THE CHALLENGES THAT AFFECT MIDWIVES IN TERMINATION OF PREGNANCY AT BOHLABELA DISTRICT IN LIMPOPO PROVINCE

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DECLARATION

I, N.S Mayimele, declare that the research paper hereby submitted to the University of Limpopo for the degree of Masters in Development has not previously been submitted by me for a degree at this University or any other University, that it is my own work in design and in execution and that all material contained therein has been duly acknowledged.

Signed:----------

Date:----------

DEDICATION

This work is dedicated to all midwives who perform TOP at the Bohlabela District in Limpopo Province. I hope that this work will be useful to all facilities designated to provide TOP services to improve reproductive Health Services to all women who volunteer to perform TOP.

ACKNOWLEDGEMENTS

A work of this nature is undoubtedly not done “all by my self” but it is one that many people have contributed to.

I am greatly indebted to the following for their support towards the accomplishment of this work:

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ABSTRACT

The study sought to develop guidelines that are aimed at improving Termination of Pregnancy (TOP) services that are rendered by public hospital based midwives. The researcher applied a qualitative and descriptive design. The study targeted midwives in the Bohlabela District, which has three hospitals. A non-probability purposive sampling was used to 6 midwives who are currently conducting TOP services in the hospitals. Data collection was both in-depth and conducted in face-to-face interviews with each participant. The findings of the study were analyzed, categorized into sub-themes, and revealed that midwives who conduct TOP services experience the following challenges, namely: inadequate human resource, poor infrastructure, lack of equipments, poor management support, and lack of support from doctors.

Based on the findings of the study, it is imperative that all hospitals be designated centres for TOP services, so as to reduce the workload in the few hospitals that currently are inundated. The infrastructure needs to be improved, information about TOP services to the public has to be disseminated through awareness campaigns, and scarce skills allowances must be introduced. In addition, more staff members need to be employed. The study further recommends that the TOP policy guideline be reviewed in terms of allowing other competent health professionals to perform TOP.

Chapter two discusses the literature review regarding the challenges that affect midwives who conduct TOP. In this study, theresearch compares the practice of TOP by the developing and developed countries, looks at related to laws at on TOP; gives an overview of sterilization Act in South Africa; mentions the amendments of laws on TOP; considers other legal restrictions; presents mandatory counseling for TOP clients; focuses on religious, cultural and traditional beliefs. The researcher has consulted different literatures, journals articles and website on challenges that affect midwives in rendering TOP in Limpopo, South Africa and world wild.

Chapter three presents research methodology that consists of research design; area of study; population; sampling method; data collection method and procedure; ensuring trust worthiness; and ethical consideration, to be followed by limitation of the study.

Chapter deals with data analysis and interpretation.

Chapter five presents the researcher's conclusions and recommendations.

ABBREVIATIONS / ACRONYMS

AWRR = Advancing Women's Reproductive Rights

CTOP = Choice of Termination of Pregnancy

IPAS = Protecting women's health

IUD = Intra uterine death

MVA = Manual Vacuum Extraction

OPD = Out Patient Department

RSA = Republic of South Africa

TOP = Termination of Pregnancy

WHO = World Health Organization

Z.C.C = Zion Christian Church

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CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND OF THE STUDY

The termination of pregnancy (TOP) has since the promulgation of the Choice on Termination of Pregnancy (CTOP) Act No 92 0f 1996, currently under review, been a controversial subject in South Africa. Women who request abortions and those perform abortions are exposed to negative attitudes from society due to many reasons, including religious and cultural beliefs. The research focus on midwives and the challenges they experience in conducting TOP, therefore remains a contemporary research field.

It has been estimated that about 46 million abortions occur each year globally (WHO, 1998).These abortions, 20 million are performed under unsafe conditions because of unsanitary circumstances and dangerous methods of self inducement (WHO, 1998). An estimated 13% of global maternal mortality is due to unsafe abortions (WHO, 1998).

The previous Sterilization Act of 1975 states that abortion can only be performed where it is deemed that there is a permanent threat to the physical health of the women. This law benefited the whites who were well orientated with the laws as opposed to the majority of black's illiterates (WHO, 1998).

The increasing figures presented since the implementation of the CTOP Act in 1997 clearly show that this kind of service has been waited for. By the end of 2000, more than 161 867 terminations have been performed (WHO, 1998). Almost third (51132) of these terminations were requested by women above 18 years of age and 8% women were below 18 years of age. It should also be noted that in the four years of implementing CTOP, the number of termination performed has almost doubled from 1997 to 2000 (WHO, 1998).

In Limpopo Province about 2133 TOP have been performed since 1997 to date. Midwives in particular have been hit hard by this legislation because it was not part of their training and no extra staff has been appointed to render the service. The majority of midwives refuse to be involved in assisting a woman who chooses to do TOP due to cultural or religious belief (Duncan, 2000).

Midwives are demanded to conduct procedures against TOP guideline policy. The TOP policy guideline states that three clients are to be performed procedures per day. The current situation is that, midwives perform procedures to more than four clients per day in order to avoid clients not to exceed 12 weeks gestational age for TOP procedures.

1.2. PROBLEM STATEMENT

In South Africa, estimates of the number of unsafe abortions performed each year prior to 1997 were in the range of 200,000 with almost one quarter of these resulting in women being hospitalized for treatment of incomplete abortion (Rees, Katzenellenbogen & Shabodien 1997).

South Africa's maternal mortality ratio during that period was estimated at 32 deaths per 100 000 live birth. In the 6th month following implementation of the

TOP Act, in 1997 the number of legal abortions was estimated at over 12000. Numbers of unsafe abortions are presumed to have declined during the same period, although data to document the extent of such practices are scarce (Jewkes et al, 1997).

The researcher working as Nursing Manager observed and noticed that nurses are faced with challenges in rendering the service since they do not cope with the workload because very few midwives are interested in rendering the service. Those who have undergone training resign or transfer to other institution and no longer conduct TOP. Very few midwives seem to volunteer to undergo training for TOP hence there is shortage. The researcher wants to investigate why midwives are resigning those who have been trained to conduct TOP.

1.3. RESEARCH QUESTION

1.3.1 What are the challenges that affect midwives who conduct TOP?

1.4. PURPOSE OF THE STUDY

The purpose of the study is to develop guidelines with regard to improvement of TOP services by midwives in Bohlabela district of Limpopo Province.

1.5. OBJECTIVE

To determine the challenges affecting the midwives who conduct TOP in Bohlabela district.
To describe the challenges affecting the midwives who conduct TOP in Bohlabela district.

1.6 DEFINITION OF CONCEPTS

According to Neuman (2000) a single construct can have several definitions according to various people. In this study, different definitions of concepts are described to highlight their broader meanings. The researcher also indicates appropriate definitions which will be used in the study.

- **Challenges**

According to Pollard (1994) and Soanes (2000) challenges refer to a demanding task to someone to take part in a contest and to call to prove something,
In this study challenges refers to problems that test the ability of the midwife to render TOP services to women who volunteer to perform TOP.

- **Midwife**

A midwife is a person who is educated and competent to practice midwifery, assumes accountability and responsibility for independent decision making in such practice and is registered as a midwife in terms of the Nursing Act No 50 of 1978 (SANC scope of practice R2598 as amended).

It is supported by (WHO, 1996) definition of midwifery a person who, having been regularly admitted to a midwifery educational programme duly recognised in the jurisdiction in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered / or legally licensed to practice midwifery
For the purpose of this study, the midwife shall mean those nurses who have been trained and are working in a unit where TOP are conducted in

designated hospitals to conduct TOP by manual aspiration of the conceived products below 12 weeks gestation.

- **Midwifery regimen:**

Shall mean ‘the regulation and implementation of those matters which through midwifery intervention, have an influence on the course and management of pregnancy, all stages of labour and the puerperium and include the provision of care plans, their implementation and evaluation and the recording of the course of pregnancy, labour and puerperium and of any health problem and the care received by the mother and child whilst in the charge of the midwife’ (Nursing Act no 50 of 1978 as amended).

