EXPERIENCES OF REGISTERED NURSES AT ONE COMMUNITY HEALTH CENTRE NEAR PRETORIA PROVIDING TERMINATION OF PREGNANCY SERVICES

L.R.C. Mamabolo, MA (Health Studies)
University of South Africa
Department of Health Studies

J.E. Tjallinks, M Cur
University of South Africa
Department of Health Studies
Corresponding author: tjallje@unisa.ac.za.

ABSTRACT

Legalising abortion in many countries has given women the choice or right to decide to terminate a pregnancy. In South Africa the Choice on Termination of Pregnancy (CTOP) Act, 92 of 1996, was promulgated in 1997. This legislation promotes reproductive rights including the choice to have an unwanted pregnancy terminated timeously, safely and legally. This exploratory, descriptive and contextual qualitative (phenomenological) study was designed to gain insight into the experiences of registered nurses providing TOP services and to provide relevant recommendations. Participants comprised registered nurses providing TOP services at one community health centre near Pretoria. Registered nurses have the right to refuse to participate in TOPs; those who do provide services could experience psychological trauma.

KEYWORDS: Abortion, Choice on Termination of Pregnancy Act, nurses' rights, nurses' experiences of providing TOP services, registered nurses, South Africa, termination of pregnancy (TOP).

INTRODUCTION AND BACKGROUND

According to a study conducted by the Medical Research Council in 1994, women in need of an abortion found alternative ways to abort if the legal way was inaccessible to them. This study indicated that out of 200 000 back-street abortions that had been performed, 44 686 of these women had to be admitted to South African hospitals. Previously, an estimated 425 women died annually in hospitals from septic abortions (*Microsoft Encarta Encyclopaedia Plus* 2004).

Abortion on request was legalised in South Africa in 1996 (Act 92 of 1996). This Act enabled women from the age of 12 years to terminate their pregnancies before 12 weeks' gestation without the permission of their partners or parents. The Act furthermore

mandated doctors and nurses to perform abortions on request, changing the role of the registered nurse. A registered nurse may perform the TOP procedure if a pregnancy is under twelve weeks' gestation, and she should provide counselling to the patient.

This Act created conflict between personal, moral and professional demands in the health care system. Nurses might have ambivalent feelings about TOPs, based on their personal, moral, religious and professional views. On the one hand, nursing ethical codes expect nurses to respect (preserve) life, to promote health and to alleviate suffering, while on the other hand, the CTOP Act gives pregnant women a choice to terminate their pregnancies, without consent from partners, parents/guardians or family members. These women's rights could have implications for the rights of registered nurses (Knudsen, 2006:1).

The CTOP Act, caused a high demand for TOP services, impacting on the healthcare system. Inadequate numbers of registered nurses and clinics are available to render competent care to the TOP clients. Some registered nurses refuse to be involved in TOP services (Barometer, 2000:7). The CTOP legislation has empowered women to make informed choices, while nurses are governed by an ethical code based on religious and moral grounds: the preservation of life. This dichotomy led to the study on which this article is based. Poggenpoel and Myburgh (2006:3) found little research available on exploring or describing experiences of nurses involved in TOP services in South Africa.

The purpose of the study was to describe and explore the experiences of registered nurses who participated in the TOP procedures, at one clinic near Pretoria.

The following research question was formulated: *What are the experiences of registered nurses who participate in TOP procedures at a community health clinic?*

This was translated for the participants as: *How did you experience participating in termination of pregnancy services; what was it like for you?*

The objectives of the study were to describe the experiences of registered nurses involved in TOP services at one community health centre in Gauteng; gain an understanding of their experiences; and explain how registered nurses coped when actively involved in TOP procedures

LITERATURE REVIEW

Abortion remains a debated and emotional issue in South Africa. Organisations, such as Doctors Against Abortion, oppose the CTOP Act (1996). In South Africa, pro-life nurses and doctors state that preserving and protecting life is what they stand for, not taking the life of another human being. Anti-abortion groups, representing doctors and nurses (Doctors for Life and Nurses for Life), have repeatedly stated their intentions to refuse to participate in TOPs and refuse to refer women to abortion clinics. Some nurses imposed their own beliefs on clients seeking to terminate their pregnancies.

