|---|---|---|---|---|---|---|---|---|---|
| | | % | n | % | n | % | n | % | n | n |
| 48.1 | Excellent support from their families | 20.0 | 4 | 55.0 | 11 | 25.0 | 5 | 100 | 20 | 0 |
| 48.2 | Excellent support from their partners | 25.0 | 5 | 35.0 | 7 | 40.0 | 8 | 100 | 20 | 0 |
| 48.3 | Excellent support from nurses | 20.0 | 4 | 10.0 | 2 | 70.0 | 14 | 100 | 20 | 0 |
| 48.4 | Excellent support from medical doctors | 45.0 | 9 | 10.2 | 2 | 45.0 | 9 | 100 | 20 | 0 |

Some respondents (20.0%; n=4) disagreed with the statement that TOP clients received excellent support from their families, 55.0% (n=11) were neutral and 25.0% (n=5) agreed with the statement. Of the respondents, 40.0% (n=8) agreed with the statement that TOP clients received excellent support from their partners, 25.0% (n=5) disagreed and 35.0% (n=7) were neutral.

Some respondents (70.0%; n=14) agreed with the statement that TOP clients received excellent support from nurses, 20.0% (n=4) disagreed and 10.0% (n=2) were neutral.

Reportedly, 45.0% (n=9) of the respondents disagreed with the statement that they received excellent support from the doctors, 10.0% (n=2) were neutral and 45.0% (n=16) agreed.

## 6.37 SUMMARY

According to this study's findings only 20.0% (n=4) of these nurses would work in TOP services if they could choose their own job allocation sites. The study findings also revealed that 90.0% (n=18) indicated that they were Christians.

Although respondents reported to be Christians, more than half, 70.0% (n=14) respondents indicated that they did not feel guilty because of their involvement with TOP services. Similarly, 55.0% (n=11) respondents also reported that they did not have negative feelings about their involvement in TOP services as portrayed in table 6.3.

The findings of the study revealed that 60.0% (n=12) respondents indicated that they never had children and 20.0% (n=4) reported having one child as portrayed in figure 6.3. The findings in this study also revealed that 75.0% (n=15) respondents reported that their TOP training was adequate. However, 20.0% (n=4) felt their TOP training was inadequate.

Most respondents (84.2%; n=16) disagreed that there were no official counselling for TOP clients. However, 60.0% (n=12) of the nurses indicated that there were no official counselling services for nurses providing TOP services as portrayed in table 6.17. Furthermore, 65.0% (n=13) respondents reported that nurses providing TOP services did not get any support from management.

Of the respondents, 89.5% (n=17) expected their employers to understand in rendering TOP services was stressful. Similarly, 94.7% (n=18) of the interviewed nurses expected their employers to provide counselling services and a more acceptable working environment. An equal number of respondents, 89.5% (n=17) expected their employers

to provide sufficient resources, more days off to rest and better remuneration (see table 6.18).

The challenges encountered by nurses providing TOP services, could impact on women requesting these services in the public health facilities in the NWP. Nurses who are expected to provide TOP services without adequate human and material resources, without managerial support, without counselling services and without family and community support, might be unable to provide high quality TOP services in NWP.

Chapter 7 of this study will present the conclusions, limitations, summary and recommendations.

# CHAPTER 7

# Conclusions, limitations and recommendations

## 7.1 INTRODUCTION

This chapter concludes with the research findings of the study pertaining to the three phases. In phase 1 of the study, the challenges encountered by women who had used TOP services were identified. Phase 2 of the study addressed the challenges of women who requested TOP services, without accessing them. Phase 3 focussed on the challenges encountered by nurses providing TOP services in the public health facilities in the NWP.

Therefore the conclusions and recommendations are based on the purpose, research questions and findings of the study in the three phases. The limitations identified during the course of the study are mentioned. Recommendations, to address the identified challenges in the public health facilities in the NWP, are presented. This chapter also includes guidelines for providing improved TOP services and recommendations for future studies.

The study was guided by the Health Belief Model (HBM) as a conceptual framework and the research questions were derived from the three major tenets of the HBM (Mackey 2002:8), namely:

- Modifying factors
- Likelihood of action
- Individual perceptions

## 7.2 RESEARCH DESIGN AND METHOD

The study was non-experimental, descriptive and quantitative. The study attempted to identify the challenges encountered by women who had used TOP services, those women who had requested but who did not access TOP services, and nurses providing TOP services in the NWP.

The descriptive design is used to describe characteristics of individuals, situations or groups and the frequency with which each phenomenon occurs (Polit & Beck 2006:498). The researcher used quantitative data collection instruments, namely structured interview schedules. The purpose of quantitative research is to measure concepts objectively and to examine numerical and statistical procedures and relationships between them (Parahoo 2006:49:50). Ethical issues were considered throughout the whole process of the study by ensuring that permission to conduct the study had been received from all relevant authorities before the study commenced, and from each respondent.

Two research assistants collected data at the 14 sites providing TOP services in the NWP for the first two phases. The recruitment and training of the research assistants are described in detail in chapter 3 of this thesis. The researcher conducted all the interviews with the nurses herself.

Data were collected from 150 women who had used TOP services in phase 1. In phase 2 data were collected from 50 women who had requested TOP services, but could not access them. In phase 3 interviews were conducted with 20 nurses providing TOP services in the NWP.

## 7.3 SUMMARY OF THE RESEARCH FINDINGS ACCORDING TO THE THREE PHASES OF THE STUDY

- Modifying factors such as age, parental, and marital status had an impact on pregnant women who wanted to utilise TOP services in the NWP. The study's findings revealed that most women who used TOP services in phase 1 were between 21-25 years, the same age group in phase 2 (see figures 4.1 and 5.1). The findings revealed that respondents, 94.0% (n=141) in phase 1, (90.0%; n=45) in phase 2 and 90.0% (n=18) in phase 3 reported that they were Christians. The religious affiliation could pose a challenge to the accessibility of TOP services.

- In phase 1, a number of respondents indicated that they never had children (36.7%; n=55) and also in phase 2 (36.0%; n=18). In phase 1 most of the women who had used TOP services were single (71.3%; n=107) and also in phase 2

(82.0; n=41). This confirms that most of women who requested TOP services in the NWP were single.