- **Termination of pregnancy**

A procedure for terminating an unwanted pregnancy either by traditional midwife or trained midwife before 12 weeks of gestation from the age of 12 years with or without the permission of the parents or spouse (Pollard,1994).
For the purpose of this study termination of pregnancy shall mean when the midwife inserts a drug into the cervix that will ripen the cervix and make it open for the expulsion of conceptions.

- **Practice**

Pollard (1994) defines practice as a repeated exercise to improve skills.
Practice refers to the professional work, business or place of business of a doctor, lawyer (Pollard, 1994)
In this study practice will mean the activities of the midwives for conducting termination of pregnancy.

1.7 SIGNIFICANCE OF THE STUDY

It was hoped that the findings of the study would:

- Provide guidelines that will improve the challenges affecting midwives who conduct TOP. Such guidelines will be communicated to the Department of Health and Social services and to the midwives who conduct TOP in order to improve quality of care provided to patients.

- Provide appropriate inputs from midwives themselves for proper TOP policy amendments by the government and facility managers where TOP services are rendered.

1.8. CONCLUSION

Chapter one deals with the background and overview of the study, statement of the problem, research objectives, research question and the significance of the study.

1.9. LAYOUT OF THE SUBSEQUENT CHAPTERS

Chapter two

Chapter two will discuss the literature review regarding the challenges that affect midwives who conduct TOP. In this study the researcher will compare the practice of TOP by the developing and developed countries related to law on TOP, overview of sterilization Act in South Africa, amendment of laws on

TOP, other legal restrictions, mandatory counselling for TOP, religious, cultural and traditional beliefs. The researcher has consulted different

literatures, journal articles and websites on challenges that affect midwives in rendering TOP in Limpopo, South Africa and world wide.

Chapter three

Chapter three is research methodology which consists of research design, area of study, population, sampling method, data collection method and procedure, ensuring trustworthiness, ethical consideration to be followed and limitation of the study.

Chapter four

Chapter present with data analysis and interpretation.

Chapter five

Chapter five presents researchers conclusions and recommendation.

CHAPTER TWO

LITERATURE REVIEW

2.1. INTRODUCTION

Literature review is a systematic and through search of all types of published literature to identify as many items as possible that are relevant to a particular topic (Oman, Krugman & Fink, 2003). The researcher used books, journals articles and internet explore have been accessed to give new interpretation of old material or combine new with old interpretations.

The literature review may evaluate the sources and advise the researcher on most recent or relevant information. The subject of the study is still new, therefore no relevant literature on challenges that affect midwives who conduct TOP published yet. The subject published related to TOP amongst others are characteristics of women seeking abortion at Urban based government hospitals, Professional nurses attitudes towards providing TOP services and the attitude of the community towards TOP were also limited.

Literature survey is the first step in investigating a cognitive theory. The main purpose for this is that it helps researchers to obtain as much knowledge about the current problem as possible. This helps to avoid the repeating of experiments performed before. Problems encountered before can be taken into account and avoided and positive aspects of the study can also be noted. The researcher must be careful not to let these considerations cloud the current issues (Lincoln & Guba, 1981). According to (Neuman, 2000) a good literature review places a research project in context, it shows the path of prior research and how the current project is linked to the former research.

In chapter two literature reviews will focus on the overview of sterilization Act of 1975 in South Africa comparing with the current Act No 92 of 1996. The comparison on similarities and differences of laws, other legal restrictions, health facilities and personnel in public hospital for TOP services, payments for TOP, availability of resources for TOP, religious and cultural beliefs on regarding TOP in developed and developing countries will be outlined.

Most women in the world live in countries where abortion is legal, even though there are some countries where abortion is still illegal. According to (The Pro life infonent, 2004) about 61% of the population globally lives in the 54 countries that have laws authorizing abortion. The other 39% are in the 97 countries that generally forbid abortions (Jonston, 2001).

2.2. OVERVIEW OF STERILIZATION ACT OF 1975 IN SOUTH AFRICA

The previous sterilization Act of 1975 in South Africa states that abortion can only be performed where it is deemed that, there is a permanent threat to the physical or mental health of the women, could cause severe handicap to the child, or was the result of rape (which had to be proven), incest or other unlawful intercourse, such as with a woman with a permanent mental handicap (Guttmacher, Kapadia & Naude 1996).

To qualify for an abortion under these circumstances, women had to receive approval from two independent physicians, neither of whom could perform the actual procedure. In some cases the approval of either a psychiatrist or a magistrate was also necessary before permission was granted. Approved abortion had to be performed in a state hospital, and records of all legal abortions conducted were strictly kept (Guttmacher et al, 1996). This law

benefited the whites who were well oriented with the laws as opposed to the majority of black illiterates.

Women continued seeking TOP despite the possibilities of serous health risks. Statistics of women admitted in Gynaecological wards increased due to women presenting with incomplete abortions. Maternal morbidity and mortality resulting from septic abortions also increased (Guttmacher et al, 1996).

Prior 1994 the widespread of incidence of illegal and safe abortion had been a concern in South Africa. The legislation has been implemented since 1997.The researcher wants to determine the challenges that affect midwives in TOP. Most of the midwives refuse to perform TOP. Their problems will be determined by this study (WHO, 1998).

The main objective of the TOP Act no 92 of 1996 is to reduce maternal morbidity and mortality as a consequence of unsafe and incomplete abortions (WHO, 1998).

In November 1996 the South African government promulgated an Act No 92 of 1996 regarding freedom of choice in respect of Termination of pregnancy (TOP). The increasing abortion figures presented since the implementation of the TOP Act in 1997 clearly show that this kind of service has been waited for. In Limpopo Province about 2133 TOP have been performed since 1997 to date. The researcher wants to compare the laws regarding TOP in different countries and evaluate if ever TOP services in South Africa does raise standard of women (Jonston, 2001).

2.3. LAWS REGARDING ABORTION IN DIFFERENT COUNTRIES

The researcher wanted to compare the laws regarding TOP by developed and developing countries since the study was done in South Africa which is a developing country.

Most developed countries like India, Italy and Great Britain, abortion law specify the types of medical facilities in which abortions may be performed and the categories of health providers permitted to perform this procedure. The procedure is performed when the gestational age is not more than 12 weeks (Rahman et al, 1997). It is the same as South Africa and African countries like Cameroon as some of the developing countries in public facilities only midwife who is trained to conduct TOP is allowed to perform procedures below 12 weeks and if more than 12 weeks only the medical practitioners who conduct TOP (WHO, 1998). Unlike Belgium which requires that abortion be performed under “good medical conditions” in a facility with adequate means of providing the woman with counselling and information on the public support to which she would wish to deliver and elect either to keep the baby or put up for adoption(Rahman et al,1997).

In France there is a provisional legal abortion since 1975 which allows any woman declaring herself in distress in the first 12 weeks of pregnancy. The abortion Act requires that two doctors agree to an early abortion (The Pro life infonent, 2004).

Few nations like Botswana and Cameroon specify only that a registered or qualified “medical practitioner” must perform the procedure (Rahman et al, 1997). In Zambia abortion became legal for medical and social reasons in 1972. (Harrison et al, 2000). In Israel abortion is permitted on mental health judicial and foetal impairment grounds, allows abortion when the pregnant women is unmarried, under “marriage age” or older than 40 years

The challenge to the midwife is when a young woman below age request TOP and she is still young to understand the consequences of doing TOP at her age in case she cannot fall pregnant again when she got married. The challenges to midwives in public facilities are when the client wants to perform TOP while the pregnancy is above 12 and doctors refuses to assist the midwife. The midwife is permitted to perform TOP procedure when the pregnancy is below 12 weeks. Regardless of the Act that permits women to do abortions to avoid street abortions, clients come to the hospital with septic abortions and it is the same midwife who will take care of those clients and some of them are clients whom TOP have performed before and advantage and the disadvantages of TOP have been given during pre and post counselling sessions. The Act does not indicate how often is one person allowed to do TOP hence you find one person presenting herself to the clinic twice in a year or more. Some clients use TOP as a method of family planning despite of health education given.

In United State of America, in 1996 only 7% of hospital offered the TOP services compared with 50% of hospitals in 1973 and more residence are refusing to undergo training to do abortions (Fawcus, 1997. In South Africa only designated institutions are permitted to conduct TOP and in the public sector. In Limpopo Province out of 43 hospitals only 30 hospitals have been designated to render TOP services.