For example, in Bloemfontein a nurse reportedly prayed for women seeking abortions before sending them to an abortion clinic. Three Christian groups, namely the Christian Lawyers Association of South Africa; Christians for Truth in South Africa, and the United Christians Action challenged the CTOP Act in South Africa in court in 1998, based on the argument that human life starts at conception, so abortion terminates the life of a human being (http://en.wikipedia.org/wiki/abortion).

Abortion can be defined as the intentional ending of a pregnancy through the evacuation of the uterus before the foetus has a reasonable chance of survival (Varga, 2002:283-298). Abortion implies foeticide: the intentional destruction of the foetus in the womb, or any untimely delivery brought about with intent to cause the death of the foetus (http://en.wikipedia.org/wiki/Reproductive_rights). According to pro-life groups, human life begins from the moment of conception, so abortion is the murder of a defenceless human being (http://en.wikipedia.org/wiki/Reproductive_rights). For the purpose of this article, abortion was defined as the separation and expulsion, by medical or surgical means of the contents of the uterus of a pregnant woman (Choice on Termination of Pregnancy Act, 92 of 1996).

Registered nurses in South Africa can perform TOPs up to twelve weeks' gestation. Policies have been developed to train nurses for the procedure, but its implementation remains problematic. This could be due to nurses' negative attitudes towards TOPs. Valuing is part of being human, thus the morality of abortion could cause ethical dilemmas to society and individuals. Religious issues influence people's beliefs and values. Moral arguments against abortion depend on the theological status of the foetus and its potential right to life, versus the view that a foetus has not yet attained personhood (Barometer, 2002:4).

A professional code of ethics, based on personal morality, is regarded as the key to a safe practice (Searle, Human & Mogotlane, 2009:266). Nurses must observe the norms of their profession, such as the conservation of life, loyalty to patients and colleagues, and adherence to the law (Searle et al., 2009:267). Nurses find themselves in a dilemma, as the ethical code stipulates that they should preserve life. In terms of the Nursing Act, 10 of 1997 and its related regulations, the nurse also has a professional and ethical obligation to nurse the patient before and after the TOP procedure, despite conscientious objections to TOPs. The principle of unconditional acceptance should be adhered to. Nurses should accept the woman who chooses to have a TOP and view her as someone in need of care. Although the nurse may not agree with the woman's choice, the woman should be nursed within her own frame of reference and not the nurse's (Searle et al., 2009:122). The study thus explored the experiences of registered nurses providing TOP services.

SIGNIFICANCE OF THE STUDY

The significance of the study relates to its "potential for contributing to, and extending, the scientific body of nursing knowledge" (LoBiondo-Wood & Haber, 2002:56). Findings of this study could improve education as well as management and research, pertaining to the needs of registered nurses. The findings of the study will facilitate the formulation of guidelines for registered nurses involved in previous termination of pregnancy services. Equipping registered nurses with counselling,coping skills and competencies will strengthen and advance their nursing skills working with TOP clients. The study could influence collaboration between nursing and other health support systems subsequently affecting care given to clients utilising TOP services.

The study could enlighten nurse managers and policy-makers on the experiences of registered nurses providing TOP services. Results of the study could enable primary healthcare services to improve the quality of TOP services.

RESEARCH DESIGN AND METHODOLOGY

An exploratory, descriptive and contextual qualitative study was chosen because it attempted to describe human experiences of nurses providing TOP services (Brink, 2006:119). The researcher adopted a phenomenological approach to examine nurses' human experiences through their descriptions of providing TOP services. These experiences are called 'lived experiences'.

Qualitative research involves the systematic collection and analysis of subjective data provided by involved people about the phenomena, including how they interpret the experiences and meaning attached to the experience (Brink, 2006:119).