- Transport was found to be a barrier for pregnant women who wanted to access TOP services in the NWP, considering the vastness and mainly rural areas and high unemployment rate in this province. The findings revealed that of the respondents in phase 1, 29.0% (n=44) had to travel 25-50 km before they could access TOP services (see figure 4.5) while 40.0% (n=20) indicated that they had to travel 25-50 km (see figure 5.5) in phase 2. The findings revealed that out of 19 designated TOP facilities in the NWP, only 14 sites were active during the period of the study (2009).

- Finances could also pose as a barrier to access TOP services in the NWP considering that in phase 1 (77.3%; n=116) and in phase 2 (80.0%; n=40) reported that they were unemployed.

- The findings of this study showed that 90.0% (n=135) in phase 1 indicated that they requested TOP services for the first time, similarly in phase 2 (92.0%; n=46) reported the same on number of times using TOP services. The findings indicated that TOPs were not used as contraceptives by women who requested TOP services in the NWP.

- Almost the same percentage of respondents, 56.7% (n=85) in phase 1 and phase 2 (52.0%; n=26) agreed that nurses refused to render TOP services (see tables 4.2 and 5.2). The experiences and perceptions about nurses providing TOP services could pose a challenge to women requesting TOP services in the NWP.

- According to the findings in phase 1, 48.0% (n=71) of the respondents and 40.0% (n=19) in phase 2 reported that they were dissatisfied with TOP services (see table 4.2 and figure 5.6). The level of satisfaction of women who requested TOP services could also pose a barrier to accessing TOP services in the NWP.

- The findings in phase 1 revealed that 88.5% (n=131) and in phase 2, 88.0% (n=44) of the respondents reported that before a nurses placed the women on the waiting list, they performed a sonar to confirm the pregnancy.

- Respondents (53.3%; n=83) in phase 1 and 53.1% (n=26) in phase 2 disagreed with the statement that TOP services are accessible to the public (see tables 4.3 and 5.5). Consequently it could not be explained why 38.7% (n=58) in phase 1 and 46.9% (n=23) in phase 2 said the TOP services were accessible to the public.

- In phase 1, 47.3% (n=71) of the respondents and 65.3% (n=32) in phase 2 agreed that their religious beliefs could prevent them from accessing TOP services (see tables 4.6 and 5.12). Similarly, 57.0% (n=85) in phase 1 and 60.4% (n=29) in phase 2 also agreed that TOP is a sin. The cultural and religious beliefs could pose as challenges to women requesting TOP services. Furthermore, the findings revealed that in phase 1, 69.3% (n=104) and in phase 2, 85.7% (n=42) of the respondents reported that they felt relieved when the TOP procedure was over.

- The findings showed that 67.0% (n=100) of respondents in phase 1 and 32.0% (n=16) in phase 2 reported that the reasons why they requested TOP services in other provinces, concerned the privacy and confidentiality of the TOP services in other provinces. The privacy and confidentiality of TOP services could impact on the perceived accessibility of TOP services in the NWP.

- The quality of the TOP services was a concern for many pregnant women who wanted to utilise the TOP services and they also felt that policy makers should address these challenges, as indicated by 87.0% (n=40) in phase 2.

- Some women who used TOP services felt that TOPs were still stigmatised and that they did not receive support from their communities indicated by 67.1% (n=100) in phase 1.

- Modifying factors such as demographic, socio-psychological and structural variables were influencing factors that could prevent the nurses from providing TOP services as outlined in the HBM figure 2.1 (Mackey 2002:8).

- The limited number of nurses providing TOP services in the NWP could pose a challenge to women requesting TOP services. Only 20 nurses in the entire NWP provided TOP services during 2009 when the data were collected. Only 20.0% (n=4) of these nurses preferred to work in TOP services, implying that 80.0% (n=16) would prefer to work in other departments.

- The nurses felt that it was realistic to manage less than ten TOPs per month and the study findings revealed that 70% (n=14) of the nurses managed 11-51 and more TOPs per month.

- Of the nurses working in TOP services, 60.0% (n=12) had no children and 20.0% (n=4) reported having one child as portrayed in figure 6.3.

- As many as 75.0% (n=15) of the nurses reported that their TOP training was adequate and 20.0% (n=4) felt their TOP training was inadequate. The training of nurses on TOP services could pose a barrier if nurses regarded their TOP training to be inadequate.

- The findings revealed that 60.0% (n=12) nurses working in TOP services reported that they would prefer using pills to perform TOP services and only 10.0% (n=2) preferred vacuum extractions as a method of performing TOPs.

- Of the nurses, 60.0% (n=12) reported that there were no official counselling services available for nurses performing TOP services in the facilities providing TOP services in the NWP as portrayed in table 6.17.

- As many as 65.0% (n=13) of the nurses in phase 3 of this study reported that they did not get any support from management. However, nurses working in TOP services, expected support by means of providing enough resources, more days off to rest and better remuneration from their employers as shown by 89.5%

(n=17) respondents. The same percentage of respondents reported that they expected their employers to understand the stress involved in rendering TOP services.

- A high percentage of respondents (94.7%; n=18) expected their employers to provide counselling services, more manpower and more acceptable working environments (see table 6.18).

**Conclusions: Phases 1 and 2**

It can be concluded from findings that most of women who requested TOP services in phases 1 and 2 were single and requested TOP services for the first time. Most of these women were Christians and religion might thus pose a barrier to the accessibility of TOP services in the NWP.

It is therefore concluded that women requesting TOP services in the NWP might not be able to access TOPs due to challenges such as distances women had to travel before they could access TOP services. Out of 19 designated TOP facilities in the NWP, only 14 sites were active during the period of data collection (2009). The implications of non active TOP sites led to women travelling long distances before they could access TOP services and socio-economic implications were huge because the majority of these women were unemployed.

Some women, who requested TOP services, reported that nurses refused to provide TOP services and this could also pose as a barrier to women who want to access TOP services. Women who requested TOP services were dissatisfied with the provision of TOP services and this could also pose as a challenge to women who requested TOP services. Most of women confirmed that nurses placed them on waiting lists and nurses performed sonars to confirm their pregnancies. Moreover, respondents in phases 1 and 2 reported that TOP services were inaccessible to the public in the NWP.