The challenges facing midwives are shortage of trained staff to perform TOP, increase number of clients requesting TOP, poor infra structures where procedures are conducted. There are long queue for TOP and midwives do not cope with the workload.

2.4. AMENDMENT OF LAWS ON TOP

Developing countries such as Central Asia, North Africa and Middle East in 1985, revised its public health laws to expand the grounds for legal abortion to include preservation of the woman's mental health when it is seriously jeopardized by the continuation of pregnancy. TOP should be performed before the viability of the foetus. At first abortion law only permitted a woman to perform TOP when pregnancy resulted from rape or incest or where there is strong probability that the foetus will develop serious abnormality (Guttmacher et al 19960)

South African amended the previous sterilization Act of 1975 which states that abortion can only be performed where it is deemed that, there is a permanent threat to the physical or mental health of the women, which could cause severe handicap to the child, or was the results of rape (which had to be proven), incest or other unlawful intercourse, such as with a woman with a permanent mental handicap (WHO, 1998). The law has been amended by CTOP Act NO 92 of 1996 which allows any women who wish to perform TOP procedure when the gestational age is below 12 weeks without the permission of the third party.

The challenges to midwives are that women no longer practice family planning. They utilize TOP as a method which contributes to workload. Midwives do not cope because of long queues of clients waiting for the procedure.

The law has been amended by the Choice on Termination of pregnancy Act No 92 of 1996 as amended enables all women of any age in South Africa to access a safe, legal TOP within the first 12 weeks on demand and from 13 weeks under specified circumstances (WHO, 1998).

The challenges to the midwives are that, clients are not aware about the amendment of the Act, where there are still some of the clients who perform street abortion or present themselves to the hospital while they are already above 12 weeks gestational age. The midwife gives pre counselling to those clients but the client denies solution taken by the midwife causes conflict of interest between the client and the midwife. Midwife are taken to be rude when take such decisions.

2.5. OTHER LEGAL RESTRICTIONS FOR TOP.

Laws often contain conditions that must be observed for TOP. Restrictions include the following gestational age, designated hospitals which procedure may be performed, consent; mandatory counselling. There is no uniformity in calculating gestational age for TOP. Each country decides on the gestational age that they require performing TOP (Guttmacher et al, 1996).

In United States, gestational limits for abortion on request range from foetal viability. Belgium, France, Great Britain, permits an abortion at any time to protect a woman's life or foetal impairment grounds but in South Africa abortion is permitted during the first 12 weeks gestational age by the trained midwives and above 12 weeks the medical practitioners are the one to decide if there is genuine reason or medical reasons that will pose a threat to the women's life or permanent physical impairment (Harrison & Berer, 2000).

Russian Federation and South Africa permits abortion on mental health, socio economic grounds beyond the gestational age limit (Harrison & Bere, 2000).
The challenge to the midwives is lack of understanding by the clients that, midwives are not allowed to conduct TOP if above 12 weeks following the Act

No 92 of 1996. Clients expect midwives to assist them as they request. Only doctors are allowed to perform procedures above 12 weeks (WHO, 1998).

2.6. CONSENT FOR TOP

In Mexico a woman requires husband consent for abortion but the Chief Intern of the institution may override the husband's refusal if a physician is able to demonstrate that the procedure is necessary to protect the woman's health. Unlike in Denmark, Italy and Norway a minor requires parent consent for authorization of the procedure or from a court of law or hospital committee (Rahman et al, 1997). In South Africa the CTOP Act No 92 0f 1996 allows any pregnant woman to volunteer to perform TOP without the permission of the parent in case of minor (WHO, 1998).

2.7. HEALTH FACILITIES AND PERSONNEL IN PUBLIC HOSPITAL FOR TOP SERVICES

In Great Britain, India abortion services are restricted to designated public institution under good medical conditions which can provide information, counselling should a woman chooses to keep her child or put for adoption or foster care (Harrison & Berer,2000). It is the same as South Africa where there are designated facilities to perform TOP. Personnel only midwives who have been trained to perform TOP below 12 weeks and medical practitioners (WHO, 1998).

The challenge to the midwife is that, there is no support from doctors to assist them when the pregnancy is above 12 weeks and the client despite of counselling she insists of performing TOP.

2.8. MANDATORY COUNSELLING BY MIDWIVES.

In all developing and developed countries counselling is done by the midwives and medical practitioners to each and every woman who requests TOP in the facilities where TOP is performed. Pre and post counselling must be done and full information must be provided on source of support for married and unmarried women in case of social reasons. In United States it is the same as practiced in South Africa a woman is given pre counselling and examination is done to check the gestational age of the foetus by manual and ultra sound in order to assist the woman in taking decisions (WHO, 1998).

If a woman chooses to do TOP, after the procedure she is given post counselling followed by family planning to prevent unwanted pregnancy. Information on brochures and posters are available to show women who request TOP to assist a woman to understand more about pregnancy (Rahman et al, 1997).

The challenge to the midwife is that, whether the client is coming for the first or second time counselling is necessary, and counselling consume more time which contribute to long waiting period for the procedure until the clients are more than 12 weeks gestational age. Since only one midwife is allocated at the clinic it becomes a challenge to midwives if they fail to perform procedures to some of the clients due to workload.

Another challenge to the midwife is that, despite of pre-and post counselling given by midwife; one client may come for TOP twice in one year. Because of shortage of staff midwife do not have quality time to give information. Those who repeat contribute to long waiting list for the procedure. Some clients do exceed 12 weeks while they are still waiting an appointment date for the TOP.

2.9. RESTRICTIONS ON INFORMATION FOR TOP

It is a common practice that countries restrict or limit advertisement regarding TOP. In France and Greece the policy is that medical care should be non commercial (Jonston, 2000). It is the same as in South Africa, professional nurses and doctors are not allowed to advertise their service. For awareness there are some topics presented by certain specialist related to the topic of that months in the health calendar which are presented in the radio slots. In Limpopo Province midwives also have radio slots where they present TOP at SABC Munghana Lonene and Phalaphala FM

The challenge to midwife is giving of information in the church and midwives are not allowed to give health talk in some of the churches like Roman Catholic Most of the pamphlets are written in English and most of out service users do not understand English hence community do not have enough information (Jonsto,2000)

2.10. PAYMENTS FEES FOR TERMINATION OF PREGNANCY

Many governments that permit TOP to be legal, fees for abortion are included in their national insurance coverage. There are other countries that are selective in funding TOP services, for example Austria and Lithuania. Only subsidised abortions are performed for medical are performed for medical reasons for example rape or incest (Fawcus, 1997). Unlike in South Africa where TOP services are free to all women who volunteer to perform TOP below 12 weeks pregnancy (WHO, 1998).

In South Africa only in private practice whir clients are expected to pay fees according to the practitioner. The challenge to midwife is that some clients use TOP service as a method of family planning because they are getting this

service free. More clients are reporting to TOP clinic for the procedure which to unnecessary workload which could have been prevented. One midwife in a clinic does not cope with the work.

2.11. AVAILABILITY OF RESOURCES TO PERFORM TOP

Although South Africa is the wealthiest in Sub Sahara Africa its resources are not spread adequately to provide basic needs like TOP to assist women who are staying in rural areas. For new act to be successful in reducing morbidity and mortality from unsafe TOP procedures in south Africa, TOP services will have be implemented so that they are available and accessible to all women . this will involve patient outreach, provider education, equalization and expansion through out the country and continuous monitoring of how these activities are progressing (Guttmacher et al 1996).The IPAS donated funds for equipments without budget for services (Althus, 2000).

In Limpopo province the South African Ministry of Health has designated 42 hospitals for TOP procedures but only 30 facilities are providing TOP services. There are limited resources to provide the services, for example poor infrastructures, shortage off staff, midwives and doctors who are willing to perform procedures (Althaus, 2000).

The National Health Services has made abortion free of charge, but in practice procedures are largely unavailable and most abortions are performed by pregnant women themselves which is a life risk. Unlike in Great Britain abortion resources are not available since women still do abortion by themselves in Ireland women are denied access to information on abortion. In Portugal because most of the doctors and nurses are unwilling to assist women who want TOP, most abortions are done at the private clinics. Only the rich who can afford to pay private clinics use them. (Rivera, 1997). It is the

same in South Africa where women travel from rural to urban areas where TOP is accessible and is done free.