Population and sample

The population comprised all registered nurses employed at one community health centre. The researcher used non-probability purposive sampling, implying judgmental sampling that involves the conscious selection by the researcher of certain participants (Burns & Grove, 2005:352). The participants chosen met the following eligibility criteria: be trained in TOP management and have worked in TOP services at the participating clinic for more than one year;

Participants were experts in providing TOP services (Polit & Beck, 2008:357). The size of the sample was considered satisfactory when data saturation was reached, implying that no new information was forthcoming during subsequent interviews (Polit & Beck, 2008:358). Predetermination of the number of participants was therefore impossible (Streubert Speziale & Carpenter, 2007:29).

Ethical principles

The researcher considered the rights of the participants (Streubert Speziale & Carpenter, 2007:66-67). The interviewer established trust between herself and the participants respected them as autonomous beings, thus enabling them to make sound decisions (Burns & Grove, 2005:83; Streubert Speziale & Carpenter, 2007:59-61). Ethical principles adhered to included participants' informed consent, confidentiality, anonymity and protection from harm. Participants knew they could withdraw from the study at any stage without incurring negative consequenaces. If emotional issues should arise, participants would be referred to a professional counsellor. Audio-taped interviews would be destroyed once transcribed. Transcriptions were kept in a locked cupboard at the researcher's home.

DATA COLLECTION

Data were gathered by means of phenomenological interviews (Kvale, 1996:81-107). The interviews focused on the lived experiences of each participant. The researcher used reflexivity, bracketing and intuiting to exclude preconceptions of the phenomenon in order to enter the world of the participants with an open mind.

One broad question was asked: "How did you experience participating in the procedure of termination of pregnancy at this community health centre?" The interviewer created a context for the participants to speak freely and openly by utilising communication techniques such as clarification, paraphrasing, summarising, probing, and minimal verbal and non-verbal responses. The researcher did so to prevent the participants from feeling that they were being "cross-examined" on the topic (Burns & Grove, 2005:85).

Participants' permission was obtained to audio-tape interviews. Comprehensive and accurate description was achieved by adding handwritten notes to the verbatim-transcribed accounts (Streubert Speziale & Carpenter, 2007:212). During the interviews, the interviewer used bracketing (placing preconceived ideas aside) and intuiting (focusing on the lived experience of the participants regarding the termination of a pregnancy). The researcher continued interviewing participants until data saturation was reached as demonstrated by repeated themes.

DATA ANALYSIS

Qualitative data analysis was conducted with rigour and care (Polit & Beck, 2008:508). *Rigour* in qualitative research refers to striving for excellence and is associated with discipline, scrupulous adherence and strict accuracy (Burns & Grove, 2005:55). Data were descriptively analysed, using Tesch's method of descriptive analysis (Creswell. 1994:154-156). An independent coder analysed the data independently (Creswell, 1994:158; Krefting, 1990:216). .

Data were broken down into manageable categories, subcategories and meaning units. Categories reflected definite patterns of the participants' experiences and feelings regarding their involvement in TOPs. Themes were derived from the in-depth interviews conducted with three participants, namely affective responses, cognitive and perceptual views. Categories and subcategories were present in each theme. Consensus discussions between the independent coder and the researcher identified themes, which were redefined. A literature control was done to verify the results (Polit & Beck, 2008:105-106).

Measures to ensure trustworthiness

Measures to ensure trustworthiness were applied. Guba's (Lincoln & Guba, 1985:290-327) strategies of credibility, transferability, dependability and conformability were applied. Activities in achieving credibility were prolonged engagement in the filed, keeping reflexive journals, the researcher's authority, peer reviews and structural coherence. Transferability was achieved through dense description of the data and purposive sampling. Dependability was achieved by a description of the method of data gathering, data analysis and interpretation. Confirmability was achieved by ensuring auditing of the entire research process and reflexive analysis.