After the TOP procedure had been concluded, women felt relieved. The women's religious, cultural and moral beliefs might have had some impact in the accessibility of TOP services. It is also evident from the findings that women in the NWP had reasons for seeking TOP services in other provinces because they felt that these services were

more private and confidential. Women from the NWP might continue requesting TOP services in other provinces if policy makers do not address the quality of TOP services provided in the NWP.

TOPs reportedly were stigmatised, women who requested TOP services in the NWP did not get support from their communities. This might pose a challenge to women who requested TOP services in the NWP.

**Conclusions: Phase 3**

Too few nurses provided TOP services in the NWP. Hence nurses felt that it would be realistic to manage fewer than ten TOPs per month at each clinic. Some nurses who provided TOP services, felt that their TOP training was inadequate and that they preferred pills as a method of performing TOPs and very few preferred vacuum extractions.

No official counselling services were provided for nurses providing TOP services in the NWP. Reportedly, management did not provide adequate support to nurses providing TOP services in the NWP. These nurses expected their employers to understand the stress involved in providing TOP services, to provide sufficient resources, more days to rest, better remuneration and more acceptable working environments.

**Recommendations: Phases 1 and 2**

- Health education should be strengthened in the public health facilities in the NWP on the importance of using contraceptives and condoms. To prevent unplanned pregnancies, contraceptive and emergency contraceptive services must be available and accessible throughout the NWP to reduce the need for TOPs.
- The Department of Health in the NWP should ensure that all 19 designated TOP facilities are active to address the challenge posed by distances for women to access TOP services.

- Policy-makers should address the quality of TOP services in the NWP in order for women not to seek TOP services from other provinces.

- The Department of Health of the NWP should enhance the education and awareness campaign to destigmatise TOPs in the NWP.

- The Department of Health to include information technology that can be accessible to all the residents of the NWP as a communication strategy to inform the community about the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, and the availability of TOP services in different areas.

**Recommendations: Phase 3**

- The Department of Health in the NWP should increase the number of nurses providing TOP services, to ensure that TOP services are provided daily at these facilities and that no waiting periods for women requesting TOPs would be needed. This should reduce the need for TOPs after 12 weeks' gestation.

- The Department of Health in the NWP should improve counselling services for nurses providing TOPs in the NWP. Nurses working in TOP services should receive regular counselling services and have monthly debriefing sessions with their colleagues working in TOP services.

- Management should provide regular support, sufficient resources and more days to rest. Management should explore the possibility of training lay counsellors to provide pre and post counselling to women who request TOP services.

- The Minister of Health should advocate for nurses providing TOP services and declare TOP services a specialised service. Nurses providing TOP services should receive incentives and make the salary package of TOP nurses more attractive to encourage more nurses to do TOP services.

- That nurses working in TOP services should receive in-service training to increase their knowledge and expertise in the provision of TOP services in order for the nurses to be supportive to women who request TOPs and to develop more interest in the service.

- The management of public health facilities providing TOP services in the NWP should allow nurses to work at TOP services by choice.

- The management of the public health facilities where TOP services are provided should be more involved and supportive to the TOP service providers because some of the nurses felt that managers were only interested in the statistics of TOP services without showing any interest in the nurses providing TOP services in the NWP.

- The management of public health facilities in the NWP should develop retention strategies in order to retain those nurses who already work in TOP services and to strengthen TOP services in the NWP.

- The environments in which TOP services are provided should be improved and bigger rooms should be provided to allow privacy and confidentiality of TOP services.

- The Department of Health in the NWP must conduct an audit of all the TOP facilities in the NWP and identify those facilities that have structural problems and develop a plan to improve structures to enhance the working environment of nurses providing TOP services and to be conducive to women who requested TOP services in the NWP.

- TOP facilities should be separated from ANC and midwifery services. Facilities must be provided where women requesting TOPs could be managed privately and confidentially.

## 7.4 RECOMMENDATIONS FOR FURTHER RESEARCH

The following recommendations are made for further research:

- The perception of nurses providing TOP services on the support received from management

- The needs of nurses providing TOP services for accessing counselling and debriefing services
- Views of the community on TOP services, including illegal TOP services
- Views and opinions of doctors on the provision of TOPs
- The implication of the provision of TOP services beyond 12 weeks' gestation
- The impact of waiting lists on the provision of legal and illegal TOP services

### 7.4.1 Contributions of the study

The study might contribute to the improved provision of TOP services in the NWP and creating a conducive environment for both women who request TOP services and nurses providing TOP services in the NWP. The information collected about the challenges experienced by pregnant women to access TOP services, could be valuable to predict the like hood of taking the necessary health actions in practice. This information could be useful to the policy makers to draft suitable policies and guidelines for service providers to enhance the provision of TOP services in the NWP. The Minister of Health would also be given a copy of the proposed guidelines to advocate for better remuneration and retention strategies for nurses who are willing to provide TOP services in the NWP. The policy makers would also have a better understanding of how women who requested TOP services viewed general practitioners (GPs) and might develop strategies to accommodate GPs who provide TOP services in the NWP.

The researcher design and compile guidelines to improve the service delivery to women requesting TOPs and the quality of work life for nurses working in TOP services.

The Department of Health would receive a "Bill of Rights" that can be used by pregnant women that wishes to make use of TOP services (see annexure I).

The Department of Health would also receive guidelines on nurses providing TOP services to propose strategies to improve the provision of TOP services in the NWP (see annexure J).

The managers in the TOP facilities would receive guidelines proposing strategies on how to acknowledge and support the work done by nurses providing TOP services in the NWP (see annexure K).

The Department of Health would receive proposed programme for counselling and support of professional nurses in the TOP services (see annexure L).

The managers in TOP facilities would also receive proposed programme for counselling and support of women requesting TOP services in the NWP (see annexure M).

### 7.4.2 Limitations of the study

Generalisation of the study's results might be limited since the study was conducted only in one province. The study will have to be repeated in the other eight provinces prior to generalisation of the research to South Africa.

TOP is a sensitive matter and some of the respondents felt embarrassed; hence some of the questions were not answered. Some of the respondents refused to be interviewed due to the unbearable pain after the TOP procedure.

