

**EXPERIENCES OF REGISTERED MIDWIVES PERFORMING
TERMINATION OF PREGNANCY AT POLOKWANE / MANKWENG
HOSPITAL COMPLEX IN LIMPOPO PROVINCE**

by

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*A mini-dissertation submitted in partial fulfilment of the
requirements for the degree*

Master of Public Health (MPH)

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DECLARATION

I, **Tshwene Josephine Gwangwa**, declare that the mini-dissertation **“Experiences of Registered Midwives Performing Termination of Pregnancy at Polokwane / Mankweng Hospital Complex in Limpopo Province”** hereby submitted for the degree Master of Public Health (MPH) at the University of Limpopo has not been submitted previously by me at this or any other university, that it is my own work in design and in execution, and that the sources that I have quoted have been indicated and acknowledged by means of complete references.

Tshwene Josephine Gwangwa :

.....

Date Signed :

.....

DEDICATION

This mini-dissertation is dedicated to my late parents, Kwena Junias, Tlou Rosina Manamela and mother in law Mokibelo Hellen Gwangwa. May their souls rest in peace. I would also like to pay tribute to my beloved husband, Matthews Lesiba Gwangwa, for his unconditional love, support and comfort, and my sons, Nhlake and Thabo Gwangwa, for their love and continuous support throughout my studies.

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ABSTRACT

Legalising Termination of Pregnancy (TOP) in South Africa has given women the choice to decide to terminate an unwanted pregnancy. The implementation of the Choice on Termination of Pregnancy (CTOP) Act No. 92 of 1996 which was promulgated in 1997 engendered many challenges for the registered midwives performing TOP. A qualitative phenomenological study was conducted to explore and describe the experiences of registered midwives performing TOP at Polokwane / Mankweng Hospital Complex, which is one of the public hospitals in Limpopo Province. Registered midwives with 12 months or more experience in the TOP clinics participated in this study. Interviews were conducted with the participants. The audiotaped interviews and observational notes were transcribed and coded using Tesch's qualitative and systematic approach of analysing textual data. The major themes that emerged from the data analysis include lack of resources, emotional and psychological trauma, lack of support, religious and cultural beliefs, blaming and coping mechanisms. Several sub-themes were identified that reflected the themes in greater detail. These were shortage of human and material resources, stress and frustration of midwives, rejection and labelling of midwives performing TOP, conscientious objection, cultural beliefs, lack of support by colleagues and management, failure by the community to use contraceptives, self-blaming, debriefing to assist registered midwives and self-acceptance. Guidelines based on contextualisation of these themes and sub-themes to improve identified challenges included retention of personnel through recognition and incentives, increase budgeting for essential equipment, planned debriefing sessions, promotion of positive attitudes by colleagues and intense training on reproductive health, including TOP.

Keywords: abortion, termination of pregnancy, pregnancy, registered midwife, experience, challenges performing termination of pregnancy, conscientious objection.

LIST OF ABBREVIATIONS

CTOP	Choice on Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NDoH	National Department of Health
SANC	South African Nursing Council
TOP	Termination of Pregnancy
UN	United Nations
WHO	World Health Organization

DEFINITION OF CONCEPTS

Pregnancy

Pregnancy is the process comprising the growth and development of a new individual within a woman's uterus from conception through foetal period to birth (Anderson, 2002). Pregnancy is divided into three periods of three-month intervals called trimesters. The law permits termination of pregnancy up to 12 weeks which is referred to as the first trimester (Anderson, 2002).

Termination Of Pregnancy

Termination of pregnancy (TOP) means the separation and expulsion by medical or surgical means of the contents of the uterus of a pregnant woman (South Africa, 1996). It is done on the request of an individual or for medical reasons such as chromosomal abnormalities. In this study, TOP is referred to as an intentional act to terminate pregnancy on the request of an individual.

Registered Midwife

A person who is qualified and competent to independently practice midwifery in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (South Africa, 2005). In this study, a registered midwife is referred to as a midwife who has undergone the midwifery abortion care training programme which was introduced during the passing of Choice on Termination of Pregnancy Act (CTOP Act No. 92, 1996).

Experience

A person who is qualified and competent to independently practice midwifery in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (South Africa, 2005). In this study, a registered midwife is referred to as a midwife who has undergone the midwifery abortion care training programme which was introduced during the passing of Choice on Termination of Pregnancy Act (CTOP Act No. 92, 1996).

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction

The transition to democracy in South Africa created an opportunity for politicians to demonstrate their commitment to gender equality and ending discrimination in public health. A new Bill of Rights was passed, which insisted on gender equality and on the right to health, including reproductive health and necessitated the passing of Termination of Pregnancy (TOP) Act No. 92 of 1996 (South Africa, 1996) as amended by Termination of Pregnancy Act No. 1 of 2008. According to the World Health Organization (WHO, 2003), it is clear that the South African government is committed to working towards making TOP services accessible to all women, irrespective of colour or social standing. Under the new Constitution (Act No. 108 of 1996) which recognises gender and reproductive rights, it became possible to obtain TOP services on request (South Africa, 1996).

In South Africa, the Choice on Termination of Pregnancy (CTOP) Act (Act No. 92 of 1996) came into operation in February 1997. Women have the right to terminate their pregnancies on request during the first 12 weeks of pregnancy. The CTOP Act No. 92 of 1996, as amended, provides for reproduction rights of women and extends freedom of choice by affording all pregnant women the right to choose to have TOP without the permission of their parents or partners (South Africa, 1996). Before the legalization of the CTOP Act, TOP was considered a criminal act in South Africa and was regulated through the Abortion and Sterilization Act No. 2 of 1975 (South Africa, 1975). This Act also justified therapeutic abortion if pregnancy resulted from rape, incest, a grossly abnormal foetus or continuing pregnancy that poses a danger to the woman's physical or mental health.

The CTOP Act No. 92 of 1996, as amended, allows only medical doctors to perform TOP above 12 weeks up to 20 weeks, if continuing pregnancy poses a threat to the woman's physical and mental health (South Africa, 1996). Over the past 10 years there has been improvement in the safety of TOP procedures and access to treatment for complications resulting from "back street" abortions in developing countries such as the United States (Jewkes, Rees, Dickan, Brown & Levin, 2005).

The improvements in the safety of TOP procedures such as Manual Vacuum Aspiration (MVA) are also observed in South Africa since the CTOP Act No. 92 of 1996 was passed. The availability of trained midwives to perform TOP had a dramatic impact on the performance of safe procedures, including MVA which is safer than sharp curettage. WHO recommends MVA as the preferred method for uterine evacuation because it is safer, faster, more comfortable, and associated with a shorter hospital stay over. It is also the simplest yet effective technique that allows a qualified health provider to perform TOP in a treatment room (WHO, 2003). MVA is used to perform TOP for women who are below 12 weeks pregnant.

Unsafe abortion is a preventable cause of maternal deaths globally (Benson, Andersen & Sumandari, 2011). Reducing the morbidity and mortality of women with regard to childbirth in South Africa is one of the ten strategic objectives of the National Department of Health (NDoH). The CTOP Act is one of the many preventative mechanisms put in place to reduce illness and death of pregnant women in South Africa (Department of Health, 2004). Worldwide, an estimated 68000 women die as a result of complications from unsafe TOP (back street) every year (WHO, 2003).

It has been noted that the TOP rate is rising yearly, especially after the law was passed in South Africa. In Limpopo Province, the rate of TOP increased from 6.1 per 1000 in 1997 to 53.8 per 1000 in 2007 (Statistics South Africa, 2008). This is a clear indication that the TOP rate was increasing after the law had been passed. Challenges exist in the further expansion of services due to shortage of trained TOP service providers despite the increased demand for

and utilisation of TOP services. Furthermore, the few available TOP service providers cannot cope with the number of clients who seek TOP. South Africa has trained registered midwives to perform first trimester TOP to improve access to safe TOP services (South Africa, 1996).

Mobility of trained registered midwives from Limpopo to other provinces within South Africa or through migration to other countries affects the number of TOP service providers. The NDoH stipulates that the number of public institutions performing TOP is also declining due to shortage of TOP service providers. There is a concern that the rise in maternal deaths might be related to a shortage of TOP providers (South Africa, 2007).

The CTOP Act makes allowance for health care providers to conscientious objection (Naylor & O'Sullivan, 2005). The right to object to perform TOP is supported by the constitutional rights of all South Africans to freedom of thought, belief and opinion. The conscientious objection clause in the CTOP Act No. 92 of 1996 allows health care workers to refuse to perform TOP based on their personal beliefs and religious practices (South Africa, 1996).

1.2 Research Problem

There appears to be an increase in the number of clients seeking TOP at Polokwane / Mankweng Hospital Complex in Limpopo Province after the TOP law was passed in 1997. The percentage of TOP performed at hospitals in Limpopo Province increased from 0.6 percent in 1997 to 5.1 percent in 2007 (Statistics South Africa, 2008). The attitudes of health care workers and the community make access to TOP services difficult because the community are afraid of the stigma that is attached to the community members who perform TOP as they are labelled killers or murderers by the very community in which they live. Registered midwives are also viewed as murderers by their colleagues who object to TOP. Little is known about the personal and professional experiences of registered midwives who are currently working as TOP service providers at Polokwane / Mankweng Hospital Complex. Lack of information on the experiences of registered midwives performing TOP

prompted the researcher to explore their experiences when performing TOP.

1.3 Research Questions

In his study, the following research questions were asked?

- What are the experiences of registered midwives performing TOP?
- What are the guidelines that can be used to assist registered midwives when performing TOP?

1.4 Aim of the Study

The aim of the study was to determine what is experienced by registered midwives performing TOP at Polokwane / Mankweng Hospital Complex, which is one of the public hospitals in the Limpopo Province.

1.5 Objectives of the Study

The objectives of the study were to:

- Explore and describe the experiences of registered midwives performing TOP.
- Determine guidelines that can be used by registered midwives performing TOP.

1.6 Research Method

Qualitative research is the term used for a number of diverse approaches which seek to understand by means of exploration, human experiences, perceptions, motivation beliefs and behaviour. In this study the researcher explored the experiences of participants performing TOP.

A qualitative, explorative and descriptive study approach using a phenomenological design was used in this study. Qualitative research is a

systematic, interactive, subjective approach used to describe and give meaning to life experiences. Qualitative research is conducted to describe and promote the understanding of human experiences such as pain, comfort and caring (Polit, Beck & Hungler, 2001).

The qualitative explorative approach is a means to understand perceptions and actions of participants. The purpose of exploration is to gain better understanding of how people think and to explain their behaviour as individuals and as a part of a group (Parahoo, 2006).

The descriptive research provides an accurate portrayal of characteristics of a particular approach of an individual or a situation. Descriptive research is a way of discovering new meaning, describing what exists or determines the frequency with which something occurs and categorizing information. Descriptive studies are conducted when little is known about a phenomenon (Burns & Groove, 2005).

1.6.1 Study Site

The study was carried out at Polokwane / Mankweng Hospital Complex. The complex has two hospital campuses which are about 30 km apart. Mankweng Hospital is situated 2 km from the University of Limpopo - Turfloop Campus. The Polokwane Hospital is situated 3 km east of the Polokwane city centre. The study focused on the reproductive health clinics where TOP is performed. Services offered at the reproductive health clinic include the following:

- Fertility control for both males and females
- Gynaecological operations and oncology
- The average number of clients who seek TOP service per month is eighty (80)
- Average TOP performed is forty five (45) per month
- The number of registered midwives performing TOP is seven (7)
- The ratio is one (1) registered midwife to six (6) clients per month

1.6.2 Study Design

A phenomenological approach was used in this study. Phenomenology stresses the notion that only those who experience phenomena are capable of communicating its meaning to the outside world (Parahoo, 2006). The design is considered suitable for obtaining insight into human experiences. The focus is to obtain information that would facilitate understanding of the registered midwife's experiences whilst performing TOP (de Vos, Strydom, Fouche & Delport, 2004). Participants were given a chance to relate their own experiences when performing TOP during semi-structured interviews at the study site/clinic.

1.6.3 Population

Burns & Grove (2005) define population as all the elements (individual, objects, events or substances) that meet sample criteria for inclusion in the study. The population in this study consisted of all 10 registered midwives performing TOP in the reproductive health clinics at Polokwane / Mankweng Hospital Complex.

1.6.4 Sampling and Inclusion Criteria

The sample was a non-probability purposive type. In non-probability sampling not every member of the population has an opportunity of being selected to participate in the study (Burns & Groove, 2005). Only those who met the inclusion criteria are selected. Purposive or selective sampling involves the conscious selection of participants to be included in the study. In purposive sampling the researcher selects the participants on purpose because the participants have enough experience and abilities to answer the research questions (Parahoo, 2006). In this study the participants who were selected were those who met the inclusion criteria. The sample size was determined by saturation of data and not statistically determined (de Vos et al, 2004). Data saturation is the point at which new data no longer emerge during the data

collection process (Brink, van der Walt & van Rensburg, 2006). The participants were working in the reproductive health clinic for a period of 12 months or more. This period was selected as the minimum period that was extensive enough to gather information. Participants were willing to share their experiences with the researcher.

1.6.5 Data Collection

A phenomenological study uses an interview as a tool to collect data. The researcher used an interview to collect data from registered midwives performing TOP at Polokwane / Mankweng Hospital Complex. Semi-structured interviews were used. During a semi-structured interview, the interviewer asked specific questions, but can also pose additional probing questions (Brink, van der Walt & Wood, 2012). An interview involves verbal communication between the researcher and the participants, during which information is provided to the researcher (Burns & Grove, 2005). One-to-one interviews were conducted. The registered midwives shared with the researcher their experiences regarding performance of TOP at Polokwane / Mankweng Hospital Complex. The researcher probed for more information after having posed the main question while encouraging the interviewee to talk freely (Parahoo, 2006).