DATA STRUCTURE AND FINDINGS

The structure of the data consisted of 6 themes; 8 major categories; 18 subcategories and 45 meaning units

Table 1 represents an overview of the structure of the data as it emerged during data analysis illustrating the themes and categories. Discussion was based on schematic condensation of data in the table, and highlighted by direct quotations from the participants and relevant literature.

Table 1 Data themes and categories

1	Theme 1:	Emotional and psychological trauma
	1.1	Frustration
	1.2	Stress
	1.3	Being labelled
	1.4	Feelings of rejection
2	Theme 2:	Lack of resources
	2.1	Extra-personal resources
	2.2	Personal resources
3	Theme 3:	Lack of support
4	Theme 4:	Debriefing
5	Theme 5:	Positive experiences
	5.1	Support system
	5.2	Feelings of sympathy
6	Theme 6:	Concern for uninformed colleagues

Theme 1: Emotional and psychological trauma

The following categories were identified: frustration, stress, being labelled and feelings of rejection, related to the feelings of the TOP providers.

Category 1: Frustration

TOP providers felt frustrated when involved in TOP services. One sub-category identified that the providers were frustrated about the prevailing situation. The following statement highlighted this aspect: *"Oh, very much frustrating, especially when I have to make a decision"*. This experience was supported by Dondashe (2001:47) who reported that one registered nurse expressed her frustration by stating: "I find it very frustrating when I see a young girl of 12 years signing without parental consent".

Frustration is a feeling of being thwarted, characterised by interference with ongoing behaviour. Frustration is applied to the feeling of being unable to exert any influence on an outcome (Sørlie, Kihlgren & Kihlgren, 2005:137).

Category 2: Stress

Participants experienced stress in the TOP unit, highlighted as: *"What disturbs me most is when you terminate someone when the procedure takes long"*. A second sub-category of stress was described as follows: *"What affects me most is when the client breaks down, because most of the time they decide to do termination of pregnancy but there's a stage where they are emotionally affected"*.

Dyson and White (1999:478) found that nurses dealing with TOPs experienced stress. Nurses providing daily counselling and performing TOPs experienced heavy emotional effects (Mariner Tomey, 2004:37-38). Stress is the way that a person responds to the environmental demands of pressures. Stress is provoked by the fact that one cannot manage the demands being made. A certain degree of stress is a normal part of everyday life, but when stress becomes constant, it can lead to physical or mental problems (Mariner Tomey, 2004:29-30).

Category 3: Being labelled

Registered nurses involved in TOP services, experience two types of labelling: perceived and received labelling. Perceived labelling is when a person feels that he/she is being labelled, while received labelling is when he/she is called names. Quotations demonstrate perceived and received labels: *"You know killing and doing all these diabolical things that people are talking about... Because they are already obsessed with their feeling that you are a killer, finished and klaar"*. "*Some of them are calling us serial killers ... They will keep saying we are killing children and stuff like that"*.

Labelling means attaching linguistic symbols to a person's behaviour. Labels influence a person's behaviour as well as people's perceptions of and reactions to the label bearer

(Sørlie et al., 2005:137). Dondashe (2001:49) found participants were called 'names' for taking part in TOPs.

Category 4: Feelings of rejection:

TOP providers felt rejected by colleagues, due to negative comments, as stated: *"The talking, you know, most of the time when you are around them, they have to talk about TOP and everything that is bad about it, you know"*. Engelbrecht, Pelser, Ngwena and Van Rensburg (2000:6) pointed out that health care workers display hostility towards those providing TOP services. TOP providers felt rejected by colleagues due to being involved in TOPs.

Theme 2: Lack of resources

The second major theme related to the lack of resources in the clinics where TOPs were provided. Deficiencies that hampered efficient service delivery were extra-personal (environmental) resources or personal (human) resources.

Category 1: Extra-personal resources:

One quotation highlights this aspect "*So suctions that we are having are mobile suctions and ….mobile equipments you have to move them around, unlike syringes whereby you just, you know, use it"*. Extra-personal resources were material resources needed to achieve effective TOPs, including the equipment used. Sufficient and suitable equipment should be made available for improved service delivery, such as ultrasound machines to assess gestational age (*Barometer,* 2002:18).