The challenge to midwife is that clients present themselves to the clinic with septic abortions. Since such patients are nurse by the same midwife who conduct TOP it is n extra routine for the midwife which needs extra human resource who are not available.

2.12. SOCIO ECONOMIC FACTORS IMPACT ON TOP.

There is 20% of the Worlds population lives in the six countries that permit TOP for socio economic background which are the age, marital status and the number of living children (Rahman et al, 1997).

In some countries like Great Britain, Taiwan and Zambia the laws allow the effect of the continuation of pregnancy on a woman's living children as an important factor. Unlike in Finland, India and Japan, socio economic consideration is based on the protection of woman health whereas in child. Wealthy Chilean women can obtain TOP in private clinics, where they are likely to receive safe services and they are unlikely to be reported to the police. Wealthy Chilean women obtain TOP in these clinics, without fear of prosecution. In South Africa the socio economics is not considered for TOP except where the pregnancy will endanger the women's life and in case of rape and incest (http:www.cbctrust.com/historylaw religion.php).

These well to do Chilean women receive other services from pre counselling and counselling after the TOP (Rahman et al, 1997).

In India legal TOP are available in many rural areas and majority of TOP provided are believed to be performed in facilities by personnel not authorised by law. The situation in India does not show that legalising abortion does not

assure that it is accessible because it is estimated that average four women a year still resort to illegal abortion because of social taboos, misconception about the law and lack of skilled parishioners (http:www.cbctrust.com/history law religion.php) accessed 14 June 2006.

In china because of the concern of overpopulation, the government came with a harsh law in 1979. In urban areas couples were only permitted to have only one child. While in rural areas they were only allowed to have two children in very limited circumstances. A cultural preference for male children coupled with one child policy has resulted in a growing imbalance between the number of men and women in china today. (http:www.cbctrust.com/history law religion.php) accessed 14 June 2006

In Kenya abortion law remains restrictive, allowing abortion when the women s life is in danger. If women do illegal abortions, one can face an imprisonment of 14 years. The price for illegal abortion is very high which puts women into health risk. (http:www.cbctrust.com/history law religion.php) accessed 14 June 2006.

The challenge to midwife is when women present themselves at advanced stage where midwife cannot assist to perform TOP. This is because rural women do not have access to TOP.

2.13. RELIGIOUS, CULTURE AND TRADITIONAL BELIEFS.

Religious, cultural and traditional beliefs practices may be in conflict with this reproductive health rights and may be detrimental and harmful to the individual. For an example the Roman Catholic Faith denies women’s rights to use contraceptives and to do TOP. In black culture TOP is not encouraged since it believes that TOP might kill the men after making love with a woman

who has performed it. Since the government has given permission to those who do not want to participate in assisting a woman who chooses to do abortion still respect their religious belief, nurses tend to give reasons that they cannot volunteer to render the service according to their religious beliefs (Norris, 1999).

A study conducted by Medical Research in 2000 reveals that legalizing abortion in South Africa would save lives and health of women (Duncan, 2000). Negative attitudes of black community and some of the professionals in TOP services are of a grave concern to midwives who conduct TOP. This challenge contributes in shortage of staff for rendering TOP. South African law that allows an individual to refuse in assisting a woman who requests TOP according to her religious and cultural belies practices (WHO, 1998).

In February 2001, sister Charles in Mpumalanga Province advised hospital management in writing that she had become a Jehovah's Witness, and she did not wish to assist with uterine evacuations connected with abortion, and she was a theatre trained nurse. Management advised her to make some provisions in such situation. In August and September 2003 she was forced to participate in abortion despite her protest. The matter was reported to Doctors for life.

The sister went on maternity leave and coming back she was no longer placed in theatre, and the position was also taken from her and she submitted resignation (http: //www. consciencelaws.org/Repressionconsciencience-37) accessed 13 June 2006. The challenge is that the rights of the midwife were not considered which also contradict TOP Act No 92 of 1996 which allows a midwife to refuse if she is not willing to assist a woman who chooses to perform TOP.

From the Christian perspective, two areas are clear, that every human person has the right to life, is clear from the Human Rights Declaration. In addition, Holy Scripture, and Church Tradition have always emphasized the sacredness of life and dignity of each and every human being. From the point of Christianity and the Church's stand, TOP must be condemned in the strongest terms possible. No one has the right to put an end to human life, although the loss of life may be allowed, but only in extraordinary circumstances.

There is no stand for abortion even in pre Christian African tradition (Turyomumazima, 2000). The challenge to the mid wife is that clients who belong to those churches do go to hospitals and request TOP. As midwives they do not have right to refuse to assist if a clients request TOP because it is their right to perform TOP. Doctors for life will assist and give legal advice in cases where nurses, doctors and other health care workers are being pressurised to participate in TOP. The incident occurred in Philadelphia hospital again highlights the unbearable pressure exerted on healthcare professionals to take part in TOP Act against their conscience (http://www.consciencelaws.org/Repressionconsciencience-37) accessed 13 June 2006.

2.14. THE POSITION OF THE MAJOR CHURCHES AND SPIRITUAL GROUPS ON TOP.

There is some division on abortion policy in the Anglican Church which was discussed in Synod in 1980.The other group feels that it is immoral for a woman to do abortion and the other group feels that abortion could be done in the circumstances such as real economic hardships abortion may be morally sound, thus should not be denied to women.

In 1989 the Anglican Church took a position that abortion be allowed only if the pregnancy endangers the women's physical or mental health life. It stated that abortion should never be used except for serious therapeutic reasons. The challenge is that nurses are seen as sinners, that is why they are not accepted by the community members because of the conflict between the TOP Act and the church leaders (http://www.cbctrust .com/history religion.php) accessed 30 June 2006).

In 1989 the church adopted a statement that permits a woman to do TOP where the women's life is in danger. There was no agreement on circumstances under which abortion may take place. Lutheran church in Canada rejected abortion, and regarded it as immoral, and that it may also lead to the death of the mother. (http://www.cbctrust.com /history law religion.php) accessed 30 June 2006. The challenge is that midwives are not to decide for their clients, their responsibility is to give information and the clients should take their own decisions. Church leaders see midwife as sinners who work against God.

Roman Catholic Church considers contraception "intrinsically evil'' and takes the most rigid stance against abortion. Debate still continues in Catholic Church. Today Catholics believe that it is a woman's choice to do TOP. There are two groups which differ in opinion, one says abortion should be a right of every woman and the other group believes that TOP should be done only when it endangers the woman physically or to her mental health (http://www.cbctrust.com/history law religion.php) accessed 14 June 2006). The challenge is that midwives give information on TOP which contradicts their Christian faith. Midwives are trained to give pre counselling to everyone and the client decides on her own not considering religious and cultural belief of the client.

2.15. CONCLUSION

Chapter two focused on literature review. Many publications by various authors were consulted for the purpose of this study. The findings in the literature are that world wide there is a shortage of human resource in all the health facilities. Better resources are available at the private sectors. In most countries laws regarding TOP are the same for an example the gestational age for TOP which is from conception to 12 weeks. In most countries TOP is available only in few countries where it is inaccessible to clients of poor status like in Great Britain. The aim was to develop guideline on the improvement of TOP services at various health facilities world wide and try to compare with South Africa. The objective of the study is to determine and describe the challenges that affect midwives who conduct TOP.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. INTRODUCTION

Chapter three deals with the research design, targeted population, area of study, sampling methods, ethical considerations, data collection methods and procedures of the study. The aim of the study is to determine and describe the challenges affecting the practice of TOP by the midwives.

The objectives of the study were to:
To determine the challenges that affect midwives who conduct TOP.
To describe the challenges that affect midwife who conduct TOP.

3.2. RESEARCH DESIGN

The researcher has followed a qualitative and descriptive design for data collection method (Neuman, 2000). Exploratory research is conducted to gain insight into a situation, phenomenon, community or individual (Bless & Higson-Smith, 1995). Usually no numbers or counts are assigned. A qualitative design looks at the non numerical organisation and interpretation of data in order to discover patterns, themes, and qualities found in field notes, interview transcript, unstructured open-ended questions (Wilson, 1993).