1.6.5.1 Pre-Testing the Instrument

The instrument developed needs to be pre-tested on participants similar to those who will be used in the study so that the researcher can identify problems in the design of the questions (Burns & Grove, 2007). The instrument was pre- tested at the reproductive health clinic of Rethabile Health centre. Pre-testing the instrument assisted the researcher in the adjustments of the methods and techniques employed in the study.

1.6.5.2 Field Notes

Field notes are notes taken by the researcher regarding the unstructured

observations made during the internal process and the interpretations of the observations (Polit & Beck, 2012). The researcher used an audiotape recorder to capture data and also wrote down the participant's responses.

1.6.6 Data Analysis

Data from the audiotape recordings were transcribed and analysis was done by using the open-coding method designed by Tesch, an approach in which eight steps were followed as outlined in Creswell (2009). Open-coding is the process of breaking down, examining, comparing, conceptualizing and categorizing data. The following steps were used during data analysis:

- Transcriptions from the audiotape recorder and field notes were carefully read to get a sense of the whole and some ideas jotted down as they came to mind.
- An informative interview document was picked and perused, and the researcher asked herself, "What is this about?" and wrote thoughts in the margin.
- When this task was completed for several participants, a list of all topics was made. Similar topics were clustered together. These topics were formed into columns as major topics, unique topics and residuals.
- The list was taken back to the data. Topics were abbreviated, coded and written next to the appropriate segment of the text.
- The most descriptive wording for the topics were found and turned into categories, related topics were grouped and lines drawn between categories to show interrelationships.
- A final decision on the abbreviation for each category was made and coded.
- Data material belonging to each category was assembled in one place and preliminary analysis performed.
- The existing data were recoded.

1.7 Measures to Ensure Trustworthiness

Trustworthiness is one of the strengths of qualitative research, and it is based on determining whether the findings are accurate from the standpoint of the researcher and participants (Creswell, 2009). The researcher used Lincoln & Guba's model (1985) which identifies criteria for establishing the trustworthiness, namely:

- Credibility
- Dependability
- Transferability
- Confirmability

These criteria are described in Chapter 3.

1.8 Significance of the Study

The findings of this study may have implications and applications with regard to:

- Helping the employer to understand the experiences of registered midwives performing TOP and to provide support where needed.
- Improving education and training of registered midwives in the management of TOP services.
- Facilitating the review of guidelines for registered midwives performing TOP.

1.9 Ethical Considerations

When human beings are used as participants in scientific investigation, care must be exercised in ensuring that their rights are protected (Polit & Hungler, 2003).

1.9.1 Permission to Conduct the Study

Approval for the study was obtained from University of Limpopo - Turfloop Campus Senior Degrees Research Committee. The Medunsa Research and Ethics Committee (MREC) gave ethical clearance (Appendix 6) and Department of Health in Limpopo Province granted permission to conduct the study (Appendix 7) and Polokwane / Mankweng Hospital Complex Ethics Committee provided ethical clearance (Appendix 9) and the permission to collect data were obtained from the Chief Executive Officer of Polokwane / Mankweng Hospital Complex (Appendix 8).

1.9.2 Privacy

The registered midwives working in the reproductive health clinics where TOP is performed were briefed about the study that will take place. The researcher assessed the physical area and ensured the privacy for participants. Interviews were conducted in a private room away from distractions.

1.9.3 Anonymity and Confidentiality

Confidentiality is the researcher's management of private information shared by the participants and the researcher. Complete anonymity exists if the participant's identity cannot be linked, even by the researcher, to the participant's name. Anonymity and confidentiality were maintained throughout the study by using codes and not revealing the identity of the participants (Burns & Groove, 2007).

1.9.4 Informed Consent

Participants were informed about the aim and the purpose of the study. Written consent was obtained from the study participants before being interviewed (Appendix 4). Participation was voluntarily and participants were reassured that they would not be victimized if they refused to participate and could withdraw from the study at any time if they so wished (Burns & Grove,

2009). Permission to use an audiotape recorder and field notes during data collection was obtained from participants and the importance of using such devices during data collection was explained to them (Burns & Groove, 2009).

1.10 Outline of the Chapters

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

Chapter 2 covers the literature review in the context of the research undertaken.

Chapter 3 describes the research methodology and study design used.

Chapter 4 discusses the findings in relation to the literature control.

Chapter 5 provides a discussion of the results, guidelines, limitations, and recommendations in the context of the aims and objectives of the study.

1.11 Conclusion

This chapter provided an overview of the study, statement of the problem, research, problem, research questions and objectives, methodology, significance of the study and ethical considerations. Chapter 2 encompasses the literature review.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Chapter 1 presented an overview of the study. This chapter embodies the literature review. According to Burns & Grove (2005), a literature review is a process that involves finding, reading, understanding and forming conclusions about the published research and theory on a particular topic. In most studies a literature review is done at the onset of the study and is updated or extended during the final phase. The purpose for literature review is to determine what is already known about the topic to be studied so that a comprehensive picture of the state of knowledge on the topic can be obtained. This helps to minimise the possibility of unintentional duplication and increase the probability that a new study may make a distinctive contribution (Brink, 2010).

Termination of pregnancy (TOP) remains a highly debated and emotional issue in South Africa. It has for centuries been a controversial subject that affects women around the world, irrespective of race, educational level, socioeconomic status or religious background. TOP is often opposed by governments, institutions and individuals in other parts of the world leading to stricter regulations. The majority of African countries, including Kenya, regard TOP as an offence which is punishable by law leading to imprisonment. Any person found to have assisted a woman in terminating pregnancy also risks receiving a prison sentence (Widdows, Idiakaz & Cirion, 2006).

In other Southern African countries, such as Zambia, abortion law requires that three doctors certify that the woman meet the requirements before TOP can be performed (Ngwena, 2004). It is an undeniable fact that TOP, both safe and unsafe, has always occurred and will continue to be practised in every culture and society. It is inevitable that women will continue to experience unwanted pregnancies for different reasons such as sexual assaults, non-

consensual sex, lack of birth control services and failure to use contraceptives (Brookman-Amisshah, 2004).

In developed countries, such as Denmark, England and New Zealand, women generally experience safe pregnancies, birth and motherhood due to the availability of high quality obstetric and maternal health-related care. However inadequate access to such care and unsafe abortions pose a threat to the lives of many women, and constitutes an important contributor to pregnancy-related deaths in developing countries is (Hord & Wolf, 2004)

The right to decide when to have a child is at the very core of reproductive rights and in essence means that women should be able to obtain safe and effective means of controlling their family size, including contraception and access to TOP services. Despite this, WHO estimates that approximately 20 million illegal abortions are performed globally every year (WHO, 2006). WHO has also provided global estimates of illegal abortion-related maternal mortality over the past ten years, namely, that for every eight pregnancy-related mortality one results from illegal abortion. WHO further estimates that around 68,000 women die from complications of unsafe abortion (WHO, 2007).

It is estimated that death due to unsafe abortion in Africa accounts for a global average of 13% of all pregnancy-related mortality. In the year 2000, an estimated 30,000 deaths resulted from unsafe abortion practices throughout Africa, equalling 40% of all unsafe abortion-related deaths. Of all the regions, Africa has by far the highest unsafe abortion mortality rate due to the use of high risk unsafe methods and poor access to health services (WHO, 2004).

TOP, for medical reasons, has been legal in India for nearly three decades. About 20 – 30% of clients seeking TOP are mainly teenagers from urban hospitals in India. In 1993 a study on mortality due to unsafe abortion was conducted in rural Manharashtra, India. It was found that most maternal deaths were due to unsafe (back street) abortions from teenagers as well as married and unmarried adult women (Bott, 2001). The complications of unsafe abortion affect not only the individual woman and their families, but also the

medical institutions and the society as a whole (Kamini, 2006). Treating the complications following unsafe abortion consumes vast quantities of scarce resources such as hospital beds, blood transfusion, costly medicines as well as medical personnel. The cost of treating women with complications of incomplete abortion is very high. To reduce maternal mortality, legalization of TOP was recommended.

In this chapter the history of abortion laws will be explored focusing mainly on the South African context.

2.2 Historical Overview of Abortion

Providing greater access to safe TOP reduces the public health burden of unsafe abortion, which in 2004 was estimated at 600,000 deaths and 5 million temporary or permanent disabilities annually in developing countries (WHO, 2004). TOP involves some moral and ethical uncertainties which challenge legislation all over the world.

In South Africa, before the Abortion and Sterilization Act of 1975 came into effect, abortion was criminalized under common law. It was rationalised that this was done to protect the health of women and their unborn babies (McGill, 2006). The medical profession started to seek protection from the illegal abortion they were providing. There was also pressure from women's organizations to expand the abortion law. The Abortion and Sterilization Act of 1975 was thus introduced.

The promulgation of the Abortion and Sterilization Act No. 2 of 1975 (South Africa, 1975) allowed for legal abortion if:

- The continued pregnancy would endanger the life of the pregnant woman, or if it posed a serious risk to her physical health.
- The continued pregnancy posed a serious threat to the pregnant woman's health and could result in permanent damage to her mental health.

- There was a serious risk that the child would suffer from physical or mental defects of such a nature as to be irreparably handicapped.
- The pregnancy was a result of unlawful sexual intercourse, including rape, incest or intercourse with a mentally defective female who does not understand the consequences of intercourse or parental responsibility.

Before legislation of the Abortion and Sterilization Act of 1975, government policies were seen to suggest that the black population was growing too fast and becoming a burden to the country's resources (Blanchard, Fonn & Xaba, 2003). According to Sigcau (2009) it was noted that contraceptives were promoted for black and coloured women as a means to control population growth. Despite the Abortion and Sterilization Act of 1975, women continued seeking backstreet abortions and many died due to complications related to such choices (Benson, Andersen & Sumandari, 2011). TOP law in the South African context was formulated around the Roman Dutch law in defence of therapeutic abortion.

The Abortion and Sterilization Act of 1975 did not increase access to safe and legal abortion. No improvements in reproductive health care for the majority of South African women took place. In reality, restrictive abortion laws forced many women to opt for backstreet abortion. The rate of rape and incest affecting women in South Africa is a practical reality that needs to be considered because it often results in unwanted pregnancies which leads to either TOP the legal route or backstreet abortion (van der Westhuizen, 2001).

In Beijing, a conference was held in 1995 to address the rights of women. The total of 187 United Nations (UN) member states adopted the Declaration and Platform of Action which recognizes women's right to control all matters related to their sexuality, including their sexual and reproductive health. The International Conference on Population and Development was also held in 1994 in Cairo. At this conference 179 UN member countries acknowledged that advancing gender equality, eliminating violence against women and

ensuring women's ability to control their own fertility are the cornerstones of population and development policies (Braam & Hessini, 2004).

Internationally, human rights in the area of reproductive and sexual health were affirmed during the International Conference on Population and Development in Cairo in 1994 (United Nations, 1996) and the fourth World Conference on Women in Beijing in 1995 (United Nations, 1995). Women were given the power to make decisions freely and responsibly on matters related to their sexuality including sexual reproductive health, free of coercion and discrimination regarding TOP. Restrictions such as age and requirements for parental or spousal consent were abolished, services should be freely accessible and readily affordable, and privacy and confidentiality should be assured to women at all times (United Nations, 1995, 1999). Moreover, efforts to reduce the number of unwanted pregnancy have been intensified through education campaigns and provision of contraceptives worldwide.

2.3 Amendment of the Termination of Pregnancy Laws

In 1994, South Africa was liberated from the apartheid regime and its laws which oppressed women, especially in matters related to reproductive health in which husbands were making decisions on behalf of their wives (Mhlanga, 2003). South Africa amended the previous Abortion and Sterilization Act No. 2 of 1975 which could offer abortion only on the grounds stipulated in the Act, which had to be proven. The law has been amended by the Choice on Termination of Pregnancy (CTOP) Act No. 92 of 1996 which allows any women who wish to access TOP services when the gestational age is below 12 weeks, without permission of the third party.

The South African government started to respond to the reproductive health needs of women by tackling issues such as TOP. Democracy in South Africa prompted politicians to demonstrate their commitment to gender equality and ending discrimination in public health. A new Bill of Rights was passed, which insisted on gender equality, the right to reproductive health and created an

opportunity for the passing of Termination of Pregnancy (TOP) law in the form of CTOP Act No. 92 of 1996 (South Africa, 1996).

The nursing personnel implementing the CTOP Act have to practice within the parameters of the Nursing Act of 2005, which governs the practice of a nurse, the Health Act No. 61 of 2003, the Constitution of the Republic of South Africa (Act No. 108 of 1996), the South African Nursing Council (SANC) Regulation 2488 of 1990 on the regulation relating the conditions under which the registered midwives may carry on their profession, Regulation 2498 of 1984, as amended, the scope of practice of professional and enrolled nurses, Regulation 888 of 1987 as, amended, on the Acts and Omissions in respect of which the SANC may take disciplinary actions.