Category 2: Personal resources

Participants expressed this experience as "*I think the first thing is that of human resources. It's a general problem but I think more people should be trained, especially those who are interested in doing the service"*. Personal resources mean the workforce involved in TOP. In South Africa, inadequate human resource capacities are allocated to the provision of the service, resulting in high stress levels and burnout (*Barometer,* 2002:5).

Theme 3: Lack of support

This theme included the participants' experience of lack of support from colleagues and management.

Category 1: Lack of support from colleagues

Participants stated: *"Our colleagues don't support us"*.

Category 2: Lack of support from managers

These experiences were reported as: *"I think support from colleagues and support from the managers especially, because if a manager doesn't support you, how can you*

expect colleagues to support you?" Support is a category of verbal communication that is person-enhancing, involving positive, facilitative and respectful statements that communicate the worth of another person (Yoder-Wise, 2007: 541). Management should ensure a safe and secure environment for TOP providers to feel valued and appreciated (Jooste, 2003:332).

Theme 4: Debriefing

Among issues to conduct the study was the lack of debriefing for TOP providers. Participants referred to this experience:

Category 1: Formal debriefing

"*Once a month there is a debriefing session at the region where TOP providers meet monthly and there's a psychologist*".

Category 2: Informal debriefing

"At the present moment it was just discussion and sharing amongst ourselves".

Category 3: Emergency debriefing

"To some extent it is, but at times you will find that you need an immediate debriefing because the emotional issues have got to do with termination of pregnancy".

Category 4: Problems with debriefing

"*Especially midwives should have access to a psychologist any time, especially when she's emotionally affected, there and then".* Debriefing means a discussion held after an intense event or catastrophe where all aspects of the events are discussed and analysed (Steele & Beadle, 2003:131-136). The main aim of debriefing is for nurses to share feelings, assess their strengths and find new meaning in everyday experiences, feeling supported (Sørlie et al., 2005:139).

Theme 5: Positive experiences

Despite mainly negative experiences, the nurses expressed some positive reactions. Two main categories emerged from the data: support systems in place and feelings of sympathy for clients.

Category 1: Support systems: professional

This was expressed as *"We've got a psychologist whom you can tell, eh, your problems. She is able to listen".*

Category 2: Support systems: collegial

One participant reported her experience *" He is always there to check on us for the fact that he comes and shows interest in what we are doing, how we are coping*".

Category 3: Feelings of sympathy

TOP providers felt sympathy for clients. Experiences were "Some *people, when you look at them, you may find that it will be difficult, it will be difficult for them to cope"* and *"I become a little more sympathetic"*. Dondashe (2001:40) found that TOP providers supported the clients emotionally and assisted them to find meaning in their experiences.

Theme 6: Concern of uninformed colleagues

This theme referred to the lack of information that other registered nurses and staff had regarding TOP issues. This experience was portrayed as "*They need to be educated because most of them don't actually know what is happening and they don't even have interest"*.

Dondashe (2001:44) emphasises the importance of training other health care workers to understand TOP-related issues, including training modules for different levels of nurses (Warenius, Faxelid, Chishimba, Musandu, Ong'any & Nissen, 2006: 124). Nurses should be informed about their right not to participate in TOP if it violates their morality. In such a case, nurses have a responsibility to inform the employer in writing of their conscientious objection to participating in the TOP services (Pera & Van Tonder, 2005:84).

CONCLUSIONS

Registered nurses involved in TOPs experienced mixed feelings, such as rejection, depression and stress. They used available coping mechanisms to handle their stress levels. Each registered nurse needed to find a way of dealing with her feelings after TOP. Most of them talked to each other about their experiences.

The nurses required counselling and psychological support to perform according to their professional standards. Planned psychological support services should be provided as part of TOP services, ensuring counselling to TOP health care providers on an ongoing basis (*Barometer,* 2002:17).