The definition is supported by (Streubert & Carpenter, 1999) who indicate that in qualitative research, researchers conduct extensive investigation using unstructured interviews, observations, in the real life of the study participants midwives as they experience challenges when conduct TOP to women who volunteer to come to the service. By using a qualitative design, it was possible

to capitalise data as a means for understanding and interpreting challenges of midwives who conduct TOP (Polit & Hungler, 2000).

- **Descriptive design**

Descriptive research is a method where the researcher, select a specific event, condition or behaviour and make observation and records of the phenomenon (Polit & Hungler, 2000).on the other hand, Seaman (1987) indicated that that in descriptive research, the researcher plans to assemble new information about an unstudied phenomenon and its purpose is to obtain new knowledge by describing concepts of the collected data about the phenomenon under study. Descriptive studies enabled the researcher to gain additional information about certain characteristics within a particular field of study, with the purpose or providing a picture of the situation as it naturally occurs (Burns & Grove, 1997).

In this study, a specific aspect was selected title “Challenges that affect midwives who conduct TOP”. All the information obtained was recorded using a tape recorder and some information was recorded as field notes. The information obtained fully in the next chapter that will deal with presentation, discussion of findings and literature control.

3.3. AREA OF STUDY

Area of study was Bohlabela district situated South East of Limpopo Province about 235km away from Polokwane. Bohlabela is one of the Nodal point district amongst the six districts in Limpopo Province and it is at the cross boarder of Mpumalanga Province. Bohlabela district has two Municipalities, which are Bushbuckridge and Maruleng Municipality. The population is about 1087974 composed of lower and middle class. Nationality, they are all Africans. Ethnicities, there are few whites and Indians. There are lots of Pedi

(Pulana), and Tsonga. Bohlabela district consists of different ethnic groups that are Sotho, Swazi. There are a lot of informal settlements due to refugees from our neighbouring countries e.g. Mozambique, Swaziland and Zimbabwe. Most of them are unskilled labourers working on the farms.

The district is hot in summer and too cold in winter. Bohlabela district is a mountainous area with vegetations and waterfalls.

Residents are practicing different religions the district but most of them are Zion Christian Church and Nazarene Church. They use public transport such as buses and taxis to go to work. There are more young females than males and most of them are illiterate. Adult males depend mostly on business, running spaza shops and general dealers.

3.4. POPULATION

Population refers to individuals in the universe who possess specific characteristics, or to a set of entities that represent all the measurements of interest to the practitioner or researcher (De Vos, 2004). In this study population consists of all midwives in hospitals under Bohlabela district who are currently rendering TOP services. There are three hospitals in Bohlabela and in each hospital.

3.5. SAMPLING METHOD

Sampling is described as taking a portion of a population or universe and considering it representative of that population or universe. Sampling is done to increase the feasibility, cost effectiveness, accuracy and manageability of the prospective survey (De Vos, 2004). Marshall & Rossman, (1995) state that a sample comprises of the elements of the population considered for actual inclusion in the study.

According to (Neuman, 2000) sampling means taking any portion of a population or universe as representative of that population. Polit & Hungler (2000) defined sampling as a process of selecting a portion to present the entire population. (Seaman, 1987) and Parahoo (1997) supports this definition by defining a sample as a subset of the target population and the procedure for selecting a small proportion of the population is then called sampling.

The researcher used purposive sampling in this study. Purposive sampling involves selecting a group of people because they have particular traits that the researcher wants to study (Marshall & Rossman, 1995). The samples of the study comprised of 6 midwives who are currently conducting TOP in the three hospitals at Bohlabela district.

3.6. DATA COLLECTION METHOD

Data collection method was in depth unstructured individual interview to enable the researcher to describe the challenges that affect midwives who conduct TOP. De Vos (2004) and Polit and Hungler (2000) define interview as method of data collection in which one person (interviewer) asks questions to another person (respondent). Interview allowed the researcher to explore greater depth of meaning than can be obtain with other techniques.

Unstructured interview using one central was asked as **“Could you kindly give challenges that affect your practice in TOP since you have started to render the service”.**

Good interpersonal relation skills may be used to get cooperation and more information from the participants (Burns & Grove, 1997). Data was collected by one person only and this ensures that there was a consistency and reliability in the manner in which data was collected as supported by (Brink,

1996). Two midwives were interviewed per day in each hospital. Each participant was scheduled for two hours.

The researcher use the office organised by the participants in their working environment. The environments were conducive as they were quiet in their unit manager's office.

3.6.1. PROCEDURE FOLLOWED FOR DATA COLLECTION

- **Initiation phase**

This was the introduction phase during which the researcher and the participants introduce each other to establish rapport. The participants were explained about the research topic, questions, its purpose and the significant of the study.

- **Working phase**

In this phase data was collected using the following questions" what are the challenges affecting you in rendering TOP services since you have started" followed by probing questions which made the participants to give more information until data became saturated. What are your suggestions which can improve the challenges affecting TOP? Interviews were conducted in English since the participants were professional nurses.

- **Termination phase**

After the interviews the researcher asked the participants if there is anything that needs to be clarified regarding the study related to their work and the study. The researcher thanked all the participants for their time and sharing

their experience for the benefit of staff and clients. Debriefing was done which is the way during which participants got the opportunity, after the study to work through their experience. The participants were informed about the end of the interview and their role as participants.

3.6.2. DATA RECORDING METHODS

- **Tape recorder**

In order to overcome inaccuracy tape recorder and filled notes have been utilized to record the information from her participants. This was done within twenty-four hours to ensure that no information was lost. After the interview, the tape recorder was opened and made the participants listen to what they been saying by answering the questions asked by the researcher.

- **Filled notes**

Filled notes represents the researcher's efforts to record information while the participants explaining to synthesise data and to understand data (Polit & Hungler, 2000). The researcher was responsible to take notes and sometimes make follow up question to what has been said by the participants for clarification purposes.

3.6.3. ENSURING TRUST WORTHINESS

Lincolin & Guba (1981) criterion for trustworthiness has been utilized to ensure the validity and credibility of the study. The gaol of the qualitative research was to accurately represent the participant's experiences. Lincoln & Guba (1981) suggest four criteria to indicate trustworthiness. Guba's model

describes four criteria of trustworthiness, namely truth value, applicability, consistency and neutrality, which are relevant to the evaluation of the worth of research.

These four criteria have been described within the qualitative research perspective. Each criterion has been presented with relevant strategies to meet the requirement of these criteria. Truth value was ensured by using the strategy of credibility, applicability was ensured by using the strategy of transferability, consistency was ensured by using strategy of dependability and neutrality was ensured by using

Strategy of conformability (Lincoln & Guba, 1981).Streubert & Carpenter (1999) also support the use of these measures-credibility, dependability, conformability and transferability to ensure trustworthiness. They indicate that credibility includes activities that increase the probability that credible findings will be produced. The purpose is of this exercise is to have people who have lived the described experience validate the reported findings represents their experiences (Streubert & Carpenter (1999).

TABLE 3.6.1 Application of Trustworthiness Using Lincoln & Guba (1998)

STRATEGY	**PRINCIPLE**	**MEASURE**	**APPLICATION**
Credibility	Truth-value	Prolonged engagement	-The researcher first called participants to explain and give necessary information regarding the study and to make an appointment. -An average of 2 hours was spent

			in each participants conducting in-depth individual interview -Follow up probing questions was made to get more information and clarifications. -One hospital was visited per day -Interviews were conducted in the Unit Manager's office -The environment was conducive to prolonged engagement with the participant
		Method triangulation	-Individual in-depth interview were used to collect data -Observation of non-verbal expression was done
		Method checking	-After the interviews a tape recorder was replayed and the participants were asked to listen to the tape to verify the information while the researcher was checking the filled notes.
		Authority of the researcher	-The researcher is an Assistant Director for Nursing. She is involved in supervision at the clinical area

STRATEGY	PRINCIPLES	MEASURE	APPLICATION
Applicability	Transferability	Sampling	-Purposive sampling was used to select midwives who are currently conducting TOP -Participants were assured of confidentiality throughout the study
		Data collection	-Individual in-depth interviews were used to collect data. -Field notes were also documented to make sure that the findings of the transcriptions correspond. -Tape recorder was used in order to capture everything during interviews.
Consistency	Dependability	Audit trial	-Cassette and filled tape transcription notes were kept notes
		Dense description	-As discussed under transferability
		Method under triangulation	-As discussed under credibility
Neutrality	Conformability	Triangulation	-As discussed under credibility

		Reflexive analysis	-The researcher continuously reflected on her own values and beliefs and examined how they could influence data collection and analysis.