The CTOP Act replaced the restrictive provision in the Abortion and Sterilization Act No. 2 of 1975 and promotes reproductive rights and choices. The CTOP Act reflects the intention of the legislature to make TOP accessible. Other countries such as England, Denmark and New Zealand passed the TOP law in 1973. Developing countries such as Central Asia, North Africa and the Middle East in 1985 also revised their abortion laws to expand the grounds for abortion where it only permitted a woman to terminate her pregnancy if the pregnancy resulted from rape, incest or where there is a strong probability that the child would suffer from physical or mental defect of such a nature as to be irreparably handicapped (Benson, Andersen & Sumandari, 2011). The same grounds are applicable in South Africa (South Africa, 1996).

In Denmark, the TOP Act which is still operative today was passed in 1973. The TOP Act allows TOP on request up to the end of the 12th week of pregnancy. The same law was passed in South Africa in 1996 permitting TOP on request by the woman during the 12th week of pregnancy and authorizes registered midwives to provide TOP service for those women (South Africa, 1996). In some countries such as England, New-Zealand Denmark and the United States of America where TOP is legalized, only doctors are permitted to perform even the first trimester TOP (Singh , 2006).

Access to safe TOP depends on the legal status of TOP in the country. “Back street abortion” is performed in countries where the law prohibits or restricts access to safe TOP. In countries such as Denmark and England where TOP is permitted on request it is mostly safe where public services are widely available. The law usually stipulates some conditions, such as gestational limits, consent requirements, pre- and post-counselling (WHO, 2004). The same conditions are applicable in South Africa (South Africa, 1996).

Legality of TOP is not a guarantee to access safe TOP as this depends on the availability of services. Many unsafe abortions are still performed because of ignorance of the law on the part of women. Lack of confidentiality and judgmental attitudes of medical personnel towards women seeking TOP force the women to seek back street abortion (Mhlanga, 2003).

2.4 The Influences of Religion and Culture on Termination of Pregnancy

TOP is still a matter of moral and religious concern even though legal availability of TOP services on request is widely accepted. Religion, particularly Catholics, has become an organized force against TOP. Abstinence is the only contraceptive method that is preached by Catholics, although it is not followed by every Catholic member resulting in some women falling pregnant and choosing to opt for TOP (Dolgin, 2004). No church accepts any form of abortion. The Roman Catholic Church believes that once a baby is conceived its life should not be terminated at all. Catholic doctrine preaches that TOP is always the intentional taking of someone’s life and should not be allowed (Dolgin, 2004).

Religion has been cited as a strong influence on how the public make sense of TOP. It has been found that the church has predominantly framed TOP as murder and as an indication of moral degeneration. This understanding stems from the idea that life begins from conception and has negative consequence for woman who may be considering TOP or who may have had TOP as a murderer. The Christian religions and other “pro-life” organisations argued that

the unborn child has a right to life. Many believe that abortion is murder and inherently immoral (McGill, 2006). In South Africa TOP is legal although the law is under constant attack from “pro-life” activists with various legal challenges having been mounted (Stevens, 2007).

Although several religious traditions have been the source of moral outrage over the frequency of abortion in the United States, Hoffman & Mills Johnson (2005) maintains that some religious groups have raised strong arguments for the pro-choice stance. Some have also distanced themselves from debate, arguing that although the moral concerns are founded, each person needs to be guided by their own conscience regarding decisions involving TOP (Hoffman & Mills Johnson, 2005).

Mojapelo-Batka & Schoeman (2003) encountered the influence of religion in their study where participants experienced guilt and shame after having TOPs. These negative feelings were informed by the church, an organization understood by society to regard TOP as a sin (Mojapelo-Batka & Schoeman, 2003). However, even among the church groups there are cases where TOP issues present legitimate moral dilemmas such as in the case of rape, mental retardation or when the mother’s life is endangered by pregnancy (Voster, 2007). McGill (2006) and Greene (2006) noted that in South Africa TOP is supported in cases where pregnancy resulted in circumstances out of the woman’s control.

In South Africa, where TOP is legal, not all women have the same ability to choose to have TOP or not as some of them have been coerced into performing TOP. Often the pressure to decide for TOP is from the sexual partners, parents or friends (Mdeleni-Bookholane, 2007). A study conducted by Bowes (2009) found that a woman who still lives in her parent’s home is considered to be under her parents’ authority. She cannot act independently and, therefore, cannot be autonomous regarding her sexuality or reproductive capacity. Political morality is founded upon respect for individual freedom and autonomy (George, 2008).

Despite the CTOP Act stating that women can make the decision to have TOP autonomously, sectors of the public still feel that the sexual partner and or the parents should be involved with the decision making (Bowes, 2009). According to Sherk (2006), women have the right to reproductive choices regarding pregnancy, TOP and contraceptives, and furthermore to choose and beyond that to have the social support necessary to live according to the choices they made (Sherk, 2006).

In a study conducted by Reich (2008), it was found that men associated fatherhood with reproducing themselves and a sign of virility and pride. TOP was therefore contested by some men because they felt it robs them of their masculinity. In a study conducted by Varga (2002), the researcher noted that support for TOP among males in South Africa is three times less than among females. Men were often reluctant to comment about TOP as it was seen as a female matter (Varga, 2002)

Some men oppose the idea that women should be able to decide to have TOP autonomously, especially if they would like to raise the baby by themselves. However others argue that men oppose TOP merely to control women's reproductive capacity (de Nobrega, 2006). Even today in some South African households, the husbands are regarded as the decision makers to whom wives must submit (Shefer, Crawford, Strelbel, Simbayi, Henda & Cloete, 2008). The man is found to be positioned as the overarching authority in the home, according to the patriarchal ideals. The conflicts and challenges within the family are addressed within the private boundaries of the family. Therefore, premarital pregnancies would be dealt with in the family. This does not give the women much opportunity to make their own decisions about their reproductive health (Bowes, 2009).

Jones, Frohwirth & Moore (2008) suggest that conflicting messages are relayed to parents in situations such as the performance of TOP can affect the well-being of the woman as well as their children. Therefore, women who choose TOP are often seen as lacking self-control and responsibility in that they should not have fallen pregnant in the first place if they were not ready to

raise a child. Despite TOP being considered morally wrong, the male participants in the study conducted by Nyanzi, Nyanzi & Bessie (2005) considered TOP to be justifiable in certain circumstances, such as for pregnant school girls in order to protect their future and avoid the legal implications such as imprisonment of the male partner for impregnating a minor. McQuoid-Mason (2010) clarifies the position concerning minor girls who are mature enough and capable of giving consent for TOP, that they should be allowed to do so if they so wish. Failure to do so will be undermining the stipulations of the CTOP Act No. 92 of 1996.

Repeated TOP is a challenge which is faced by TOP service providers. The matter of concern is that most teenagers are having insufficient knowledge about contraception and sexuality, and it is difficult for the teenagers to take responsible decisions on healthy sexual matters. Insufficient knowledge about sexual matters exposes teenagers to unprotected sex and the consequences that follow, such as unwanted pregnancy. In circumstances where the law permits TOP, access to safe services can still be restricted by scarce resources such as limited availability of trained registered midwives who are willing to offer TOP services (Mhlanga, 2005).

Tautz (2004) indicates that countries such as India, Ghana and South Africa where TOP has been approved, attitudes and stigmatization of TOP seeking women by health care providers prevented access to the service. In Nigeria, TOP was permitted only to save the life of a pregnant woman, the practice was common although it occurred under unsafe conditions similar to that of backstreet abortions (Henshaw, Adewole, Singh, Bankole, Oye-Adeniron & Hussain, 2008).

2.5 Conclusion

Chapter 2 expounded the literature review to gain insight on the findings of other researchers on the topic under the study. Various publications by different authors were consulted. Chapter 3 focuses on the research methodology that has been chosen for the study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

Chapter 2 discussed the literature review. This chapter focuses on the research methodology and the design that has been chosen for the study, including population, sampling, data collection and analysis, measures to ensure trustworthiness and ethical considerations.

3.2 Objectives of the Study

The objectives of the study were to:

- Explore and describe the experiences of registered midwives performing TOP.
- Develop guidelines for the improvement of the implementation of TOP services.

3.3 Research Method

A qualitative, exploratory and descriptive design was used in this study. This research method helped the researcher to explore what is experienced by registered midwives performing TOP.

3.3.1 Qualitative Research Method

Burns & Grove (2005) refer to qualitative research as the systemic, subjective approach used to describe the experiences and give meaning to them. The focus is to obtain information that would facilitate understanding of the registered midwife's experiences whilst performing TOP (Parahoo, 2006). Thus, qualitative design uses in-depth methods to explain the phenomenon under study (Denzin & Lincoln, 2008). The participants were afforded the

chance to describe what they experienced personally when performing TOP. The study was carried out at the reproductive health clinics of Polokwane / Mankweng Hospital Complex where TOP is performed. The responses by participants have prompted the researcher to probe further. Consequently, the participants gave more information related to the phenomenon under study (Parahoo, 2006).

3.3.2 Exploratory and Descriptive Research Design

The exploratory and descriptive research design is a qualitative research strategy developed for the purpose of describing experiences as lived by the participants (Polit & Hungler, 2003). It provides an accurate account of the characteristics of a particular event for the purpose of discovering new meaning, describing what exists and categorizing information. Descriptive design assisted in describing the experiences of midwives performing TOP.

3.3.3 Phenomenological Research Design

A phenomenological research approach was used with the aim of exploring and describing what was experienced by registered midwives performing TOP at Polokwane / Mankweng Hospital Complex. Parahoo (2006) stated that phenomenology stresses the notion that only those who experience phenomena are capable of communicating them to the outside world. This research design is suitable for obtaining insight into human experiences as the participants are afforded the chance to describe their experiences from their own perspective.

In this study, interviews with registered midwives focused on obtaining information regarding their experiences when performing TOP. Participants were given the opportunity to describe their experiences about the phenomenon under study. The researcher bracketed her own experiences with regard to the phenomenon before the interviews in order to gain greater clarity into her own misconceptions and to avoid having an influence on the information given by the participants. The researcher conducted the interview

on a one-to-one basis to facilitate her own understanding of the phenomenon as described by the participants (de Vos et al, 2004; Burns & Groove, 2005; Parahoo, 2006).

3.4 Population and Sampling Method

3.4.1 Study Population

The population consisted of all 10 registered midwives who performed TOP at Polokwane/Mankweng Hospital Complex. The study was conducted at the reproductive health clinic of Polokwane / Mankweng Hospital Complex in the Capricorn District of Limpopo Province.

3.4.2 Sampling

Purposive sampling is used when the participants included in the study have knowledge of the phenomenon studied (Creswell, 2004). Non-probability purposive sampling was used in this study. Participants were chosen on the basis of their experiences in their area of work and abilities to answer the research questions.

3.4.3 Sample Size

Sample size was determined by data saturation. According to de Vos, Strydom, Fouche & Delport (2006), theoretical saturation means that no new or relevant data seem to emerge regarding a theme. A sample of 6 participants was interviewed and saturation was reached.

3.4.4 Inclusion Criteria

Inclusion criteria used in this study observed the rules of purposive sampling whereby the participants included had some experience concerning TOP and these participants had to comply with the following criteria:

- Registered midwives working in the reproductive health clinic performing TOP for a period of 12 months or more.
- Expressed a willingness to share their experiences with the researcher and to sign an informed consent form.

3.5 Data Collection Method

A phenomenological study was used as a tool to collect data. The researcher used an interview to collect data from registered midwives performing TOP at Polokwane/Mankweng Hospital Complex. Semi-structured interviews were used (Brink et al, 2012).

3.5.1 Preparation for Data Collection

Permission and approval to undertake the study was obtained from University of Limpopo Medunsa Research Ethics Committee (MREC, Appendix 6), the Provincial Department of Health Research Committee (Appendix 7) and the Chief Executive Officer of Polokwane / Mankweng Hospital Complex (Appendix 9). Once approval was granted, the researcher informed the hospital management under which the clinics operate. The researcher clarified the purpose of the study to the clinic managers who then introduced her to the registered midwives performing TOP. The participants were given consent forms to sign before recruitment to the study in the selected clinics. A private room was prepared for conducting interviews.

The purpose of the study was outlined to the participants before starting with the interview session in each clinic. Data were collected through semi-structured interviews in a private room away from distracters. An audiotape recorder was used to capture the interview sessions and field notes were written by the researcher.

3.5.1 Pre-Testing of the Instrument

The instrument developed was pre-tested on registered midwives who were not going to take part in the main study so that the researcher could identify problems in the design of the questions (Burns & Grove, 2007). The registered midwives who were performing TOP at Rethabile Reproductive Health Clinic were used to pre-test the instrument in order to investigate the feasibility of the main study and to detect the positive flaws of the data collection instrument. The results of the study showed that the instrument was feasible and allowed the researcher to evaluate the length of time to be taken during each interview (Appendix 5).

3.5.3 Interview Preparation

The researcher made an appointment with the registered midwives who were selected as part of the research sample. Rapport was established to build a relationship of mutual trust. Close rapport with the interviewee afforded access to richer information (Polit & Beck, 2008). In this study, the researcher and the participants had a common vocabulary which facilitated communication as the participants were registered midwives performing TOP.

Permission to interview the participants was sought after obtaining approval from the Department of Health (Appendix 7), the Chief Executive Officer (CEO) of Polokwane / Mankweng Hospital Complex (Appendix 8) and the participants themselves (Appendix 4). The appointments were made with the participants who were selected as part of the research sample. The specific registered midwives were approached. The date and time for the interviews was discussed and agreed with the participants. The place for the interview was the Reproductive Health Clinics of the Polokwane / Mankweng Hospital Complex where TOP is performed. This ensured privacy and a pleasant atmosphere to allow the participants to talk freely and express their honest opinions.