The most difficult sample to obtain and interview were those women who were admitted in the gynecological wards in phase 2. Some of them did not want to disclose that they had used illegal TOP services, even after the doctors and nurses indicated that they had been admitted with incomplete TOPs.

Only structured interviews were conducted in all three phases of the study. More in-depth data might have been obtained if individual in-depth qualitative interviews had been conducted with women requesting and nurses providing TOP services in the NWP.

### 7.4.3 Concluding remarks

The purpose of this study was achieved in relation to the research questions and objectives. Disparities existed between the accessibility, availability and the quality of the TOP services in the public health facilities in the NWP.

There was a shortage of nurses providing TOP services, lack of training and structural challenges in some of the TOP facilities providing TOP services. There was a lack of support from management to nurses providing TOP services. The lack of counselling

services, for the nurses providing TOP service was a shortcoming of TOP services in the NWP.

The majority of the respondents felt that the CTOP Act was not good enough and it needed to be revised. Similarly, the women who requested TOP services also felt that the policy makers needed to look at the quality of TOP services in the NWP.

Women who requested TOP services, and nurses providing TOP services, in the public health facilities in the NWP faced challenges. Therefore, it is fundamental that the provincial policy makers should look into the recommendations of this study and implement them to enhance the accessibility of TOP services in the NWP.

Nurses indicated that they did not get support from management and there were no counselling services and debriefing sessions for them. It is crucial that the Department of Health ensures that nurses receive counselling since TOP has psychological implications which might have long term complications. Lack of trained TOP providers, unwillingness of nurses to work in TOP services, attitudes of nurses, support and structural problems will continue to be barriers to women requesting TOP services unless if these challenges are addressed. Lack of privacy and confidentiality can have negative impacts on the utilisation of TOP services provided free of charge at the public health facilities of the NWP.

Despite the provisions of the CTOP Act (no 92 of 1996), as amended by Act no 1 of 2008, TOP services will remain inaccessible to many women in the NWP as long as

- inadequate resources are supplied
- insufficient numbers of nurses work in TOP facilities
- nurses lack support, training and counselling services
- limited numbers of facilities provide TOP services
- long waiting lists necessitate women's pregnanci9es to proceed beyond 12 weeks' gestation
- women's privacy and confidentiality are disrespected at TOP facilities

Unless identified shortcomings are addressed, women from the NWP will continue to seek TOP services in other provinces and/or from illegal providers. If more effective and accessible contraceptive and emergency contraceptive services could be provided throughout the NWP, the demand for TOPs should decrease.

## LIST OF SOURCES


Abigail, W & Power, C. 2008. A systematic review of trend studies of women seeking termination of pregnancy. *Journal of Clinical Nursing* 17:2951-2962.

Aids Legal Network and Out Lesbian, Gay, Bisexual and Transgender Well being.2007.Submission of the choice on termination of pregnancy Amendment Act (no 38 of 2004) to the provincial standing committee on social development.
[Online] Available:
http://www.ouy.org.za/images/library/pdf/CTOP%20amendment_sbmission_20070
(accessed 21 October 2010).

Austin, P & Rood, D. 2008. Abortion reform clears last.
[Online] Available: hurdle.http://www.theage.com.au/national/abortion-reform-clears-last-hurdle-20081010-4yds.html (accessed 3 November 2008).

Bakkalapulo. M. 2005. Abortion in Indonesia. Listen to this item, law under parliamentary review.
[Online] Available: http://www.bbc.co.uk/radio4/womanshour/2005_38_tue_05.5html (accessed 23 September 2010).

Becker, S, Bazant, ES & Meyers, C. 2008. Couples counseling at an abortion clinic: a pilot study.
[Online] Available: http//:www.contraceptive_journal.org/article/50010-7824(08)00341-7 abstract (accessed 14 October 2010).

Bellamy, R. 2007. Patient's education: the use of the Health Belief Model to promote positive behaviour change. Email:richard,bellamy@stees.nhs.uk

Boskey, E. 2010. Health Belief Model. Use of a condom may hinge on perceived risk:
[Online] Available:
http:// find_articles.com/ p/articles/ mi_ m2248/is_157_40/ai_n137743526 (accessed 8 March 2010).

Burns, N & Grove, SK. 2007. *Understanding nursing research: building an evidence based practice*. 4th edition. Philadelphia: Saunders. Elsevier.

Bowes, T & Macleod, C. 2006. The characteristics of women seeking termination of pregnancy at an urban-based government hospital in the Eastern Cape. *Curationis* 29(4):12-18.

Bowling, A & Ebrahim, S. 2005. *Handbook of health research methods: investigations, measurement and analysis*. Berkshire: Open University Press.

Brink, H, Van der Walt, C & Van Rensburg, G. 2006. *Fundamentals of research methodology for health care professions.* 2nd edition. Kenwyn: Juta.

Ceylan, A, Ertem, M, Saka, G & Akdeniz, N. 2009. Post abortion family planning counseling as a tool to increase contraception use.
[Online] Available: http://findarticles.com/p/articles/mi_m2248_/is_40/ai_n13774352 (accessed 14 October 2010).

Charles, VE, Polis, CB, Sridhara, SK & Blum ,RW. 2008. Abortion and long term mental health outcomes: a systematic review of the evidence.
[Online] Available: http:/www. abortionrisks.org/index php?title=Charles et al (accessed 21 May 2009).

Cohen, S. 2006. Abortion and mental health: myth and realities.
[Online] Available: http://www.guttmacher.org/pubs/gpr/09/3/gpr09308.html (accessed 15 October 2010).

Coleman, PK, Coyle, CT & Rue, VM. 2010. Late-term elective abortion and susceptibility to post traumatic stress symptoms.
[Online] Available: http://www.hindawi.com/journals/jp/2010/130519.html (accessed 11 November 2010).

Colley,C. 2007. Abortion horror in Italy.
[Online] Available: http//www.apologeticspress.org/articles/3492 (accessed 17 October 2008).

Davis, C. 2007. Forty years on termination services have been transformed and nurses play a key role. *Nursing Standard* 21(30):18-19.

De Vos, AS. 2005. *Research at grass roots for the social sciences and human health service professions*. 3rd edition, Pretoria: Van Schaik.