3.7. ETHICAL CONSIDERATION.

Lincoln & Guba (1981) define ethics as a set of moral principles that are suggested by an individual or a group, are subsequently widely accepted, and offer rules and behavioural expectations about the most correct conduct towards experimental subjects, respondents and other researchers. Ethical guidelines serve as standards and as basis on which a researcher ought to evaluate her own conduct during research (Polit and Hungler, 2000).

In this study the researcher has obtained permission from the Department of Health and Social Development committee's, Chief executive officers from hospitals. The researcher has also asked permission from the respondents after explaining the nature of the study to them and how it would assist them in future. The Nurse Manager and the Deputy Manager where the candidates are working have been informed since the respondents preferred to use official hours.

The researcher also allowed the respondents to ask questions related to the study so that everyone could give informed consent and the researcher has made sure that the information remains anonymous. The researcher has ensured that the technique used should not be harmful to the respondents. The respondents have been informed about their rights to refuse or withdraw

at any time. Confidentiality has been maintained. The candidates will be informed of the outcome of the study as soon as it is available.

Ethics are concerned with doing well and avoiding harm (De Vos, 2004). The possibility of doing good depends partly on actual knowledge and partly on values. It differs according to the cultural and religious norms and values of a specific society in a particular profession and is based on the principles that are used to satisfy actions (De Vos, 2004). The researcher considered ethical issues throughout the research process. The following ethical standards were considered.

- **Voluntary participation**

The participants were told that they were not forced to participate, as it was completely voluntary. They had a right to refuse to participate without any fear. They may withdraw from participating any time if they felt they were no longer comfortable (Babbie, 2001, Polit & Hungler, 2000).

- **Informed consent**

Informed consent is the agreement or permission of the individuals after they have all the information they need to make a decision on participation. It refers to provision of adequate information to participants for them to consider whether to participate or not without any fear (Polit & Hungler, 2000).

The participants were fully informed about the purpose of the research and voluntary participation. The participants were assured of privacy, confidentiality, the right to self respect and dignity, the right to self determination and informed consent (De Vos, 2004).

- **Confidentiality**

Confidentiality involves the obligation of not divulging the information obtained from the participants to a third party without the permission of the participants (De Vos, 2004). The participant's right to confidentiality was maintained by ensuring that their names were not disclosed. Information obtained was not linked to a particular individual. The researcher was the only person who interviewed the participants.

- **Privacy**

Privacy is the right to keep certain information to oneself. It is the obligation to maintain limited access to a person's knowledge, information and property. It is the participants right to determine conditions under which private information will be divulged to others (Burns & Grove, 1997).

The researcher respected participants right to privacy by interviewing them individually in their counselling rooms and allowing them to discuss issues that they felt comfortable with. No participant was forced to talk about issues that they were not willing to share. Participants were assured that information obtained would not be linked to them and that no raw data would be published.

3.8. LIMITATIONS OF THE STUDY

- Population was very small to represent the Province or South Africa for the results to give clear picture of the study.
- The study was conducted without theoretic framework. The research was interested in describing the phenomenon that may be incorporated into a theory by other researchers.

- Limited studies on the topic.
- Participants preferred to be interviewed during working hours.

Some of the participants changed their appointments due to shortage in the wards. It was not easy to get an appointment, since they all preferred to be interviewed during working hours giving reasons that after hours they are tired and they are busy with other private activities.

3.9. CONCLUSION

Chapter three dealt with data collection and procedure and ethical consideration, Data was collected by taking notes and also using tape recorder and filled notes. Data was collected from midwives who are currently rendering TOP in three hospitals at Bohlabela district.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.1. INTRODUCTION

This chapter focuses on the research findings. The findings are categorised according to main category and sub category. In the discussion of findings, relevant data from the literature were incorporated. It should be noted that the literature, which focus on challenges affecting midwives who conduct TOP were not found. Lack of literature could be regarded as a limitation of the study

The purpose of the study was to develop guidelines on the improvement of challenges that affect midwives who conduct TOP services at Bohlabela district in Limpopo Province in South Africa. Qualitative methods were used to determine and describe the challenges affecting the midwives. The following research question was asked"

"**What are the challenges that affect you in conducting TOP services in the Bohlabela district of Limpopo province?"**

From the data collected, the following themes and sub-themes appeared more frequently as illustrated in Table 4.1 namely,

- Inadequate human resource
- Poor infra-structure
- Lack of equipment
- Poor management support
- Lack of support by colleagues
- Negative attitudes by community members.

Table 4.1. The challenges affecting midwives.

Theme	Sub-themes	Descriptors
Challenges affecting midwives	1.Inaequate human resources	Midwives who are trained for TOP services resign or transfer to other hospital. Professional nurses are not willing to volunteer to render TOP Professional nurse have the right to refuse, if you do not want to render TOP services
	2.Lack of equipment	No budget is allocated for the programme Cannule is too old and is worn-out One 50cc utilized since the programme has started
	3. Poor infra-structure	The programme started after the construction of the hospital hence Small one room is allocated to render TOP service. One room is used for assessment, counselling and as a procedure room.
	4.Poor management support	One midwife is allocated to render services in a month or for a certain period. Policy guideline not adhered related to number of clients to be counselled and procedure to be performed in a day. Religious and cultural beliefs. Lack of interest to the programme.
	5.Lack of support by colleagues	No doctor is willing to render TOP services. No adherence to TOP policy guideline

		Very few midwives are wiling to assist a woman who volunteer to provide TOP Poor management support Religious and cultural beliefs
	6.Negative attitudes by community members	Community not keen to utilise the TOP services Community do not have information of TOP Act Church members and church leaders were had negative attitude's towards TOP

4.2. PRESENTATION OF FINDINGS

4.2.1. Inadequate human resource

Inadequate human resource was highlighted as one of the major problems which midwives were experiencing. This was expressed as workload and insufficient knowledge and skills. The following discussion will explain the findings as they emanated from research findings.

Workload refers to the increased number of activities above the basic requirements. Guttmacher et al (1997) mentioned that work overload prevented nurses from giving quality service to their communities and may lead to burnout. This was found to be caused by integrated of services which left midwives with limited time to provide proper TOP services. The problem of insufficient time due to integration of services, where a midwife is expected to take observations, assessment, examination, pre-counselling, performance of procedure and issuing of treatment and post-counselling.

All the participants indicated that there is a shortage of staff. According to TOP guideline, the clinic should be run by two midwives and one enrolled nurse. In all the clinics only one midwife is allocated to render TOP services from Monday to Friday at 13.00.

One respondent reported as follow **“We are only two midwives trained on TOP services and the challenge is that, one midwife is allocated to render the following functions, that is assessment of clients, pre-counselling, performance of the procedure, giving of treatment and collection of blood before the procedure if that client is booked for the procedure”**

One participant said **“Majority of midwives do not want to participate in providing the service and they say, their religious and cultural belief does not allow them to render TOP services”.**

Another participant “for manual vacuum aspiration we are allowed to do three to four per day, for assessment there is no limit but I do assessment until 13.00 after that T tell them to come the following day since I have to do manual vacuum aspiration in the afternoon to clients whom I have inserted cytotec for induction and they have started bleeding”.

The researcher asked the participant if the statistics is decreasing or increasing since she has started to render the service. The participant said **“The stats is increasing and because sometimes one person is coming twice to perform the procedure in the same year, since there is no limit on how many times a person is allowed to perform the procedure. Neither age needed” restriction nor consent**

The researcher requested the statistics which shows whether the number of clients who come to request TOP is increasing comparing the current situation and when the programme stared. The statistics collected on a daily basis show that people are utilizing TOP service.