Informed consent forms were signed by the participants and permission to use the audiotape recorder was obtained. Participants were assured that their names would not be used and that they had the right to withdraw from the study at any time if they so wished.

The following instructions were given to the participants:

- One central question will be asked
- Follow-up and or clarifying questions will also be asked
- An audiotape recorder will be used to record the responses to help the researcher to remember the answers.
- Field notes were also being taken.

3.5.4 Interview Process

The interview session was held at the reproductive health clinics to obtain information from the registered midwives regarding their experiences when performing TOP. Interviews were conducted in a private room. Some of the participants were interviewed after duty hours as they were busy during working hours due to staff shortages. The session lasted for twenty to thirty minutes. The role of the researcher was to encourage the participants to continue talking during the interview until data reached saturation. This is the point in the study where the researcher begins to hear the same information repeatedly and no longer learns anything new (de Vos, Strydom, Fouche & Delpont, 2006).

The participants were encouraged to talk as freely as possible. To ensure an in-depth expression, the researcher allowed each participant to tell her experiences without any interference. Semi-structured interviews were used as a data collection method. The researcher started each interview by introducing herself and the topic for discussion to establish rapport with the participants. The researcher listened attentively to the participants. Data were collected from verbal and non-verbal communication. In this study, the participants shared with the researcher their experiences regarding

performance of TOP. The researcher used semi-structured interviews with the intention of understanding the participants' lived experience in their own words (de Vos, Strydom, Fouche & Delpont, 2011).

Registered midwives were asked one central question **“Please describe to me in detail all your experiences when performing TOP?”**(Appendix 5). The participants were encouraged to talk openly and freely about their experiences when performing TOP. The researcher led the interview and encouraged the respondents by non-verbal means such as nodding (to indicate interest). Communication techniques such as clarification, reflection, paraphrasing, questioning, maintaining eye contact and summarizing were used (Brink, van der Walt & van Rensburg, 2006). The researcher tactfully probed the participants in order to obtain more information in a specific area of the interview. After the participants had finished expressing their thoughts, the researcher asked the participants more specific questions for thorough exploration of the facts stated.

The researcher used probing as a communication skill along with open-ended questioning and tracking for clarification (Brink, van der Walt & Wood, 2012). Tracking allowed the registered midwives to say in their own words and show understanding of what they said. A reflective summary question was asked in order to reach an insightful synopsis. In addition, field notes were written and the researcher repeated what was written in the field notes to the participants to confirm whether what was written was what the participants had said (Polit & Beck, 2012). The researcher maintained a non-judgemental attitude throughout the interviews with the participants. All interview sessions were recorded verbatim on an audiotape recorder.

A qualitative exploratory, phenomenological and descriptive research design was used in this study. The data collection method used was individual semi-structured interviews. Participants were asked to describe their experiences when performing TOP. The sample consisted of 6 registered midwives working in the Reproductive Health Clinics at Polokwane / Mankweng Hospital Complex. Data were collected until saturation was reached. The participants

satisfied the set inclusion criteria. Data were analysed according to Tesch's approach as outlined in Creswell (2009).

3.6 Data Analysis

Data analysis involves a process in which the researcher brainstorms on the presented data in an effort to arrive at concluding statements known as findings (Corbin & Strauss, 2008). According to McMillan & Schumacker (2010), data analysis is described as the process of selecting, categorizing, comparing, synthesizing and interpreting data to provide verified explanations about the phenomenon of interest.

The interviews were transcribed verbatim (Appendix 10). Data obtained from the participants were analysed using Tesch's approach where eight steps were followed as outlined in Creswell (2009). Data analysis was done by using open coding according to Tesch's methodology. Transcripts from the audiotape recorder and field notes were read. The researcher replayed the tapes to listen to the responses as well as the entire content. The transcriptions were read and re-read and field notes were reviewed to check for accuracy. The researcher used reflexivity and bracketing to exclude preconceived ideas or biases about the phenomenon under study (Burns & Groove, 2009).

The researcher picked the most interesting transcript and highlighted recurring words and phrases, identifying differences and interrelationships. Thoughts that occurred during the transcription were written in the margin. The researcher made a list of all the topics that emerged. Data were broken down into manageable themes and sub-themes and meaningful units. Sub-themes reflected patterns of the participants' experiences when performing TOP. Themes were derived from the interviews conducted with the 6 participants. Sub-themes were presented in each theme. Themes reflect an in-depth understanding which is central to the phenomenon (Creswell, 2009).

To enhance data credibility, an independent coder was engaged for data analysis. On completion of data analysis, the researcher had a meeting with the independent coder to compare the findings. Although findings were the same, in some instances they were worded differently. After the discussion the researcher and the independent coder agreed on the wording to be used in the formulation of themes and sub-themes (Appendix 11).

The descriptions were allocated themes and sub-themes. Raw data were forwarded to an independent coder. The independent coder, a nurse researcher, was familiar with conducting qualitative data analysis. The independent coder allocated the codes from the original raw data given by the researcher. A meeting was held to achieve consensus on the categories reached independently. Final remarks on data analysis were written after agreement had been reached (Burns & Groove, 2005).

3.7 Measures to Ensure Trustworthiness

According to Streubert & Carpenter (2003), a research design is said to be trustworthy when it reflects the reality and ideas of the informant. Trustworthiness was maintained using Lincoln & Guba's model (1985) concentrating on the following criteria:

- Credibility
- Dependability
- Transferability
- Confirmability

3.7.1 Credibility

According to Polit & Beck (2008), credibility refers to confidence in the truth of data. Credibility in this study was ensured by prolonged engagement to capture realities of the study. Prolonged engagement relates to spending time with participants collecting data, verbatim transcription of audiotape recordings and checking with the second person to verify the aspects of the data. The

researcher introduced herself and spoke in the language which participants understood to establish rapport and build a trust relationship. The researcher spent thirty minutes with the participants during the interview session. An in-depth interview with the participants was conducted until data saturation was reached.

Reflexivity was done by tape recording the interview session and writing field notes. Verbatim transcription of data with repeated listening and reading of transcripts was analysed to establish themes and sub-themes. Field notes and the tape recorder were given to the independent coder to allocate themes and sub-themes. The researcher and the independent coder met and reached an agreement on the identified themes and sub-themes from the collected data.

3.7.2 Dependability

Dependability refers to stability of data over time and condition (de Vos, Srydom, Fouche & Delport, 2004). It is applied to check if findings of an inquiry will yield the same results if it is replicated with the same participants in the same context (Polit & Beck, 2008). In this study, dependability was done through an audit where relevant supporting documents were scrutinised by an independent coder. The independent coder was a researcher who is familiar with a qualitative data analysis. The researcher and the independent coder discussed the data to reach a consensus on the findings. Data collected was made available only to the researcher and the independent coder.

3.7.3 Transferability

Transferability refers to the extent to which the findings of the study can be transferred to other identical settings (Polit & Beck, 2008). A complete research design, methods and literature control were provided to the independent coder to maintain transparency (de Vos, 2004). In this study, the researcher provided sufficient descriptive data in the research report so that other researchers can evaluate the applicability of data to other context and to provide a base for further research.

3.7.4 Confirmability

Confirmability refers to objectivity, that is, the potential for congruence between two or more independent people about the relevance, accuracy or meaning of the data (Polit & Hungler, 2004). The findings of the research should be the products of the inquiry and not the researcher's bias. In this study, raw data derived from tape recorder and field notes were given to the independent coder (de Vos, 2004). Names of the participants were not used so that the information could not be linked to participants. The audiotape recorder was used for verification. Themes and sub-themes were examined. Conclusions on the findings were supported by a literature control.

3.8 Ethical Considerations

The proposal was submitted to the Medunsa Research Ethics Committee (MREC) for ethical clearance (Appendix 6). Department of Health Research Committee granted approval to conduct the study (Appendix 7). The Chief Executive Officer of Polokwane / Mankweng Hospital Complex granted permission to conduct the study (Appendix 8).

3.8.1 Informed Consent

The purpose of the study was explained to every participant before commencing with the semi-structured interview session. Informed consent was obtained from each participant before she could participate in the study (Appendix 4). Formal permission was received from the participants to use a voice tape recorder and write field notes for collecting data during interview sessions. The recordings were made available only to the researcher and the independent coder. Participation in the study was voluntary and participants were informed of their rights to withdraw from the study if they so wished and were reassured that they would not be victimized if at any time they withdrew from the study.

3.8.2 Privacy

The researcher assessed the physical area to ensure privacy for the participants. Interviews were conducted in a private room away from distracters. The purpose of the study was explained to the participants to exclude exploitation so that they could make an informed decision before signing the consent form.

3.8.3 Anonymity and Confidentiality

Confidentiality is the management of private information shared by the participant and the researcher. The data obtained in this study were not used for any purpose other than the original intention (Burns & Groove, 2007). Anonymity was maintained by allocating codes to participants as their real names were not used and their identities could not be linked to the research data (Burns & Groove, 2007).

3.9 Limitations of the Study

The findings of the this study cannot provide conclusive evidence to the reproductive health clinics of the entire Limpopo Province as the study conducted was limited to Polokwane / Mankweng Hospital Complex Reproductive Clinics situated in one of the five districts of the Limpopo Province. The study will have to be repeated in other districts in the Limpopo Province prior to generalization of the research findings in Limpopo Province.

3.10 Conclusion

This chapter focused on the research methodology and the design used for the included population, sampling, data collection and analysis, measures to ensure trustworthiness and ethical considerations. Chapter 4 discusses the research findings and the literature control.

CHAPTER 4

RESEARCH FINDINGS AND LITERATURE CONTROL

4.1 Introduction

Chapter 3 outlined the research methodology followed in the exploration of the lived experiences of registered midwives performing TOP. Chapter 4 focuses on the research findings. The purpose of the study was to explore the experiences of registered midwives performing TOP Polokwane / Mankweng Hospital Complex. Qualitative methods were used to describe and explore the experiences of registered midwives performing TOP. According to LoBiondo-Wood & Haber (2010), the purpose of a literature control is to verify whether the identified themes had been documented in order to establish credibility of the findings. In the discussion relevant data from the literature were incorporated. The following question was asked **“Please describe to me in detail all your experiences when performing TOP?”**

The findings are categorized according to the main themes and sub-themes, namely lack of human and material resources, emotional and psychological trauma, stress and frustration, religious and cultural beliefs, lack of support from colleagues and management, blaming for not using contraceptives and self-blaming by TOP providers, coping mechanisms such as debriefing and self-acceptance.

4.2 Themes Identified During Data Analysis

Data analysis yielded 6 themes and 12 sub-themes as summarised in Table 4.1. Themes in qualitative data analysis are theoretical relationships that emerge after the researchers have spent extensive time examining data, categorising and sorting of elements into groups to look for patterns (Burns & Grove, 2009).

Table 4.1: Themes associated with experiences on termination of pregnancy

Theme	Sub-theme
1. Shortage of resources	1.1 Shortage of human resources
	1.2 Shortage of material resources
2. Emotional and psychological trauma	2.1 Stress and frustration of midwives
	2.2 Rejection and labelling of midwives performing TOP
3. Religious and cultural beliefs	3.1 Conscientious objection
	3.2 Cultural beliefs
4. Lack of support	4.1 Lack of support by colleagues
	4.2 Lack of support by management
5. Blaming	5.1 Failure by the community to use contraceptives
	5.2 Self-blaming
6. Coping mechanisms	6.1 Debriefing to assist registered midwives
	6.2 Self-acceptance

4.3 Interpretation of Findings and Literature Control

The themes and sub themes were as follows:

4.3.1 Theme 1: Shortage of Resources

This theme relates to the lack of resources in the clinics where TOP were provided. Lack of human and material resources in the clinics where TOP were provided hampered service delivery.

4.3.1.1 Sub-theme 1.1: Shortage of Human Resources

The few TOP service providers that are present do not cope with the number of clients who seek TOP services as evidenced by the following statements:

Participant 1 said *“Termination of pregnancy is one of the works within the Department of Health although many people do not want to perform TOP due to their religious consideration this leads to shortage of personnel providing TOP services.”*

Participant 2 said *“We are only three midwives performing TOP at this clinic we do not cope with the work load. We use a booking list because we do not cope with the numbers. We use first-come-first-serve approach and some of the clients go beyond 12 weeks whilst still on the waiting list even if they have booked for the service when they were below 12 weeks gestation, forcing them to resort to backstreet abortion due to shortage of personnel.”*

Participant 3 said *“Where I used to work before coming here I was alone in the TOP clinic and I was not coping with the demand. Due to extreme shortage of staff I was forced to resign because the community was demanding that I perform TOP after hours at my house. Here the shortage is still present, but at least I am not alone. There is another midwife to consult if there is a need to do so.”*

Participant 5 said *“Not every registered midwife is willing to perform TOP because they feel that it is not a good thing - this contributes to shortage of staff. I appeal to the Department of Health to train more registered midwives to perform medical termination of pregnancy because it is done only by doctors and there is shortage I don’t have anyone to check and confirm my findings because I work alone. Another challenge is that we are not remunerated we are told that this is not a scarce skill. I appeal to the Department to remunerate those who are performing TOPs as a scarce skill allowance and this will encourage other midwives to work in the TOP clinics and reduce shortage.”*

Participant 6 said *“We are not being paid. We are told that this is not a speciality we are volunteering our services no one is forcing us, but at least they should give us something to motivate us this will encourage other midwives to be trained as TOP providers and reduce shortage of personnel. As I am talking to you right now another midwife has been taken to another unit to make up for the shortage and I am left alone in the TOP clinic.”*

These responses are in agreement with the findings of Mookamedi (2011) who found that on occasions where the general wards experienced staff shortages, managers would deplete TOP units to make up for the shortages in the general wards. Poggenpoel & Myburgh (2006) maintained that TOP service providers reported that it was rare to find a full staff complement in a TOP unit. Mamabolo & Tjallinks (2010) reported that shortage of human resources in TOP facilities resulted in high stress levels and burnout for those who are providing the service.