Registered nurses, who described involvement in TOP as emotionally draining, experienced inadequate support from management. They were overwhelmed by their work and the emotional burden they had to carry. They expressed a need for help with the stress they were experiencing and longed for more support from management and acceptance by their peers, in spite of being involved in TOPs. Positive attitudes, without prejudice, toward TOPs by all health care workers would benefit TOP programmes (*Barometer,* 2002:14).

RECOMMENDATIONS

Quality of care in TOP services can be improved by addressing problems at all levels, including management, service providers and communities, in the management of the TOP providers' needs for counselling, the provision of human and material resources, support from management, and collegial support.

Nurse managers should

- undergo TOP training to enhance their understanding to promote effective management
- provide support through allocating adequate human and material resources to TOP services
- encourage an open-door policy for TOP providers to get help whenever needed
- implement counselling and support guidelines to empower registered nurses involved in TOPs
- provide psychological and social support mechanisms as an integral part of TOP services through available social workers and psychologists
- implement strategies to address logistical problems of capacity and burnout.
- train more TOP providers to enable a relief system to operate
- increase TOP providers with incentives in the form of 'scarce skills' allowances to work in the TOP services
- integrate TOP into the health care system instead of being regarded as a stand-alone service.
- provide nurses with TOP in-service training to enhance their understanding of and support for TOP services
- give TOP information to community members to encourage informed decision-making
- monitor service provision through quarterly reviews to check adherence to set standards, availability of TOP equipment and availability of psychological support
- maintain quality control protocols, such as quarterly TOP reviews and psychological assessment tools, to ensure that a holistic service is rendered (Cronje & Grobler, 2003:75; Jooste, 2003:217).

Nursing education programmes should train nurses about TOP services, including that:

- nurses must be informed about their rights to participate or refuse participating in TOP services (Pera & Van Tonder, 2005:84)

- ethical decision-making skills should be addressed
- a module to develop reflective skills should be incorporated in the course content to identify defence mechanisms they might use to cope with emotional responses, helping them to develop effective ways of managing stress levels
- TOP providers should enhance their coping skills and assertiveness levels through in-service education, seminars or workshops to develop a more positive attitude towards TOPs
- values clarification workshops should be organised to gain knowledge of the concerns of registered nurses and to assist them to relate their values and belief systems to the needs of the clients (Warenius et al., 2006:126).

Ensuring the implementation of the CTOP Act's stipulations, and providing effective and efficient TOP services, could benefit from:

- orgnanising support groups of nurses involved in TOP (Yoder-Wise, 2007:541) with support from management. In support groups nurses could share their feelings, concerns, hopes and values, and stereotypes could be broken down. Trust and empathy need to be fostered (Zuzelo, 2007:345-347). The group members would have an opportunity to explore their own personal world and reflect on their experiences (Jooste, 2003:158-159).
- In *Barometer* (2002:17), it is suggested that through the involvement of a social worker and psychologist, structures and interventions for health care providers can be built into their curriculum to enhance peer support structures. Such structures should include: sharing of information and experiences; peer learning on dealing with obstacles at institutional and personal level; building solidarity between those involved in TOPs and building an enabling social context for service delivery and debriefing sessions

LIMITATIONS

During the data collection and analysis the following limitations were identified:

- Two participants in the study resigned, they could not be asked further questions nor could they be contacted to clarify the data collected.
- The qualitative study relied on the researchers' judgments of data collection and analysis. Interviews were used to collect data. Bias was minimised by the utlisation of an expert coder and strategies such as trustworthiness, reflexivity, bracketing and intuiting throughout the study.

CONCLUSIONS

Registered nurses involved in TOP services, experienced stress as a result of rejection, labelling, lack of resources and support from peers and management. Debriefing sessions were inadequate and/or unavailable. Professional nurses were not informed about some TOP-related issues and needed some values clarification sessions. Management should support TOP providers and keep abreast of TOP issues.

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