The challenge to midwives is that people do come for the service but they do not have enough information regarding the TOP Act No 92 of 1996 which stipulate that TOP should be performed by midwives when the gestational age is below 12 weeks. Some of the clients report to the clinic already above 12 weeks and giving reasons that, they did not have money to come for the procedure.

One participant expressed as follows **“Clients come to the hospital already above 12 weeks and when you ask the client why she report so late, she will tell you that I did not have money for payment”.**

Challenges to those who are willing to assist midwives cannot cope with the workload if others do not volunteer when others resign or transfer to other hospital. According to TOP guideline, the programme should be run by two midwives, one enrolled nurse and one general assistant. This was not a case in all the clinics used as samples. Only one midwife was allocated to provide TOP services from Monday to Friday at 13.00.

Ignoring the rights of midwives might have contributed to shortage of staff to perform TOP. In February 2001, Sister Charles in Mpumalanga Province advised hospital management in writing that she had become a Jehovah’s Witness, and she is no longer going to assist with uterine evacuations connected with abortion. Since she was a theatre nurse, management advised her to make some provision in such situations. In August and September she was forced to participate in abortion despite her protest. The

matter was reported to Doctors for life. The sister went on maternity leave and coming back she was no longer placed in theatre, and the position was also taken from her and she submitted resignation(http://www. consciencelaws.org/ Repressioconcience-37) accessed 13 June 2006.The challenge is that the rights of the midwife were not considered which also contradict. According to TOP Act No 92 of 1996 a midwife has the right to refuse to assist a woman who volunteers to perform TOP.

Similar problem of shortage of staff to perform TOP was revealed in other countries. In the United State of America only 7% of hospital offered the TOP services compared to 50% of hospitals and more nurses are refusing to undergo training to perform abortions (Fawcus, 1997).

Since the government in South Africa has given permission to those who do not want to participate in assisting a woman who volunteers to perform TOP, it contributes to shortage of staff because most of the midwives give reasons of their cultural and religious belief hence they may not assist a woman who request TOP (Norris,1999).

The findings could imply that, since only one midwife is allocated to render TOP services and that midwife is expected to assess clients, do pre and post counselling to clients. Workload causes stress to midwives and burnout. The policy guidelines need to be adhered to improve quality patient care. Two midwives to be allocated to render the service, one for assessment and counselling and one to perform procedures and give treatment and issue family planning. The policy guideline needs to be adhered to.

4.1.2. Shortage of equipment to perform TOP procedures

All respondents said, they are challenged by shortage of equipment, which contributes to poor adherence to maintain sterility and prevention of cross infection.

Participants mentioned that "**Sometimes it is not easy for the midwife to disinfect equipment effectively since it is only one syringe 50cc to be used for four clients in one day. The equipment is also too old they need to be replaced**".

One respondent expressed how one 50cc syringe is being utilised to perform to 3-4 clients per day. Furthermore the unit was described to have lack of budget allocated to purchase equipment. According to TOP guidelines only three clients to be performed procedures per day (Act No 92 of 1996).

The researcher observed that all the TOP clinics equipments are worn out and too old. They are utilizing equipment issued when the programme introduced by Advance women's reproductive rights Organisation.

Another concern that midwives have was the budget allocation. The programme is not included in the hospital budget to maintain and for repairs of equipment. In all the facilities they are concerned about the old equipment that is utilized for the provision of quality patient care. One respondent said **"I am using 50cc syringe that was issued by Advance women's reproductive rights Organisation (IPAS) when the programme started, the cunnule is worn-out, we have submitted inputs for the equipment but all in vein hence we are saying he management does not support us. We feel the programme is not supported like other programmes in the hospital".**

Inadequate equipment posses a threat to patients since there is no proper disinfecting of equipment as they are using one syringe and there is not enough time to sterilise the equipment in between the procedure

Shortage of equipment causes stress to midwife, because they have to wait for certain minutes to wash and disinfect the equipment for further use. Sterility is a great challenge on rendering effective and efficient TOP service.

Although the participants indicated the issue of shortage of equipment, they emphasise the importance of surgical clean and sterility in carrying out their procedures on daily basis. There is need for the budget to be allocated to buy or maintain equipments to be utilized.

4.1.3. Poor infrastructure for TOP

The infrastructure was perceived by participants as poor condition and small in size. All participants confirmed that they are rendering service in a very small room. The same room is used for the procedure, counselling and as a treatment room. Participants expressed difficulty to maintain privacy.

One participant said, "**The space is too small, it is like a toilet. There is only one room which is used as examination room, counselling room, as a procedure room and treatment room where I administer contraceptives injections or issue oral contraceptives".**

Another respondent said**, there is no privacy, clients make queue in the passage, and seen by everybody. My colleagues even verbalises loudly that, you are coming to kill babies in so much that clients even hear**

them when passing those remarks. No space to give health education as a group since we are short staffed and it is time consuming to give individual health education and there is no manpower to do that since I am allocated at the clinic being alone".

One participant said **"Because clients just queue in the passage and seen by everyone while waiting for assessment, due to lack of privacy one general assistant saw one client who was her neighbour. She told the mother in law of the client that she saw her daughter in law at the TOP clinic in our hospital where I'm working and that client was divorced since the husband was not aware that his wife was pregnant".**

One participant mentioned "**it is not possible to maintain privacy because all the clients are waiting in the passage while waiting for consultation. Everyone who passes there looks at them as killers some of the workers even ask them funny questions. The client does not feel free while waiting for pre counselling and the procedure. While you are still busy with one client one will open the door while you are busy examining the client or while you busy with counselling colleagues also enter in the room looking what they want".**

Majority of the participants said that, there was no proper communication with the service providers to consult them to check if ever the room allocated for TOP will be suitable for the programme. The programme was introduced after the construction of the hospital, which means the programme was not planned before hence now it creates a challenge.

Another challenge expressed by participants is management support with regard to space to provide TOP services. When they are asked assistance from the management when the clinic is full, and they are called to come and wetness the situation, they do not listen to them, they tend to be busy with

meetings. Participants expressed their feelings of leaving the service because of lack of support

Although South Africa is the wealthiest in Sub Saharan Africa its resources are not spread adequately to provide basic needs like TOP to assist women who are staying in rural areas (Guttmacher,1996). According to literature developed countries are reported to be of good standards. Poor infra-structure particularly where the study was conducted in South Africa particularly Limpopo Province.

In Limpopo Province the South African Ministry of Health has designated 42 hospitals for TOP procedure but only 30 facilities are providing TOP services. There are limited resources to provide the service, for an example poor infrastructure, shortage of staff, midwives and doctors are not willing to assist to perform procedures.

There is a need for proper infrastructure to be built or to be allocated for the TOP service since clients have a right to privacy. Three rooms need to be allocated for assessment, counselling session, procedure room; office for records and waiting area for the clients not to wait in the passage seen by everyone who passes there. This is a challenge to the midwives who need to respect client's privacy render an efficient and quality service.

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4.1.4. Lack of management support

Majority of participants mentioned that, there is no specific budget for the programme allocated; hence they do not have equipments, only consumable supplies received from the hospital stores. No ward round done by Nurse Managers to see and check if ever what is being reported is true about the space.

One respondent said "**There is no support at all. I have attended workshop at Mpumalanga Province and we were issued with guidelines policies which stipulate how the clinic should be staffed. The policy guidelines also indicates that the service providers should get one day off per month as a rest day but the Deputy Manager of the unit said she cannot comply with the policy guidelines. I even submitted motivation in writing for me to get rest day according to the policy and I was answered verbally instead of a written correspondence as I did. The hospital managers when you asked assistance from the management if you are experiencing problems related to patients, they do not listen to you; they tend to be busy with meetings. At some stage you feel like leaving the service because of lack of support".**

One participant said " **It is long we have been complaining about the space and requesting them to come and see how difficult it is to work in one room, they keep on promising that they will come. We feel the service is not considered like other programmes; therefore we feel we are not supported by management. The hospital managers never visited the clinic to see what is happening at the clinic".**

The National Health Service has made abortion free of charge, but in practice procedures are largely unavailable. Management fail to support the programme by providing personnel according to TOP guidelines who can assist at the TOP with the workload. This is contributed by respecting the religious and cultural belief of the staff since they may not push them to volunteer to participate in providing the service. Clients who fail to get appointment for the procedure they go to private sectors and pay lot of money meanwhile the programme is available free provided by the government, which is the same practice in Great Britain and Portugal abortion resources

are not available; women still do abortions by themselves (Rahman et al, 2000). Management fail to provide conducive environment for the staff to render the service and this contribute stress and burnout. Midwives are not given rest day in a month according to guidelines policy (CTOP Act No 92 of 1996).