Lack of monetary incentives contributed to shortage of personnel to provide TOP services. This corresponded with Mookamedi’s (2011) observations that participants were of the opinion that the work they are doing is unrecognized as there is no incentive, thus contributing to shortage of staff. This also upheld the findings of Marek (2004) that nurses in South Africa expressed dissatisfaction with their role as TOP service providers as they are not

recognized as scarce skill providers and are not paid for the service they are rendering.

Harries, Stinson & Orner (2009) also found that there is often not enough staff to provide TOP services and that only a certain number of clients is taken per day. Large numbers of women were turned away due to shortages of staff resulting in them seeking backstreet abortion. This concurred with the study of Engelbrecht (2005) who reported that a challenge of shortage of TOP providers and facilities resulted in TOP clients resorting to backstreet abortion.

4.3.1.2 Sub-theme 1.2: Shortage of Material Resources

Shortage of material resource is impacting service delivery negatively. This was highlighted by some participants as follows:

Participant 2 said *“Lack of equipment such as sonar machine is a challenge. I sometimes make a mistake of misdiagnosing clients because I only rely on the history from the clients and physical examination and sometimes when I aspirate pieces of human being comes out.”*

Participant 3 said *“Due to lack of proper equipment I relied on the history from the client and sometimes I made a mistake of underestimating the gestational age and when I perform MVA pieces of a baby came out.”*

Participant 5 said *“Like here, we do not have equipment such as sonar machines to confirm gestational age. Therefore, I use bimanual examination and history from the client sometimes due lack of equipment such as a sonar machine you make a mistake with dates and bimanual examination and you find yourself aspiration a viable foetus.”*

Mookamedi (2011) also found that on occasion, because of lack of equipment, TOP providers are not able to confirm the gestational period through physical examination, and rely on the history as given by the client who sometimes misses a month or two. It is at these times that a well-formed foetus is aborted.

She also stated that lack of supplies impacted negatively on the service as the bookings were done according to the availability of equipment.

4.3.2 Theme 2: Emotional and Psychological Trauma

The participants reported mixed feelings regarding the provision of TOP services. The sub-themes identified were stress and frustration, rejection and labelling.

4.3.2.1 Sub-theme 2.1: Stress and Frustration of Midwives

Stress means emotional, physical strain, tension or experiences that are difficult to manage and frustration is prevention to satisfy an act or an emotional response to such a hindrance (The Oxford Dictionary, 2009).

Participants experienced stress and frustration in the TOP clinics when performing TOP. Some highlights were as follows.

Participant 1 said *“I become emotional to see a 12 year old pregnant girl coming to the clinic seeking for TOP. This usually happens when young girls engage in unprotected sex at an early age and become pregnant which is unwanted. Although the Act states that consent is not needed from the parent, consent is obtainable from the client herself.”*

Participant 2 said *“What affects me emotionally is when a young pregnant girl who is about 23 weeks pregnant needs TOP and starts crying when she is told that she has exceeded the approved gestational age that of 12 weeks becomes para-suicidal and want to kill herself because she does not want the pregnancy. I am bothered by those who come for the service more than once.”*

Participant 3 said *“TOP procedure affects me emotionally; sometimes I come across clients who do not accept being pregnant. I put myself in the boots of the client having an unwanted pregnancy which might lead to stress and*

frustration. Sometimes when I perform MVA the foetus comes out in pieces. I could not sleep at night recalling the procedure. This tortures me.”

Participant 4 said *“TOP affects me emotionally. I cannot sleep at night. Sometimes I dream about the procedure having nightmares and a feeling of drowning babies and killing them and this is stressful and I am not coping well.”*

Participant 5 said *“I become frustrated with clients that come to seek TOP services when they are above 12 weeks because I cannot perform medical TOP and I become frustrated especially when pieces of the foetus come out during MVA. This causes emotional stress.”*

Participant 6 said *“It is very hard to cope with the challenges. If the service is not provided here and now as requested, we get insults from the clients. This causes emotional trauma. Imagine if I have to counsel sixteen clients alone per day it is very exhaustive and you just become irritable.”*

Shellenberg & Frohwirth (2009) reported feelings of guilt, shame anxiety or other negative feelings about self as a perceived stigma. Poggenpoel & Myburgh (2006) and Mayers, Parkes, Green & Turner (2005) also found that midwives who were performing TOP for a large number of women often reported emotional exhaustion and occasionally presented with depression based on the work they do.

4.3.2.2 Sub-theme 2.2: Rejection and Labelling of Midwives Performing TOP

Rejection means to refuse to accept or acknowledge a situation or person (The Oxford Dictionary, 2009). TOP providers felt rejected by their colleagues who called them names and made them unwanted as evidenced by the following statements:

Participant 1 said “*Challenges will shake your thinking when people are referring to you as killing or terminating the little baby’s life although I consider myself not killing but helping women who are pregnant and do not want the pregnancies.*”

Participant 4 said “*I am having a guilty feeling of being a murderer, especially when labelled by the colleagues.*” Another participant echoed this sentiment “*I am being labelled as a serial killer by colleagues who are not for TOP.*”

Engelbrecht, Pelsler, Ngwena & van Rensburg (2000) alluded to the perception held by the other midwives who labels those who chose to perform TOP as murders, contributes to negative emotions experienced by TOP providers. Mamabolo & Tjallinks (2010) also pointed out that health care workers display hostility towards those providing TOP services and make them feel rejected by colleagues due to being involved in TOP services.

Harries et al. (2009) also concluded that many TOP providers were regarded as murders and baby killers who were expected to preserve and not take life. Those who were providing TOP services felt stigmatized and experienced burnout as they could not endure the comments of their colleagues. Shellenberg & Frohwirth (2009) reported feelings of guilt, shame, anxiety or other negative feelings about self by TOP providers as perceived stigma when referred to as murderers. Lebese (2009) also found that negative remarks from colleagues and others made the participants feel rejected and condemned.

4.3.3 Theme 3: Religious and Cultural Beliefs

Lack of interest to the TOP programme by midwives’ cultural and religious beliefs also hinder the service delivery. TOP is still a matter of moral and religious concern even though legal availability of TOP services on request is widely accepted.

4.3.3.1 Sub-theme 3.1: Conscientious Objection

Pera & van Tonder (2005) stated that professionals found themselves in a dilemma to carry out their professional duties and to satisfy their religious and cultural beliefs as evidenced by the following statements:

Participant 1 said *“I am having my own belief system based on my religion. Unlike those who will be saying I am a Roman Catholic and my religion does not allow me to perform TOP and do not support those who are performing TOP.”*

Participant 2 said *“We have conscientious objectors. Not all doctors want to perform TOP due to their religious and cultural beliefs; there is only one doctor who performs above 12 weeks terminations.”*

In the study conducted by van Vuuren (2001) participants reasoned that so many people reacted to TOP practices based on religious grounds without ever being in a situation where TOP had to be considered an option. He also found that religious discourse tended to marginalise and silence women. This discourse contributed to the fact that women seeking TOP, experienced religion as strict and punitive. Rakhudu, Mmelesi, Myburgh & Poggenpoel (2006) confirmed that religious stigma is attached to those terminating pregnancies and that people are vocal about their disapproval.

4.3.3.2 Sub-theme 3.2: Cultural Beliefs

The right to freedom of association as enshrined in the Constitution of the Republic of South Africa allows people to uphold their cultural beliefs which are demonstrated as follows:

Participant 3 said *“Some doctors do not agree to perform TOP either below or above 12 weeks stating that their culture does not allow them to perform termination of pregnancy.”*

Participant 6 said *“Not all doctors are willing to perform TOP due to their cultural beliefs. I can say 99% of doctors are not willing to perform TOP. There is only one doctor, who assists with the TOPs, but when she is on leave or at Mankweng Hospital because she works at the two hospitals there is no one to assist.”*

Harries et al. (2009) also found that abortion services were often not provided due to “pro-life” doctors not wanting to be associated with abortions. The impact of conscientious objection on service provision included all aspects of abortion processes from refusing to prescribe or to administer necessary medications. In the study conducted by Mokgethi (2011), the participants indicated that traditional healers were against TOP services because of their moral and religious beliefs. However, they were of the opinion that TOP should be performed in cases of rape and incest

4.3.4 Theme 4: Lack of Support

The participants reported a lack of support from colleagues and management

4.3.4.1 Sub-theme 4.1: Lack of Support by Colleagues

Midwives who are performing TOP are not supported by their colleagues. This is evidenced by the following comments from the participants:

Participant 2 said *“We have problems with clients who come for TOP being above 12 weeks because doctors do not support the TOP programme so we have to refer the client to the social worker or to start antenatal clinic after counselling.”*

Participant 4 said *“Colleagues do not support us instead they label us as murderers.”*

Participant 5 said *“Not all midwives perform TOP. Some feel that it is not a good thing to do and therefore do not support those who perform TOP.”*

Lack of support by colleagues was also confirmed by Mokgethi, Ehlers & van der Merwe (2006) who reported that clients were left alone to care for themselves before and after TOP procedures by health care providers who did not want to be involved in TOP services. In the study conducted by Mokgethi (2011), respondents indicated that support received from their nursing colleagues was very poor, especially from those who had never worked in TOP facilities because they regarded TOP services as cruel and immoral.

Harries et al. (2009) also found that registered midwives who were not TOP providers expressed their dislike of CTOP care. They were prepared to restrict their involvement to pre and post abortion counselling or basic nursing duties and were not willing to support those who perform TOP services.

4.3.4.2 Sub-theme 4.2: Lack of Support by Management

This sub-theme describes lack of support from management as evidenced by:

Participant 3 said *“Lack of support from management forced me to resign from the previous facility where I was working before as TOP provider because I was overworked, the manager would take the other TOP provider to other units to make up for the shortage and as such I was left alone in the clinic.”*

Participant 5 said *“Management is not supportive. There is no debriefing sessions arranged for us, that is why I usually arrange for debriefing session with a psychologist myself.”*

Participant 6 said *“Right now as I am talking to you I am alone in this clinic; the other midwife is being taken to the other unit to make up for the shortage in that unit.”*

These responses concurred with the findings of Mookamedi (2011) who found that on occasions where the general wards experienced staff shortages, managers would deplete TOP units to make up for the shortage in the general wards. Sibuyi (2004) also reported that lack of support by management

impacted negatively on the provision of TOP services where participants reported physical exhaustion due to shortage of personnel.

In addition, Mamabolo & Tjallinks (2010) found that registered nurses described the procedure as emotionally draining due to inadequate support from management who do not provide relevant equipment at the TOP clinic. Lebesse (2009) corroborated that midwives performing TOP complained about lack of emotional support from managers who pass negative remarks and do not allow midwives to attend debriefing sessions. The respondents in the study conducted by Mokgethi (2011) indicated that managers are not supportive. They are only interested in the statistics for TOP services provided and not the personnel providing the services. Mayers et al. (2005) also found that there is usually lack of support from managers who do not allocate adequate staff to the TOP clinic, and that support from managers would encourage the TOP providers to perform their work diligently because they will feel that they are cared for.

4.3.5 Theme 5: Blaming

Blaming is defined as a pervasive tendency to assume that a person who has suffered a misfortune must have done something wrong to deserve it (The Oxford Dictionary, 2009). Under this theme the following sub-themes emerged:

- Failure by the community to use contraceptives
- Self-blaming

4.3.5.1 Sub-theme 5.1: Failure by the Community to Use Contraceptives

Failure to use contraceptives was highlighted as major cause of unwanted pregnancy. Despite counselling done to clients before and after TOP procedure, clients come for repeat TOP services. This was expressed as follows:

Participant 1 said *“Some women become pregnant not because they want to, but because of gender-based violence where women are raped or are forced to have sex without protection such as condoms and pills. Women do not have a say in sexuality matters, resorting to TOP. Some women come for TOP service more than once because they do not use contraceptives, but use TOP as a contraceptive method.”*

Participant 2 said *“Community do not use contraceptives. I do not know if they lack information on how to use contraceptives or what? Women who are 39 - 40 years become pregnant because they are not using contraceptives and resort to TOP when pregnant. Teenagers are ignorant to use the available family planning methods and resort to TOP which they repeatedly come for the service.”*

Participant 4 said *“Some clients come more than once for TOP service, even after being pre- and post-counselling regarding TOP and the use of contraceptives. Clients use TOP as a method of contraceptive. They do not attend family planning clinic and do not use contraceptives.”*

Participant 5 said *“People do not use family planning services because they are not well informed about contraceptives and TOP, especially those who come from the rural areas. There are no TOP information brochures, leading to backstreet abortion.”*

Participant 6 said *“We have a challenge of clients who do not want to use contraceptives. When you ask them about contraceptives they will tell you that “they make fat.”*

Lebese (2009) found that TOP providers blame family planning providers and clients for the increases in TOP requests. Family planning providers were blamed for not making available information to the clients on the use of contraceptives in order to prevent unwanted pregnancies. Clients were also blamed for not taking responsibility in regulating their own fertility.