Dragoman, M & Davis, A. 2008. Abortion care for adolescents. *Clinical Obstetrics and Gynecology* 51(2):281-289.

Engelbrecht, MC. 2005. Termination of pregnancy policy and services: an appraisal of implementation and operation of the Choice of Termination of Pregnancy Act 92 of 1996. Unpublished Master's dissertation. Bloemfontein: University of the Free State.

Essilfie-Appiah, G, Hofmeyer, G J & Moodley, J. 2005. Misoprostol in obstretrics and gynaecology: benefits and risks. *South African Journal of Obstetrics and Gynaecology* 11(1):9-10.

Ferreira, ALCG, Souza, AI, Lima, RA & Braga, C. 2010. Choices on contraceptive methods in post-abortion family planning clinic in the Northeast Brazil.
[Online] Available: http://www.reproductive-health-journal.com/content/7/1/5 (accessed 14 October 2010).

Gipson, JD & Hindin, MJ. 2008. "Having another child would be a life or death situation for her": understanding pregnancy termination among couples in rural Bangladesh. *American Journal of Public Health* 98(10):1827-1832.

Gold, RB & Nash, E. 2007. State abortion counseling policy and fundamental principles of informed consent.
[Online] Available: http://sparty.suttmail.org|pbs|gpr|10|4|gpr10046.html (accessed 14 October 2010).

Goodyear-Smith, F, Knowles, A & Masters, J. 2006. First trimester medical termination of pregnancy: an alternative for New Zealand women. *Australian and New Zealand Journal of Obstetrics and Gynaecology* 46:193-198.

Goodwin, P & Ogden, J. 2007. Women's reflections upon their past abortions: an exploration of how and why emotional reactions change overtime. *Psychology and Health* 22(2):231-248.

Griffith, R. 2007. Abortion law: an opportunity to inform the debate. *British Journal of Midwifery* 15(8):514-515.

Griffith, R & Tengnah, C. 2007. Termination of pregnancy: a case for a change in the law. *British Journal of Community Nursing* 12(7):317-321.

Gryte, M. 2010. Inner healing after abortion.
[Online] Available: http:www.preterm.org/what-to-expect/after-your-abortion-emotional-spiritual-concerns.php (accessed 27 September 2010).

Hammarstedt, M, Lalos, A & Wulff, M. 2006. A population based study of Swedish gynecologists' experiences of working in abortion care. *Acta Obstetricia et Gynecologica* 85 (8):229-235.

Harkreader, H, Hogan, MA & Thobaben, M. 2007. *Fundamentals of nursing caring and clinical judgment*. 3rd edition. Philadelphia: Saunders Elsevier.

Harries, J, Gabriel, M & Mitchell, E. 2007. Delays in seeking an abortion until the second trimester: a qualitative study in South Africa.
[Online] Available: http://www.ncbi.nlm.nih.gov/pmc/aricles/PMC2039724/ (accessed 21 October 2010).

Harries, J, Stinson, J & Orner, P. 2009. Health care providers' attitudes towards termination of pregnancy: a qualitative study in South Africa. *British Medical Council Public Health* 9 (296):11.

Health Systems Trust. 2005. Better health for all.
[Online] Available: (http://www.hst.org.za/healthstats/47/data (accessed 13 April 2011).

Henshaw, SK & Kost, K. 2008. Trends in the characteristics of women obtaining abortions. 1974 to 2004.
[Online] Available: http://www.guttmacher.org/pubs/2008/09/23/TrendsWomenAbortion-wTables.pdf (accessed 15 October 2010).

Hoffman, JP & Johnson, SM. 2005. Attitudes towards abortion among religious traditions in the United States: change or countinuity mhtml:file://c:\Documents and setting\ (accessed 23 September 2010).

Hughes, K, Semelka, S, Heaven, J & Meyer, J. 2007. New anti-abortion law places Columbia in spotlight.
[Online] Available:
http://blogs.columbiatribune.com/politics|2007|0|new_antiabortion_law_places_co.html (accessed October 2008).

Humpel, HS & Strydom, H. 2005. Aborsie as morele dilemma in Suid-Afrika. *Maatskaplike Werk* 41(4):337-348.

Jewkes, RK, Gumede, T, Westaway, MS, Dickson, K, Brown, H & Rees, H. 2005. Why are women still aborting outside designated facilities in Metropolitan South Africa? *British Journal of Obstetrics and Gynaecology* 112 (9):1236-1242.

Jomeen, J & Cairns, J. 2005. Policy into practice. *The Official Journal of the Royal College of Midwives* 8(8):340-341.

Jones, RK, Finer, LB & Singh, S. 2008. May 2010 Characteristics of US. Abortion patients, 2008 (2010).
[Online] Available: http://citeseert.ist.psu.edu/viewdocor/summary?doi=10.1.1.168.3601 (accessed 27 August 2010).

Jones, K, Singh, S, Finer, LB & Frohwirth, LF. 2006. Repeat abortion in the United States.
[Online] Available: http://www.gutmacher.org/pubs/2006/11/21/or29.pdf (accessed 15 October 2010).

Joyce, TJ, Henshaw, SK, Dennis, A, Finer, LB & Blanchard, K. 2009. The impact of state mandatory counseling and waiting period laws on abortion: a literature review.
[Online] Available:
http://international_period_familyplanningperspectives.org/pubs/MantoryCounseling.pdf (accessed 14 October 2010).

Kadayifçi, O, Kadayifçi, O & Ürünsak, IF. 2007. Ethical and legal aspect of abortion. *Ethics, law and moral philosophy of Reproductive Biomedicine* 2(1):61-66.

Kane, R. 2009. Conscientious objection to termination of pregnancy: the competing rights of patients and nurses. *Journal of Nursing Management* 17(2):907-912.

Kavlak, O, Atan, SU, Saruhan, A & Sevil, U. 2006. Preventing and terminating unwanted pregnancies in Turkey. *Journal of Nursing Scholarship* 38(1):6-10.

Lang, F, Joubert, G & Prinsloo, EAM. 2005. Is pregnancy termination being used as a family planning method in the Free State? *South African Family Practice* 47(5):52-55.