Mhlanga (2003) also found that insufficient knowledge about sexual matters exposes teenagers to unprotected sex and the consequences that follow such as unwanted pregnancy. Limited contraceptive choices and judgemental attitudes of health providers particularly towards young and adolescent women are perceived as barriers to accessing contraceptives. These sentiments are in accord with the findings of van Vuuren (2001) that illiteracy played a role in the effectiveness of contraceptives. Despite the fact that some women use contraceptives, they still become pregnant and midwives had no reason to judge them if they want TOP performed.

This was confirmed by the study conducted by Mookamedi (2011) in which repeated TOP requests were thought to be the indication that contraceptives were not used despite the advice given to clients during pre- and post-counselling. Furthermore, Jewkes et al. (2005) demonstrated that women admitted to using no contraceptives at all. They also made reference to the fact that a clinic in Soweto which is performing TOP has found that the overwhelming majority of women using the service have not used any contraceptives.

Young girls are not using contraceptives and rely on TOP as a means of contraception. The above statement was supported by Matshogo (2013) on the South African Broadcasting Corporation (SABC) talk show “Yilungelo Lakho” who stressed the point that backstreet abortion was claiming lives of the youth who do not use contraceptives, but resort to TOP when pregnant.

4.3.5.2 Sub-theme 5.2: Self-Blaming

In this study, TOP providers blamed themselves for mistakes that happened during the performance of TOP. The following statements sustain this notion:

Participant 2 said *“Clients discontinue using contraceptives which were advised on discharge after TOP. When these clients come for repeat TOP I refer such clients to the next service provider or counsellor because I blame*

myself if the client stopped using contraceptives and I ask myself where I have failed with my counselling.”

Participant 3 said *“I sometimes make a mistake of performing TOP on a client who is above 12 weeks because I am not yet competent to use the sonar machine and I had no one to confirm the dates. I depended on the history from the client. Occasionally, I blame myself for terminating a viable foetus.”*

Lebese (2009) found that TOP providers blame family planning providers and clients for the increase in TOP requests. Family planning providers are blamed for not empowering clients with information about the use of contraceptives to enable them to prevent unwanted pregnancies. Clients were blamed for not taking responsibility in terms of regulating their fertility.

4.3.6. Theme 6: Coping Mechanisms

The participants use available coping mechanisms such as debriefing and self-acceptance to handle their mixed feelings such as stress, frustration and blaming

4.3.6.1. Sub-theme 6.1: Debriefing to Assist Registered Midwives

Debriefing is defined as providing participants with a retrospective explanation of the purpose of the investigation (The Oxford Dictionary, 2009). Debriefing was mentioned as a mechanism used by participants to cope with the work in order to minimize emotional and psychological trauma, as supported by the following participants' responses:

Participant 1 said *“Debriefing session with a psychologist or colleagues make me feel better to cope with the situation.”*

Participant 4 said *“Debriefing session is done to make it easy to cope with the procedure, although it is still unacceptable.”*

Participant 5 said *“Debriefing was organized and held monthly where as colleagues we come together and share our experiences and sometimes a psychologist is invited in the debriefing sessions so that we can vent all our frustrations, especially after you have made a mistake with dates and bimanual examination and you find yourself aspirating a viable fetus.”*

Participant 6 said *“Debriefing makes it easier for us to come to terms with what we are doing, but we do not get enough time for debriefing which should at least be twice a year. Right now, I got a debriefing session two years ago.”*

These responses concurred with the findings of the study conducted by Lebese (2009) where registered midwives experienced a sense of belonging by interacting with and sharing experiences with fellow TOP providers. Sharing of experiences served as an emotional outlet for the participants. van Vuuren (2001) also found that workshops arranged by the government served a good purpose to meet other TOP providers and discuss issues such as experiences and difficulties they faced in their work environment. In a study conducted by Harries et al (2009) it was found that participants felt that TOP was a procedure they could come to terms with over time when they realize that they are not facing the challenges alone. In a study conducted by Mokgethi (2011), respondents indicated that they had regular meetings with their colleagues to vent their feelings.

4.3.6.2 Sub-theme 6.2: Self-Acceptance

This study shows that TOP providers have accepted themselves, despite all negative criticisms from their colleagues and others. These are evidenced by the following statements:

Participant 1 said *“I have been doing this work for almost six years. When I am doing my job I do not regard myself as killing, but as helping the women who are pregnant and do not want more children, those who are raped and those who were forced to have sex without using contraceptives I love what I am doing.”*

Participant 2 said *“Emotionally I am okay. I love my work. I am one person who likes to assist people, especially those with unwanted pregnancies.”*

Participant 3 said *“When I perform TOP I am in the boots of the clients who were falling pregnant without planning (o kile wa bona?). Just imagine going through the pregnancy you do not want. I have no problems doing TOP. I am ok with my work.”*

Participant 4 said *“I am assisting people who fall pregnant and the pregnancy is unwanted.”*

Participant 5 said *“I am appealing to the Department to train TOP providers on medical abortion. If they train us we will also offer medical termination as well because I am satisfied about what I am doing and that is helping those in need.”*

Participant 6 said *“I chose to work in this clinic I don't want to work in maternity; we are volunteering, no one is forcing us, I love my work.”*

These statements are in agreement with the findings of the study conducted by Lebesse (2009) that the legalization of TOP seemed to give the TOP providers a sense of control over the situations in which they probably felt helpless in the past when women were dying of complications of illegal abortion. Moreover, van Vuuren (2001) observed that TOP providers felt comfortable with what they were doing because they sincerely believed in what they were doing and that they could bring about positive changes in other women's lives.

In the study conducted by Engelbrecht (2005), participants also expressed satisfaction of being able to provide a service that was safe and enjoyed helping people to prevent back street abortions. Lebesse (2009) also reported that negative remarks and feelings of rejection by colleagues and others made midwives to find a way to cope with those feelings through self-acceptance. Likewise, Mokgethi (2011) indicated that registered nurses performing TOP

reported that they often feel satisfied with a job well done assisting those who require TOP services and that they could work in TOP facilities if they could choose their own work allocation sites because they did not have negative feelings about their involvement in TOP services.

4.4. Conclusion

This chapter focused on the research findings and the literature control. The findings were categorized according to the main themes and sub-themes, namely, shortage of resources, psychological and emotional trauma, religious and cultural beliefs, lack of support, blaming and coping mechanisms. Chapter 5 focuses on the discussion of the findings, guidelines, limitations and recommendations.

CHAPTER 5

DISCUSSION, GUIDELINES, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

Chapter 4 focused on the research findings and the literature control. This chapter outlines the discussion of the findings, guidelines, limitations and recommendations of the study. No attempt was made to generalise the results of the study as it was conducted and confined to Polokwane / Mankweng Hospital Complex.

5.2 Discussion of Research Findings

Six themes and twelve sub-themes were identified from the interview transcripts of the participants. These themes included lack of resources, emotional and psychological trauma, religious and cultural beliefs, lack of support, blaming, and coping mechanisms.

5.2.1 Lack of Resources

The long waiting lists at the clinics revealed that the clients were not attended to timeously due to shortage of personnel. The number of registered midwives allocated to the reproductive clinics did not meet the demand of clients who seek TOP. Midwives who were allocated to the TOP clinics were sometimes taken to other units if there was a shortage in those units. According to the participants, TOP services were not on the priority list of the managers as there was no replacement provision for those who resigned and left the service, thus leading to an increased workload which caused stress and burnout on the part of the midwives performing TOP. Nobody was allocated to the TOP clinic, even when there was shortage of personnel which compromises women to access reproductive health services.

Shortage of personnel is also contributed to by the CTOP Act (Act No. 92 Of 1996) which makes provision for health care providers to invoke conscientious objection. The right to object to perform TOP is also supported by the Constitutional rights of all South Africans to freedom of thought, belief and opinion (South Africa, 1996). The midwives working in the reproductive health clinics felt trapped and compelled to do the work because no one was willing to work or assist them, even when they could not cope with the workload.

Staff shortages continued to be problematic despite the fact that the TOP Act (Act No. 92 of 1996) allows for a facility to provide TOP services only if there is sufficient medical and nursing personnel. In South Africa, TOP services are offered free of charge by hospitals and clinics designated to offer the service, although the service is not readily accessible due to long waiting periods caused by shortage of TOP providers.

Legality of TOP is not a guarantee to access safe TOP as this depends on the availability of the service. Due to long waiting lists, some of the clients go beyond 12 weeks gestation, even when they came to the facility whilst still below 12 weeks and were eligible for TOP. This caused them to resort to backstreet abortion and later to come back to the same clinic with complications requiring emergency treatment which must be offered by the same midwives, adding to the workload.

Lack of resources made it difficult for the midwives to render quality care which the clients need. The participants in this study experienced lack of equipment as a particular challenge which led to emotional and psychological trauma. Equipment such as sonar machines which help in estimating gestational age were critically lacking in the reproductive health clinics. The midwives resorted to manual examination which resulted in them sometimes miscalculating the dates and sadly also the termination of a viable foetus. The practical reality is when the midwife experiences the pieces of human flesh coming out during MVA.

5.2.2 Emotional and Psychological Trauma

Potgieter & Andrews (2004) refer to the provision of TOP services as a public health discourse with emotional and psychological effects on the part of affected individuals. In this study, the participants described TOP service as an exhaustive and emotional task to perform. Participants mentioned that they were stigmatized, called names and labelled as serial killers and murderers by their colleagues, and therefore suffered emotional and psychological trauma.

A significant finding that emerged from this study was that the participants were not always professionally trained to perform TOP on clients above 12 weeks gestation; such clients were referred to doctors who are permitted by the Act (CTOP Act No. 92 of 1996) to perform TOP on clients who are above 12 weeks gestation. Occasionally, due to lack of equipment to confirm gestational age, TOP providers performed TOP on clients with a fully developed foetus; this was evidenced by pieces of a human being aspirated during MVA. This experience caused considerable emotional and psychological trauma to the TOP service providers. Gestational age is a key indicator for acceptability to perform TOP. The acceptable gestational age is 12 weeks for midwives to perform TOP as stated in CTOP Act No. 92 of 1996.

5.2.3 Religious and Cultural Beliefs

Religion is regarded as a primary opposing influence for TOP. The Roman Catholic Church has become an organized force against TOP and believes that once a baby is conceived its life should not be terminated at all (Bott, 2001). No church accepts any outright form of abortion. The church is often regarded as silencing the voices of women who seek TOP, irrespective of mitigating circumstances.

Religious beliefs did not prevent some midwives from being supporters of women's reproductive health where women have the right to choose to have an unwanted pregnancy terminated, whereas for other midwives it was the main reason for not being involved in the provision of TOP services. The

South African Constitution and the CTOP Act No. 92 of 1996 enshrine permission to those who do not want to perform TOP due to their cultural and religious belief to exercise their rights to associate or not to associate. Such rights must be exercised in a way that they do not prevent others from exercising their freedom to participate in TOP or to access TOP services. Although the law attempted to change the attitudes of traditional society by legalising TOP, it is still surprising to see that some health care providers are unwilling to assist women who choose to terminate their pregnancies.

The TOP Act does not force health care workers to participate in the TOP programme, but rather requires the health care provider to refer or inform women who seek TOP services where they can locate the facilities that render the service. In this study, the participants were aware that nobody was forcing them to perform TOP, but that they were doing so out of their own free will. Conscientious objection and implementation of the Choice on Termination of Pregnancy Act No. 92 of 1996 in South Africa allows people to object to performing TOP for whatever reason they may have (Naylor & O'Sullivan, 2005). TOP is still a matter of moral and religious concern even though legal availability of TOP services on request is widely accepted.

According to Pera & van Tonder (2005) as cited by Mpshe (2000) values are described as relating to mode of conduct, that is, being able to choose between "right" and "wrong" and "holding a key to decision making." Occasionally, the registered midwives found themselves in a dilemma to carry out their professional duty and to satisfy their religious and moral values. In cases where client needs care following TOP, the registered midwives have a professional and ethical obligation to care for the patient according to the Nursing Act (Act No. 33 of 2005). It is therefore important to note that the midwives may not refuse to treat the patient in an emergency following TOP. The CTOP Act (ACT No. 92 of 1996) mandates nurses to provide the basic nursing care to the clients before and after the procedure, even if nurses object to perform TOP.

5.2.4 Lack of Support

Lack of support hampers the effective use of TOP services. Participants felt that personnel who are not TOP providers did not provide the support required. TOP providers experienced that their professional relationship with their colleagues had been affected and that they were isolated from and not supported by colleagues who were not involved in TOP services. In this study it was found that feelings of guilt, resentment, and low morale implied that TOP providers became emotionally drained. The absence of psychological support was another area of concern.

Hospital management did not support the TOP programme. This was evidenced by shortage of equipment and shortage of registered midwives allocated to the TOP clinics. In this study, participants felt that management was not providing the support to the TOP programme as it should. Lack of support from the managers, colleagues and doctors who object to the performance of TOP is not in line with stipulations of the CTOP Act (Act No. 92 of 1996). There was no support from doctors to assist the midwives, especially when the pregnancy was above 12 weeks and when the client insisted on having TOP despite being counselled. There was a general lack of support from colleagues which was exacerbated by those who had no interest in helping or did not want to perform TOP, but labelled and called those who are willing names.

5.2.5 Blaming

Blaming was expressed by most participants. They expressed the feeling that clients' decision to stop using contraceptives was precipitated by the fear of being rejected by their sexual partners who will lose the sexual desire towards them. Blaming was also attributed to lack of information by the community regarding reproductive health, including the use of different methods of contraception and TOP.

In this study, repeated requests for TOP was seen as an indication that

contraceptives were not used following advice given during counselling. Counselling services are key to efficient TOP programmes and ensure that the emotional needs of the client are catered for and that clients are offered information on alternative methods to make an informed decision before and after the TOP procedure.

The problem with pre- and post-counselling is lack of time, shortage of staff and irritability of the personnel due to work pressure. A finding in this study was that most participants blamed clients for not accessing family planning and not taking responsibility in their sexual matters. Unplanned, unwanted pregnancies and backstreet TOPs are serious health problems in developing countries, including South Africa. Blaming is often a way of letting out the frustrations by the service providers due to increased workload distributed among a few service providers, especially when clients come for repeat TOP service.

The midwives blamed themselves for failed pre- and post-counselling, including the use of contraceptives, hence they resorted to referring the clients to the other service providers instead of attending to them for the second time. There is a possibility that women used TOP as a contraceptive method. This appeared to be a matter of dire concern. The concern clouded the decisions made by the midwives for those women coming for repeat TOP services because in most instances the midwives did not want to perform a repeat TOP. The midwives preferred to refer the clients to other service providers.

Lack of information and education on sexual and reproductive health is an impediment to young women seeking TOP, as they tend to delay obtaining TOP services timeously until the pregnancy is advanced and opt for backstreet abortion (Harrison, Montgomery, Lurie & Wilkinson, 2000). The blame is attributed to negative attitudes of health care providers towards teenagers who wish to access reproductive health service, lack of respect, lack of rights to privacy, confidentiality and shortage of decentralised TOP services.

The blame is also put on the CTOP (Act No. 2 of 1996) which provides that

any pregnant woman can choose to terminate pregnancy without the consent of a parent or guardian, including a 12-year old pregnant teenager. In the United States, a minor who is pregnant and seeks TOP has to obtain parental consent or delay the procedure for a period of at least 24 hours after pre-counselling. This is done in order to discourage the minor to continue with TOP. Engelbrecht (2005) confirmed that in the United States a pregnant minor has to go to court and present her intention to terminate the pregnancy if she does not want to ask for parental consent. In this study, participants felt that there should be a different set of rules for minors seeking TOP and those minors should consult their parents before being allowed TOP services because the parents are still responsible for their juvenile children.

Midwives should not blame women who choose to have their pregnancies terminated. Application of human rights to sexual reproductive health emphasizes the right to be free from all forms of discrimination, including discrimination with regard to access to sexual and reproductive health services, information and education. The woman's ability to independently decide on reproductive health matter is essential in the fulfilment of the achievement of the Millennium Development Goals (MDGs) - Goal Number 3 on Gender Equality and Goal Number 5 on Improvement of Maternal Health (World Bank, 2004).

Other participants blamed the Department of Health for not taking the responsibility to inform the community about where they can access safe TOP services, hence the community ended up with expensive backstreet abortions, which could have been procured freely and safely from government institutions.

5.2.6 Coping Mechanisms

Despite the limitations experienced, sharing was the mechanism used by participants to cope with the work they were doing. Participants used debriefing as a coping strategy to ease the emotional trauma experienced. The source of emotional support for participants seems to be from fellow

colleagues performing TOP. Sharing the experiences with each other during debriefing sessions served as a platform for letting out their emotions and healing emotionally. Interacting with and sharing experiences with fellow providers, made participants to experience a sense of belonging and being accepted. Inviting a psychologist during the debriefing sessions also helped the participants to deal with their emotional and psychological trauma.

Workshops on provision of TOP served as a good purpose to meet other health workers and discuss related issues, experiences and difficulties with one another. In a study conducted by Mayers et al. (2005), it was found that sharing experiences with colleagues provided an outlet for feelings that developed during the performance of TOP procedure especially emotional feelings.

Another coping mechanism that the participants used was to be defensive about their actions. They regarded themselves not as killers or murderers, especially when referred to as such by their colleagues, but considered themselves as carers of those in need. Some TOP providers felt comfortable with what they were doing because they believed that their services could bring about positive changes in other women's lives.

The participants also praised themselves for realising the rights of women as enshrined in the Constitution of the Republic of South Africa, including sexual and reproductive health. Participants were coping well because they enjoyed their work as evidenced by some of the responses from the participants. On a positive note debriefing sessions were found to be beneficial, however, the sessions were no longer frequently arranged by the Department of Health to include psychologists.

5.3 Guidelines to Improve Identified Challenges

According to Mkhonta (2008), guidelines provide for good planning as they outline what needs to be done, how, when, why, and by whom. Guidelines serve as a quality strategy to support decision making within organizations.

Monama (2009) stated that guidelines in health care settings have strengths when applied properly such as leading to the improvement in structures, processes and outcomes of care and attempt to improve the quality of clinical decision making and implementation of decisions made in health services.

Repeated TOP is a challenge which is faced by TOP providers as it was regarded as a contraceptive method. The matter of concern is that most teenagers have insufficient knowledge about the use of contraceptives and sexuality, and it is often difficult for them to take responsible decisions on healthy sexual matters. This exposes teenagers to unprotected sex and the consequences that follow, such as an unwanted pregnancy. Health education regarding reproductive health as well as the use of contraceptives should be taught at schools to reduce teenage pregnancy, unwanted pregnancy and high statistics of TOP in clinics.

In this study, the information gathered from the participants indicated shortage of resources, emotional and psychological trauma, religious and cultural beliefs lack of support, blaming and coping mechanisms as themes for discussion. Guidelines on these include the following:

5.3.1 Shortage of Resources

- More staff should be appointed at TOP facilities to prevent long waiting lists.
- Team spirit should be encouraged through meetings, value clarification workshops and in-service training to retain staff.
- Reproductive health services should be prioritized and adequate staff allocated to manage TOP services to meet the staffing norms as outlined in TOP protocols.
- Staff should be trained on the provision of TOP services.
- Retention strategies for TOP providers should be developed to reduce staff shortage and burnout, low morale, turnover and shortage.
- TOP service providers should be acknowledged and rewarded.

- Adequate budget allocation for provision of material resources and equipment should be ensured at TOP facilities.
- Relevant equipment should be provided for quality care such as sonar machines for accurate diagnosis of gestational age.

5.3.2 Lack of Support

- Non-judgemental actions and positive attitudes should be encouraged to be expressed by other personnel not providing TOP to TOP service providers.
- Health care providers not working within the spheres of reproductive health care should be trained on values and clarification to promote tolerant attitudes towards TOP providers.
- TOP providers should receive in-service training to increase their knowledge and expertise in the provision of TOP services.
- Management should provide regular support through counselling.
- Value clarification workshop should be continued to improve the quality of care by health workers.
- Support programmes which attract prospective TOP providers should be developed to retain the existing ones.
- Financial compensation such as remuneration for TOP providers as a specialized scarce skill should be considered. This will encourage more personnel to be trained as TOP providers.

5.3.3 Emotional and Psychological Trauma

- Value clarification workshops should be provided to the TOP providers to reduce feelings of guilt and address existing negative attitudes.
- TOP programmes should be integrated in the curriculum of nurse training from the basic level to equip nurses with information relating to TOP service.
- Staff support meetings should be convened quarterly.

- Stress management workshop should be conducted on a regular basis for TOP service providers.

5.3.4 Religious and Cultural Beliefs

- The rights of midwives and doctors should be respected if they are not willing to participate in provision of TOP due to their religious and cultural beliefs.

5.3.5 Blaming

- The community should be educated on health promotion such as the use of different methods of contraception that could be offered to the clients, especially teenagers.
- Contraceptive counselling should be strengthened through outreach programmes at school and the community level in order to reduce the incidence of teenage pregnancy and backstreet abortions.
- Health education on the importance of using contraceptives to prevent unplanned pregnancies should be strengthened in community health facilities.
- Emergency contraceptive services - “morning after pill” - should be made available and accessible to prevent unwanted pregnancy.
- Pre- and post-counselling of clients seeking TOP should be strengthened as well as the use of contraceptives to prevent repeated TOPs.
- Community awareness on TOP legislation, including CTOP and the South African Constitutional Rights should be increased through the media to ensure that the community is well informed to destigmatise TOP.
- Periodic in-service updates on new information related to TOP services should be provided.

5.3.6 Coping Mechanisms

- The Department of health should provide regular debriefing sessions with a professional psychologist to TOP providers.
- TOP providers should attend the debriefing sessions periodically.
- Planned debriefing sessions should involve the services of professional psychologist.

5.4 Limitations

Permission to collect data from one of the two campuses was delayed; this in turn pushed back the data collection process. The campus has its own ethics committee which approves all research projects which are to be conducted, even after the approval from the Department of Health to collect data was granted.

One participant resigned before data collection. Some participants preferred to be interviewed during off-duty time as they were busy during on-duty time due to shortage of staff.

The results cannot provide conclusive evidence to the reproductive health clinics of the entire Limpopo Province as the study conducted was limited to the Polokwane / Mankweng Hospital Complex Reproductive Clinics which are situated in one of the five districts of the Limpopo Province.

5.5 Recommendations

Based on the findings, the following recommendations were considered for public health incorporating practice, administration, education and research.

5.5.1 Practice

It is recommended that nursing practice be enhanced by:

- Appointing and training more staff at TOP facilities.
- Encouraging team spirit through meetings and value clarification workshops.
- Allocating adequate budget to purchase the relevant equipment that are used at the TOP facilities.

5.5.2 Administration

In terms of nursing administration, the provisions of the following are highly appropriate:

- Continuous support programmes to attract prospective TOP providers and retain the existing ones.
- Financial compensation such as remuneration of TOP providers to encourage personnel to be trained as TOP providers.
- Arrangement of debriefing sessions with a professional psychologist to allow the TOP providers to vent their stress and frustrations.
- Deliberation by South African government to review the TOP Act to stipulate the limit on how many times a person should be allowed to receive TOP service.

5.5.3 Education

With regard to nursing education, the delivery of the following is critical:

- Integrating reproductive health programmes, including TOP, into the training curriculum of nurses to equip them with knowledge relating to TOP.
- Liaising with other stake holders such as the Department of Education to integrate reproductive health programme into the basic education curriculum to inform the community at an early stage on matters related to reproductive health.
- Conducting workshops on stress management.
- Teaching the community on health promotion such as the use of different methods of contraceptives.

5.5.3 Research

Further research is recommended on:

- The views of the community regarding illegal “back street” TOP
- Opinions of doctors on provision of TOP above 12weeks
- Opinions of the community regarding TOP services for minors.

5.6 Conclusion

This chapter outlined the discussion of the findings and guidelines were developed for the themes that were identified. Limitations of the study and recommendations for nursing practice, administration, education and research were also discussed. It is envisaged that implementation of the guidelines developed from this study will have implications for the improvement of TOP service delivery.

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APPENDIX 1

Letter to Polokwane / Mankweng Hospital Complex

P.O. Box 463
Seshego
0742
Enquiries: Gwangwa TJ
Work Tel: 015 267 1114
Cell: 0823396944
Fax: 015 267 1202

14 November 2012

The Chief Executive Officer
Polokwane Mankweng Hospital Complex

Dear Sir or Madam

RE: REQUEST TO CONDUCT RESEARCH STUDY IN YOUR HOSPITAL

I am a student registered for a Masters of Public Health Degree at the University of Limpopo: Turfloop Campus. Request is hereby made to conduct a study at your hospital on "Experiences of registered midwives performing termination of pregnancy in Polokwane/Mankweng Hospital Complex." This research will be conducted in reproductive health clinics in Polokwane/Mankweng Hospital Complex.

The purpose of the study is to gain deeper knowledge on what is experienced by the registered midwives performing TOP at Polokwane/Mankweng Hospital Complex which is one of the public hospitals in Limpopo Province.

It is envisaged that the study would assist the Department of Health and Social Development to assess the need to train more registered midwives to provide termination of pregnancy services. The research project is a requirement for Masters of Public Health Degree

Sincerely

Mrs Tshwene Josephine Gwangwa

.....

APPENDIX 2

Letter to the Department of Health

P.O. Box 463
Seshego
0742
Enquiries: Gwangwa TJ
Work Tel: 015 267 1114
Cell: 0823396944
Fax: 015 267 1202

14 November 2012

The Head of Department
Department of Health Development
Private Bag X9301
Polokwane
0700

Dear Sir or Madam

RE: REQUEST TO CONDUCT RESEARCH STUDY IN YOUR HOSPITAL

I am a student registered for a Masters of Public Health degree at the University of Limpopo: Turfloop Campus. Request is hereby made to conduct a study at your hospital on experiences of registered midwives performing termination of pregnancy in Polokwane/Mankweng Hospital Complex. This research will be conducted in reproductive health clinics at Polokwane/Mankweng Hospital Complex.

The purpose of the study is to gain deeper knowledge on what is experienced by the registered midwives performing TOP at Polokwane/Mankweng Hospital Complex which is one of the public hospitals in Limpopo Province.

It is envisaged that the study would assist the Department of Health and Social development to assess the need to train more registered midwives to provide termination of pregnancy services. The research project is a requirement for Master of Public Health degree.

The researcher undertakes to observe all ethical principles for conducting the research. All information would be kept in confidence. A copy of the research report could be made available to your office if requested.

Sincerely

Mrs Tshwene Josephine Gwangwa

.....