Lebese, MV. 2009. Phenomenological study of the experiences of the nurses directly involved with termination of pregnancy in the Limpopo province. Unpublished Master's dissertation. Pretoria: University of South Africa.

Lie, MLS, Robson, SC, & May, CR. 2008. Experiences of abortion: a narrative review of qualitative studies. *British Medical Council Health Services Research* 8(150):[1-9].

Lindström, M, Jacobsson, L, Wulff, M, Lalos, A. 2007. Midwives' experiences of encountering women seeking an abortion. *Journal of Psychosomatic Obstetrics and Gynaecology* 2(4):231-237.

Lipp, A. 2007. A review of termination of pregnancy: prevalent health care professional attitudes and ways influencing them. *Clinical Nursing Journal* 23(7):1683-1688.

Lipp, A. 2008. Challenges in abortion for nurses. *Journal of Nursing Practice* 19(1):1-4.

Lipp, A. 2009. Termination of pregnancy: a review of psychological effects on women. *Nursing Times* 105 (1):27-29.

Lister, R. 2009. Obama lifts ban on abortion finding.
[Online] Available: http:///news.bbc.co.uk/2/hi/americans/7847651.stm (accessed on 21 May 2009).

Mackey, JK. 2002. Using the Health Belief Model in preventative health care principles to Israeli registered nurses.
[Online] Available: http://www.uml.edu/com/cita/jomackeypaper.pdf (accessed 7 April 2010).

MacPhail, C, Pettifor, AE, Pascoe, S & Rees, HV. 2007. Contraception use and pregnancy among 15-24 years old South African women: a nationally representative cross-sectional survey. *BMC Medicine* 5(31):1-8.

Mdleleni-Bookholane,T. 2007. Factors related to and the consequences of the termination of pregnancy at the Umtata General Hospital, Eastern Cape. *South African Journal of Psychology* 37(2):245-249.

Major, B & Appelbaum, M. 2008. Mental health and abortion.
[Online] Available:
http://www.apa.org/pi/womem/programs/abortion/index.aspx (accessed 27 March 2010).

Major, B. 2010. The big lie about abortion and mental health.
[Online] Available:
http://www.washingtonpost.Lom/wp-dyn/content/article/2010/11/05/AR2010110507322.html (accessed 11 November 2010).

Mamabolo, LRC. 2006. The experiences of registered nurses involved in termination of pregnancy at Soshanguve community health centre. Unpublished MA (Health Studies) dissertation. Pretoria: University of South Africa.

Mao, J. 2007. Knowledge, attitudes and practice of family planning: a study of Tezu village, Manipur India. *The Internet Journal of Biological Anthropology* 1(1):1-11.

Marcell, AV, Plowden, K & Bowman, SM. 2005. Exploring older adolescents' and young adults' attitudes regarding male hormonal contraception: application for clinical practice. *Human Reproduction* 20(11):3078-2005.

Mayers, PM, Parkes, B, Green, B & Turner, J. 2005. Experiences of registered midwives assisting with termination of pregnancies at a tertiary level hospital.
[Online] Available:
http://www.thefreelibrary.com/Experiences+of+midwives+assisting+with+termination+o-a0170730416 (accessed 21 October 2010).

Mesce, D. 2006. Unsafe abortion facts and figures.
[Online] Available: http://www.prb.org/pdf06/UnsafeAbortion2006.pdf (accessed 10 October 2010).

Messe, N. 2010. Pregnancy termination is sometimes necessary in health.
[Online] Available: http://www.goarticles.com/cgi-bin/showa.cgi?C=3481559 (accessed 10 October 2010).

Mitchell, EMH, Trueman, K, Gabriel, M, Fine, A & Manentsa, N. 2005. Accelerating the pace of progress in South Africa.
[Online] Available: http://www.ipas.org/Publication|assets_upload_file778_3046pdf (accessed 10 October 2010).

Mokgethi, NE, Ehlers, VJ & Van der Merve, MM. 2006. Professional nurses' attitudes towards providing pregnancy services in a tertiary hospital in the North West Province of South Africa. *Curationis* 29(1):32-39.

Morris, K & Orr, F. 2007. Is there a role for psychiatry in late termination of pregnancy? *Australian and New Zealand Journal of Psychiatry* 1(41):709-717.

Morroni, C, Myer, L & Tibazarwa,K. 2006. Knowledge of the abortion legislation among South African women: a cross-sectional study. *Reproductive Health. BioMed Central* 3(7):1-5.

Moule, P & Goodman, M. 2009. *Nursing research*: *an introduction*. London: Sage.

Mushtaq, N. 2008. Ready for new abortion law?
[Online] Available: http://ipsnews.net/africa/nota.asp?idnews=43896 (accessed 20 April 2011).

Myer, L, Rebe, K & Morroni, C. 2007. Missed opportunities to address reproductive health care needs among HIV infected women in antiretroviral therapy pregnancies. *Tropical Medicine and Health* 12(12):1484-1489.

Myser, C. 2008. Ethnographic insights regarding the social role and moral status of the fetus as patient: comparing developed and developing countries. *The American Journal of Bioethics* 8(11):50-52.

Nothnagle, M, Prine, L & Goodman, S. 2008. Benefits of Comprehensive Reproductive Health Education in Family Medicine Residency. *Family Medicine* 40(3):204-207.

Novikova, N, Weisberg, E & Fraser, IS.2009.Does emergency contraception increase women's awareness and use? *The European Journal of Contraception and Reproductive Health Care* 14(1):39-45.

Nwogu-Ikojo, EE & Ezegwui, HU. 2007. Abortion related mortality in a tertiary medical centre in Enugu, Nigeria. *Journal of Obstetrics and Gynaecology* 27(8) 835-837.

Onah, HE, Ogbuokiri, CM, Obi, SN & Oguanuo, TC. 2009. Knowledge, attitudes and practices of private medical practitioners towards abortion and post abortion care in Enugu, South-eastern Nigeria. *Journal of Obstetrics and Gynaecology* 29(5):415-418.

*Oxford Dictionary*. 2005. Oxford: New York.

Palanivelu, LM & Oswal, I. 2007. Contraceptive practices in women with repeat termination of pregnancy. *Journal of Obstetrics and Gynaecology* 27(8):832-834.

Parahoo, K. 2006. *Nursing research: principles, processes and* issues. 2nd edition. New York: Palgrave.

Patel, CJ & Myeni, MC. 2008. Attitudes towards abortion in a sample of South African female university students. *Journal of Applied Social Psychology* 38(31):736-750.

Poggenpoel, M & Myburgh, CPH. 2006. Women's experiences of termination of a pregnancy. *Curationis* 29(1):3-9.

Polit, DF & Beck, CT. 2006. *Essentials of nursing research*: *methods, appraisal and utilisation*. 6th edition. Philadelphia: JB Lippincott.

Polit, DF & Beck, CT. 2008. *Nursing research: generating and assessing evidence for nursing evidence for nursing practice*. 8th edition. Philadelphia: JB Lippincott.

Pud, D & Amit, A. 2005. Anxiety as a predictor of pain magnitude following termination of first-trimester pregnancy. *American Academy of Pain Medicine* 6(2):143-148.

Ralston, M & Podrebarac, E. 2008. Abortion laws around the world. [Online] Available: http://pewforum.org/abortion/abortion-laws-around-the-world.aspx (accessed 20 April 2011).

Rakhudu, MA, Mmelesi, AMM, Myburgh, CPH & Poggenpoel, M. 2006. Exploration of the views of traditional healers regarding the termination of pregnancy law. *Curationis* 29(3):56-60.

Randhawa, S, Hull, T & Herdiyami, R. 2008. Indonesia launches abortion laws reform. [Online] Available: http://www.radioaustralia.net.ac/programguide/strories/200809/s2359165.htm (accessed 17 October 2009).

Rasch, V, Yambesi, F & Massawe, S. 2008. Medium and long-adherence to post abortion contraception among women having experienced unsafe abortion in Dar es Saalam, Tanzania. [Online] Available: http://www.biomedcentral.com/1471-2393/8/32/abstract (accessed 10 October 2008).

Ratlabala, MC, Makofane, MDM & Jali, MN. 2007. Perceptions of adolescents in low resourced areas towards pregnancy and the Choice on Termination of Pregnancy. *Curationis* 30(1):26-31.

Regmi, K & Madison, J. 2009. Ensuring patient satisfaction with second trimester abortion in resource-poor setting. *International Journal of Gynecology and Obstetrics* 108(2010):44-47.

Rowe, HT, Kirkman, M, Hardiman, EA, Mallett, S & Rosenthal, D. 2009. Considering abortion: a 12 month audit of records of women contacting a pregnancy advisory service. *Medical Journal Australia* 190(2):69-72.

Sedgh, G, Bankole, A, Oye-Adeniran, B Adewole, IF, Singh, S & Hussain, R. 2006. Unwanted pregnancy and associated factors among Nigerian women. *International Family Planning Perspectives* 32(4):175-184.

Sedgh, G, Henshaw, SK, Singh, S, Bankole, A & Drescher, J. 2007. Legal abortion worldwide: incidence and recent trends. *Perspectives on Sexual and Reproductive Health* 39(4):216-225.

Smith, J & Scullion, J. 2010. Student experiences in the real world of nursing. *Nursing Standard* 24(19):27.

South Africa. 1975. Abortion and Sterilization Act, no. 2, 1975. Pretoria: Government Printer.

South Africa. 2005. Children's Amendment Act, no. 38, 2005. Pretoria: Government Printer.

South Africa. 1996. The Choice of Termination of Pregnancy Act (no 92 of 1996), as amended by Act no 1 of 2008. Pretoria: Government Printer.

South Africa. 1996. The Constitution of the Republic of South Africa, 1996. Pretoria: Government Printer.

Start, B. 2005. International Family law: an introduction. Burlington: Ashagate.

Statistics South Africa. 2007. Mid-year population estimates by province, gender and age.
[Online] Available: http:findarticles.com/p/articles_mi_m2248/is_157_40_n13774352 (accessed 5 May 2011).

Terre Blanche, M, Durrheim, K, Painter, D. 2010. *Research in practice: applied methods for social sciences*. 2nd edition. Cape Town. University of Cape Town.

*The City Press*. 2007. We need more abortion clinics. 12 August (see annexure H).

*The Mail & Guardian*. 2007. Unsafe abortions still killing Africa's women.
[Online] Available: (accessed 8 March 2007) (see annexure H).

The North West Province. 2007. Department of Health. Annual performance plan. Klerksdorp.

*The Sowetan*. 2009a. Abortion horror. 8 December (see annexure H)
.
*The* Sowetan. 2009b. Unsafe abortions rife among teens. 4 August (see annexure H).

*The Sunday Sun*. 2007. Inner City Abortions. 5 August (see annexure H).

*The Sunday World*. 2009. Think before you abort it. 22 November (see annexure H).

Wainer, J. 2008. Abortion and the struggle to be good in the1970s. *Australia and New Zealand Journal of Psychiatry* 42(8):30-37.

Walden, VR. 2009. The caring process. *International Journal of Human Caring* 13(1):32-38.

Weldon, C. 2010. Emotional effects of having an abortion. The abortion debate continues between pro-life and pro-choice views.
[Online] Available: http://www.suite/101.com/content/emotional-after-effects-of-an-abortion-a20357? Template (accessed 15 October 2010).

WHO. 2007. Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003.
[Online] Available:
http//www.bing.com/search?q=global+and+regional+estimates+of+the+incidence+of+unsafe+abortion+and+associated+deaths (accessed 30 July 2008).

WHO. 2005. Safety and efficiency of existing methods.
[Online] Available: http://www.who.int/reproductive-health/family_planning/_safety.htm (accessed 21 May 2009).

Wikipedia. 2008. Abortion in Poland. [Online] Available: http/en.wikipedia.org/wiki/Abortion_in_Poland (accessed 30 October 200).

Ziyane, IS. 2006. Gender based violence against Swazi women. *Africa Journal of Nursing and Midwifery* 8(1):43-54.