APPENDIX 3

Participants' Letter for Informed Consent

P.O. Box 463
Seshego
0742
Enquiries: Gwangwa TJ
Work Tel: 015 267 1114
Cell: 0823396944
Fax: 015 267 1202

14 March 2013

Dear Participant

I, Gwangwa Tshwene Josephine, a Masters of Public Health Degree student at the University of Limpopo: Turfloop Campus is conducting a research project entitled: "Experiences of registered midwives performing Termination of Pregnancy at Polokwane/Mankweng Hospital Campus in Limpopo Province"

This work is in partial fulfilment of a Masters of Public Health degree. The study will be conducted under the supervision of Dr J Kgole and Mr SF Matlala who are lecturers in the Faculty of Health Science, at the University of Limpopo. The aim of the study is to gain deeper knowledge on what is experienced by the registered midwives performing TOP at Polokwane/Mankweng Hospital Complex.

Your participation involves interviews using a tape recorder. Should you be in agreement with the request, I would like to inform you that a period of 30 minutes would be at your disposal to describe all your experiences in performing termination of pregnancy. Confidentiality and anonymity will be strictly maintained, your identity will be protected. You are hereby assured that your name will not appear in the research report. The results will be given to you only on request. Your participation is voluntary and you can withdraw from the project at any time without any penalty

Your participation is valued for the success of the study.

Sincerely

Mrs Tshwene Josephine Gwangwa.

.....

APPENDIX 4

University of Limpopo (Turfloop Campus) English Consent Form

Statement concerning participation in a Research Study.

Name of a Research Study

Experiences of registered midwives performing Termination of Pregnancy at Polokwane/Mankweng Hospital Complex in Limpopo Province

I have read the information on the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I know that sound recordings will be taken of me. I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this provided that my name is not revealed.

I understand that participation in this study is completely voluntary and that I may withdraw from it at any time and without supplying reasons.

I know that this study has been approved by the Medunsa Research Ethics Committee (MREC), University of Limpopo (Turfloop Campus) /Limpopo Department of Health and Polokwane/Mankweng Hospital Complex. I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this study.

.....	
Name of volunteer	Signature of volunteer.	
.....	
Place.	Date.	Witness

Statement by the Researcher

I provided verbal information regarding this study.

I agree to answer any future questions concerning the study as best as I am able.

I will adhere to the approved protocol.

.....
Name of Researcher	Signature	Date	Place

APPENDIX 5

Interview Questions

CENTRAL QUESTION

Describe to me in details all your experiences when performing Termination of Pregnancy?

.....

.....

.....

.....

TENTATIVE PROBING / FOLLOW UP QUESTIONS

1. What do you mean when you say?
2. Do I understand you correctly when you say that?
3. What coping mechanisms have you used when performing TOP?
4. Is there any other information you would like to share with me?


APPENDIX 6

Medunsa Research Ethics Committee (MREC) Clearance Certificate

UNIVERSITY OF LIMPOPO Medunsa Campus	
MEDUNSA RESEARCH & ETHICS COMMITTEE CLEARANCE CERTIFICATE	
MEETING:	09/2012
PROJECT NUMBER:	MREC/HS/273/2012: PG
PROJECT:	
Title:	Experiences of registered midwives performing termination of pregnancy at Polokwane/Mankweng Hospital Complex in Limpopo Province
Researcher:	Mrs TJ Gwangwa
Supervisor:	Dr C.J Kgole
Co-supervisor:	Mr SF Matlala
Department:	Medical Sciences, Public Health & Health Promotion
School:	Health Sciences
Degree:	MPH
DECISION OF THE COMMITTEE:	
MREC approved the project.	
DATE:	08 November 2012
 PROF GA OGUNBANJO CHAIRPERSON MREC	
<small>The Medunsa Research Ethics Committee (MREC) for Health Research is registered with the US Department of Health and Human Services as an International Organisation (IORG0004319), as an Institutional Review Board (IRB00005122), and functions under a Federal Wide Assurance (FWA00009419) Expiry date: 11 October 2016</small>	
Note:	
i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.	
ii) The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.	
<i>Finding Solutions for Africa</i>	
	

APPENDIX 7

Permission from the Limpopo Department of Health to Conduct the Study

 **LIMPOPO**
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Selamolela Donald Ref:4/2/2


Gwangwa T J
P O Box 463
Seshego
0742

Dear Mrs Gwangwa T J

Re: Permission to conduct the study titled: Experiences of registered midwives performing termination of pregnancy at Polokwane / Mankweng hospital complex in the Limpopo Province.

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that -
 - Further arrangement should be made with the targeted institutions.
 - In the course of your study there should be no action that disrupts the services.
 - After completion of the study, a copy should be submitted to the Department to serve as a resource.
 - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.



General Manager: Strategic Planning, Policy and Monitoring

Date: 11/19/2018

18 College Street, Polokwane, 0700, Private Bag v9302, POLOKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: <http://www.limpopo.gov.za>

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APPENDIX 8

Permission from the Polokwane / Mankweng Hospital Complex to Conduct the Study

PHD 094(1)

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT
POLOKWANE/MANKWENG HOSPITAL COMPLEX

CAMPUS POLOKWANE MANKWENG

ENQUIRIES LEHOKOA MJ TELEPHONE No. 1044/1014
REFERENCE No. S5/3/1/2 DATE 18.01.2013

Gwangwa TJ
Seshego
0742

RE-REQUEST FOR PERMISSION TO CONDUCT RESEARCH

The above matter has reference:

Permission to conduct a research study in our hospital is hereby granted by our Senior Manager-

Mankweng Hospital as the targeted institution to conduct research has no objection provided your presence does not disrupt or compromise service delivery.

Your co-operation in this regard would be appreciated.

[Signature]
Acting Senior Manager

20130121
Date

Excellent Service Delivery

POLOKWANE HOSPITAL CAMPUS
DEPARTMENT OF HEALTH & SOCIAL DEVELOPMENT
Cor. HOSPITAL & DORP STREET
PRIVATE BAG X9316
POLOKWANE
0700
TEL: (015) 297 5000
FAX: (015) 297 2604

MANKWENG HOSPITAL CAMPUS
DEPARTMENT OF HEALTH & SOCIAL DEVELOPMENT
PRIVATE BAG X1117
SOVENGA
0727
TEL: (015) 286 1000
FAX: (015) 297 0206

The heartland of Southern Africa – Development is about people!

APPENDIX 9

Polokwane/Mankweng Hospital Complex Ethics Committee Clearance Certificate

	LIMPOPO PROVINCIAL GOVERNMENT REPUBLIC OF SOUTH AFRICA
ETHICS COMMITTEE CLEARANCE CERTIFICATE UNIVERSITY OF LIMPOPO POLOKWANE MANKWENG HOSPITAL COMPLEX	
	
PROJECT NUMBER	: PMREC – 56/2013
TITLE	: Experiences of registered midwives performing termination of pregnancy in Polokwane Mankweng Hospital Complex, Limpopo Province
RESEARCHER	: Ms TJ Gwangwa
ALL PARTICIPANTS	: N/A
Supervisor	: N/A
DATE CONSIDERED	: 27 February 2013
DECISION OF COMMITTEE	<ul style="list-style-type: none">• Recommended for approval
DATE	: 27 March 2013
 PROF A J MBOKAZI Chairperson of Polokwane Mankweng Hospital Complex Ethics Committee	
 NOTE: <i>The budget for research has to be considered separately. Ethics committee is not providing any funds for projects.</i>	

APPENDIX 10

Interview Transcript

PARTICIPANT NO 5

Experience: 5 years

Language: English

Researcher: Good morning mam.

Participant: Good morning.

Researcher: How are you this morning?

Participant: I am good and you?

Researcher: I am fine thank you. I am Ms Gwangwa I am a student at the University of Limpopo. I am here to collect data on the experiences of midwives performing termination of pregnancy. I already know your name and for confidentiality and anonymity I'll address you as participant. No 5. I hope you don't mind.

Participant: Okay I don't mind

Researcher: Mam can you please describe to me in details all your experiences when performing termination of pregnancy.

Participant: Of course. Firstly with termination of pregnancy, "*you know eeee*" is like mostly not every registered nurse can perform termination of pregnancy. It may be due to our different Christian beliefs. Others feel "*you know*" that is not good to do. So with termination of pregnancy most experiences that we as TOP providers have is lack of support especially from colleagues. In our area most people are not well informed about TOP. "*You know.*" Family planning as a whole "*hey*". Lack of health promotion and information giving related to family planning is still lacking provision of TOP. Mostly "*eeeeee like before*" we used to have school health nurses who were giving information to learners at schools. "Yes" they still give information on other methods of family planning but not on TOP. Most clients when they come here at the TOP clinic, they do not know anything about TOP. Where you have to explain on how the procedure is done and how the procedure works out. TOP depends on individual midwife. Whether you are being pressurised or you like doing the procedure on your own.

PAUSE

Researcher: Thanks. Can you clarify me? What do you mean when you say the community or the clients that come here do not have full information on TOP?

Participant: Yes. What I mean "*you know*" of late most clients coming here know how to "Google" people who have access to technology access knowledge on know which medication is used and for what? "*eeeeeee*" But because we are in the rural area people do not have the computers and lack knowledge of how to goggle the information related to TOP on the internet like those living in the urban

areas and therefore lack information. They think that performing TOP may be you just have to take a pill and that is all. You have to explain to them pre and post counselling, how the pill works, how the procedure is done and what is going to happen, the whole procedure.

Researcher: Thank you mam. You have answered me. Due to the challenges that you have mentioned how do you cope with these challenges.

Participant: *You know.* It is hard. It is very hard. Normally our Department used to take us for debriefing once a year with all the other TOP providers in the province where we come together and a psychologist is invited to debrief us. Of late due to the administration problems it is not happening it has being three years since it happened. But with me because we have a psychologist here at the clinic, I just book in myself I just talk to my manager and say I am stress up. Like two days ago on Tuesday being a midwife I made a mistake. Like here we do not have a sonar machine I use bimanual examination when examining clients who come for TOP. Being a midwife and you know that midwifery is a closed book. I might have made a mistake especially that I have no one to check with me and confirm my findings I think I made a mistake during bimanual examination. As I am using a booking system, when the clients come back again I do pre counselling and bimanual examination again and give a pill. I think the client was around 22 weeks and I missed it. When you aspirate the pieces of human being come out such things really frustrate and stresses you. Because you end up doing things that you are not trained for like medical abortion which is TOP for above 12 weeks' gestation. If it happens you have to call the doctor because it is only the doctor who is allowed to perform TOP above 12 weeks. You become worried that what if the client complicates bleeds or die? The situation becomes an emergency. I call the manager and ask for an afternoon off in order to attend debriefing session with a psychologist. You know with TOP, there are a lot of challenges. Clients coming for TOP have programmed themselves that they want this "*thing referring to the pregnancy out.* If you have to follow the process of taking blood pre counselling, and booking them, the clients think that you are wasting their time. They end up insulting you and opt to back street abortion. Those are the challenges that we come across. The most frustrating thing is when you do not get support from your colleagues and management. Being a TOP provider you are labelled as a serial killer. Another challenge is that we are not remunerated. The service we render is not regarded as a scarce or speciality skill.

Researcher: Thank you mam. Is there any other information you will like to share with me?

Participant: "*Ja*" I wish that health promotion workers when giving information to the community, they can include information on TOP. In fact all health workers are trained on TOP. If you can check, there are no brochures on TOP. Even without brochures let us join hands as health workers and teach our black sisters out there about TOP to prevent backstreet abortions. If the information is available it will reduce backstreet abortion. Usually the ages that come for termination are 12-15 years who come after attempting something outside like back street abortion. If they have the information about TOP, when to request for it and where to access it they will come straight to the clinic where they know that the service is free and safe. Let us not judge our sisters who seek TOP. If we inform them about TOP they will avoid backstreet abortion and reduce maternal mortality.

Researcher: Thank you.

Participant: To add on, the other thing I am appealing to the Department is to train TOP providers on medical abortion You can see in our Department most of those doctors are from outside the country

where their religion does not allow them to perform TOP therefore it becomes a problem when a client is above 12 weeks and need TOP. The doctors who can perform TOP perform only until 12 weeks. If the Department can train us we will also offer medical termination as well.

Researcher: Thank you very much I appreciate it.

Participant: Thank you.

APPENDIX 11

Independent Coder's Declaration

CERTIFICATION FROM THE INDEPENDENT CODER

QUALITATIVE DATA ANALYSIS

MASTER DEGREE IN PUBLIC HEALTH (MPH)

MS TJ GWANGWA

This is to certify that:

I Mr Ephraim Phahlane Mafalo have co-coded the qualitative data for the study, **Experiences of registered midwives performing Termination of Pregnancy at Polokwane/Mankweng hospital complex in Limpopo Province**

Six (6) participants' interviews and field notes were re-coded. Although findings were the same, in some instances they were worded differently. After the discussion with the researcher we agreed on the wording to be used in the formulation of themes and categories.

I declare that the candidate and I have reached consensus about major themes that emerged during the discussion. Data saturation was achieved by when themes were repeated

Sincerely,


E.P.Mafalo


16/04/2013

APPENDIX 12

Letter from the Language Editor

FACULTY OF NATURAL SCIENCES
DEPARTMENT OF MEDICAL BIOSCIENCES



**the faculty of
Science**


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23 September 2013


To Whom it May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the MPH mini-dissertation by Tshwene Josephine Gwangwa: **“EXPERIENCES OF REGISTERED MIDWIVES PERFORMING TERMINATION OF PREGNANCY AT POLOKWANE / MANKWENG HOSPITAL COMPLEX IN LIMPOPO PROVINCE”**.

Sincerely Yours



Donavon C. Hiss
Ph.D. (Medicine), Dip. Freelance Journalism, Dip. Creative Writing



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WESTERN CAPE**

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