Annexure A

Letters requesting and granting consent to conduct the study from health care authorities

Annexure B

Ethical clearance certificate from UNISA

Annexure C

Consent form to be signed by each participant

# Annexure D

## Interview schedule: Phase I

# Annexure E

# Interview schedule: Phase II

# Annexure F

# Interview schedule: Phase III

# Annexure G

# Letter from statistician

Annexure H

Photocopies of newspaper reports relevant to the study

# Annexure I

# Bill of Rights

# Annexure J

# Guidelines for professional nurses providing TOP services

# Annexure K

# Guidelines for managers in charge of hospital/clinics providing TOP services

# Annexure L

# Proposed in-service training programme for professional nurses providing TOP services

Annexure M

# Proposed programme for counselling and support of women requesting TOP services

**ANNEXURE I**

A “Bill of Rights” that can be used for pregnant women that wishes to make use of TOP services

| Proposed strategies | Recommendations |
|---|---|
| • Right to access information on TOP services. | • The public health facilities managers should ensure that education and awareness on TOP services is done on daily basis by health promoters at the clinics, hospitals and schools. |
| • Right to access TOP services on request. | • The Department of Health should provide flyers, posters and pamphlets indicating clearly the facilities where TOP services can be accessed.<br>• The designated facilities to provide TOPs but which are not functional should be reopened as soon as possible.<br>• The Department of Health should also request slots at the local radio stations to disseminate information on TOP services.<br>• The health services managers should ensure that TOPs is provided daily in TOP facilities.<br>• The waiting list or booking system must be discouraged at all costs.<br>• The health service managers should ensure that they organise workshops for customer care for nurses working in facilities were TOP services are provided. |
| • Right not to be judged. | • Nurses encouraged not to have judgemental attitudes towards women requesting TOP service. |
| • Right to be treated with dignity and respect. | • Nurses to treat pregnant women requesting TOP services with dignity and respect. |
| • Right to privacy and confidentiality. | • It is recommended that information on TOP and women requesting TOP be separated with private and confidential and rooms to be used for TOP clients. |

**ANNEXURE J**

Guidelines for professional nurses providing TOP services

| Proposed strategies | Recommendations |
|---|---|
| • Ensure that nurses have a choice whether or not to work in TOP services. | • That ethical and moral dilemma should be considered when allocating nurses to TOP services.<br>• The supervisors must ensure that they respect the decision of nurses who don't want to be involved in TOP services. |
| • Provide incentives for nurses working in TOP services. | • The management to ensure that the nurses working in TOP services receive more rest day hours. |
| • Ensure that there is a retention strategy for nurses working in TOP services. | • The managers and supervisors to provide support to nurses working in TOP services.<br>• The Department of Health to provide better remuneration for nurses working in TOP services.<br>• The managers and supervisors should ensure that they develop a policy on retention strategy.<br>• That managers provide better conditions of service for nurses working in TOP services . |
| • Encourage team work between nurses working in TOP services and those not working in TOP services. | • The supervisors should encourage those nurses not working in TOP to support and work with those working in TOP as a team.<br>• Management to plan team building exercises or activities. |

**ANNEXURE K**

Guidelines for managers in charge of hospital/clinics providing TOP services

| Proposed strategies | Recommendations |
|---|---|
| • Focus on the good work done by nurses providing TOPs. | • Managers to appreciate nurses working in TOP facilities by giving them tokens of appreciations.<br>• Manager to discuss the statistics and the impact their work have on the community. |
| • Provide feedback to nurses providing TOP on the statistics. | • Managers to have one on one sessions with nurses working in TOP to allow them to converse their frustrations as well as positive aspects of their involvement in TOP services. |
| • Show interest in the work done by nurses providing TOP services. | • Managers to arrange motivational speakers twice a year to encourage nurses working in TOP services.<br>• Managers to provide equipments and human resources to boost the moral of nurses working in TOP services. |
| • Ensure that TOP services information is disseminated. | • To arrange education and awareness campaigns to disseminate information on TOP services to the community in general and other social services providers. |
| • Ensure that counseling and emotional support is provided to the nurses providing TOP services. | • Managers to allow nurses working in TOP services to go for counselling quarterly.<br>• Managers must ensure that nurses receives emotional support .<br>• Debriefing with other colleagues monthly. |

| Proposed strategies | Recommendations |
| --- | --- |
| | • That those nurses who needs counselling services more often should be allowed to do so.<br><br>• Nurses should be allowed to consult with a psychologist of their choice.<br><br>• Nurses should be allowed to take a break for few months not providing TOPs.<br><br>• Managers to look into training lay counsellors to reduce the workload of nurses working in TOP services.<br><br>• Managers to allocate social workers in TOP facilities to assist nurses with counselling services, to women who request TOPs. |

**ANNEXURE L**

Proposed in-service training programme for professional nurses providing TOP services

It is proposed that all professional nurses providing TOP service should attend an annual workshop/training programme consisting out of at least the following sessions:

| | |
|---|---|
| Session 1 | The Choice on Termination of Pregnancy Act, Act 92 of 1996.<br>In this session the professional nurses should be updated on the act and all legal aspects related to the provision of TOPs. |
| Session 2 | Discussion of the pro-choice and pro-life philosophies. |
| Session 3 | Value clarification session |
| Session 4 | Sharing experiences working in TOP services |
| Session 5 | Coping with criticism from nursing colleagues, communities and churches. |

**ANNEXURE M**

Proposed programme for counselling and support or women requesting TOP services

| Proposed strategies | Recommendations |
|---|---|
| • Counselling services to all women requesting TOP services. | • .The supervisors to ensure that pre and post counselling, is done for every women who request TOP services.<br>• The counselling services should be done to all women requesting TOP services before and after TOP services.<br>• That woman should indicate after the counselling services whether they are satisfied or not about the counselling services provided to them on a tool designed by management for that purpose. |
| • Allow womem to make their choice without being judged. | • Pregnant women should not be forced to continue with TOP if they feel after counselling that they want to change their minds not to go ahead with the TOP procedure and should not be judged. |
| • Provide enough information to allow women to make an informed decision. | • The health facilities to provide any information that would assist women to make an informed decision. |
| • Establish support groups for women who had used TOP services.<br>• Educate women on contraceptives. | • That the support groups for those women who had TOP to be established for those who want to participate in support groups and not be forced to belong to support.<br>• Nurses to ensure those women are educated on contraceptive usage and family planning be linked to TOP services. |