World wild doctors and nurses are unwilling to assist women who want TOP at the public facilities. Most abortions are done at the private clinics (Rivera, 1997). This is contributed by lack of management support to the programme to allocate sufficient resources like human resource and equipments to run the programme. This means that proper space needs to be allocated. Staffing need to be reviewed according to TOP policy guidelines.

4.1.5. Lack of support by colleagues

Other challenge expressed by participants is that colleagues do not have interest to help in performing TOP procedures. For an example taking blood from those who have been booked for the procedures. Attitudes of colleagues frustrate the midwife because they see them sitting while they are running around and they are just looking at them though they have volunteered. **One respondent said "clients see us as nurses who can assist them; they don't know that there are specific nurses who are providing the TOP services. Some patients do cry and want to be performed meanwhile its above 12 weeks despite explanations".**

One participant said, **"I never had problem with foreign doctors, they were supportive, and willing to assist where there was a problem. Since that doctor is gone, no doctor is willing to assist. Clients are sent back home if they are found to be above 12 weeks gestational age"**.

Another participant said "**We are two midwives trained on the programme but only one is allocated. We relieve each other if one is on leave and if she is on night shift. There are very few midwives willing to assist to render TOP services due to religious and cultural beliefs".**

The participant said "**when I started the service there was no support from my colleagues, some of my colleagues were saying I am a killer and that was because of lack of information on TOP. I never had problems with foreign doctors, they were supportive, and willing to assist where there was problem. Since that doctor is gone, no doctor is willing to assist. Clients are sent back home if they are found to be above 12 weeks gestational age".**

These imply that the policy needs to be reviewed about the rights of a professional to refuse in assisting the clients. The policy need to state how often is a person is allowed to perform TOP, because these also contribute to clients not adhering to family planning methods. Awareness campaign needs to be facilitated to make community aware.

4.1.6. Negative attitudes of community members

Participants expressed the negative attitudes of community members towards them performing TOP. They said at the beginning of rendering TOP services community members were not keen to utilize the service. According to African culture to perform TOP is a taboo hence it was not easy for women to volunteer to perform TOP. In one of the facilities midwives came up with the strategy by giving health talks about TOP in the radio slots and give information related to TOP.

One respondent said **"I have organised to give information about TOP in Bushbuckridge radio station through the hospital community liaison**

officer. After the first presentation I saw improvement, clients were coming asking question related to TOP. I continued to present the topic for the period of three once a month".

However some respondents indicated they were able to gain cooperation from members of the community**.** One respondent said **"No problem experienced in the community. Before I went for TOP training, I have discussed with my family that I will be conducting TOP when I come back from training. She started by educating her community and her family in order to get cooperation since the service is sensitive and it's new to our society. I sometimes give health talk to women's guild about CTOP Act No 92 of 1996 and tell them the advantage and the disadvantages of performing TOP. I encourage women to talk to their children not to ask or wait for another person to talk to them".**

One respondent said **"community members were afraid to show up at the clinic. As a team we thought of another strategy of combining TOP with family planning and Pap smear screening".** Participants further expressed that the strategy had an impact; the community showed some positive responds by coming and requesting TOP. Continuous health talk and information sharing was done to make community aware about the service and its benefits'.

One respondent said "**from my church I did not encounter any problem. I belong to Zion Christian Church (Z.C.C) as member I told them that I am from training to conduct TOP services to promote health status of women and to prevent unwanted pregnancy and to avoid death due to septic abortions".**

Although the law may have changed, attitudes haven't by the community members, some of the health professional, church leaders and traditional leaders they still believe to their religious and cultural beliefs that to perform TOP is a sin. The biggest survey done amongst doctors showed that 80% of South African doctors are against abortion on demand (DIL Abortion Clinics, 23 June 2002)

The status of women in Nigeria is extremely low. There is very little support in making abortion legal on request. Medical Association wants abortion be legalized but that is not expected in the near future with the opposition coming from the religious leaders (http:www.cbctrust.com/history law religion.php) accessed 14 June 2006.

4.3. CONCLUSION

The common challenges to midwives are inadequate human resource, poor infrastructure, lack of support by colleagues and management. This creates friction and conflicts between the employer and employees.

CHAPTER 5

GUIDELINES, CONCLUSION, AND RECOMMENDATIONS

5.1. INTRODUCTION

This chapter will discuss the guidelines developed to improve TOP services rendered by midwives, conclusions, and recommendations of the study. The objectives of the study were to determine and describe the challenges that affect midwives who conduct TOP at Bohlabela district in Limpopo Province.

5.2. GUIDELINES WITH REGARD TO IMPROVEMENT OF TOP SERVICES.

The study followed the principles of developing guidelines as described by Chin & Kramer, (1986) and Lincolin & Guba, (1981).The guidelines developed in this study are aimed at improving TOP services by midwives in Bohlabela district in Limpopo Province however, they could apply in similar situation in South Africa. The implementers of guidelines will constitute the stakeholders who collaborate with activities of improving TOP services namely, the government, employer in the public services and midwives.

- **Government**

All public hospital (regional or district) should be designated to render TOP services. The programme to have its own staff establishment and budget.

Value clarification workshop to be conducted to educate community on the advantages and disadvantages of TOP.

A client is allowed to perform TOP procedure once in a year. One client not to perform TOP procedures twice in her lifetime. If married, consent from her husband need to be obtained before the TOP procedure. Pre-counselling of both parties need to be done for the period of four weeks before the procedure and post-counselling for the period of two months in alternate weeks. This is done to make sure that clients took decision with understanding of what they are doing and its implication thereafter. Minor to come with their parents to assist in decision making. Social workers to be involved if the reason for performing TOP is social problem. And also if a client is minors, mental health disorders, rape and incest. Parents to be counselled separately with their children.

TOP guidelines should be revised by first consulting service providers more especially midwife.

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TOP clinic should be allocated three rooms, one big area health education should be given to all the clients same time to reduce time constraints due to shortage of staff.

- **Health services**

TOP service should be accessible to every one who needs it. The clinic and hospitals that render the service should operate 24 hours and during week-ends to accommodate everybody. Information should be given; promotional material should be accessible to all the people who need it in all the official languages. The environment where TOP procedure is performed needs to be improved by management, allocating bigger rooms for TOP services. Privacy

need to be maintained since the clients have rights to privacy and not to queue in the passage and be seen by everybody who passes by.

Information about reproductive Health should be made available in all the facilities. Women should get information required related to reproductive health and other health matters bothering them. Posters should be displayed in all local languages that will assist in disseminating information to the relevant people. Pamphlets should also be made available in all the facilities.

Awareness campaign on TOP should be conducted. To make women aware of their rights related to reproductive health programme available for them to utilize in order to raise their health standards.

- **Midwives**

Introduction of scarce skill allowances. Midwives who volunteer to render TOP services should be given scarce skill allowance to attract midwives since most of the midwives do not want to render this service and the midwives who currently volunteer to perform TOP procedures do not cope with the workload in the designated institutions.

Midwives responsibilities should include the following, respecting the woman's rights, needs, and decisions, providing accurate information, fostering communication, protecting the woman's privacy and dignity and promoting health (Rivera,1997). Midwives have to attend debriefing twice a year in order to share experiences with colleagues and get advises from programme directors.

5.3. CONCLUSION.

The findings of the study revealed six challenges that served as sub-themes for discussion

- Inadequate human resource

This is contributed by midwives who resign or transfer to other hospitals. In most cases they do not continue providing TOP service where they have relocated. Midwives are not willing to volunteer to render TOP services. The TOP Act allows the right of the midwife to be respected if she is not willing due to religious and cultural beliefs.

- **Shortage of equipment to perform TOP procedures**

The programme has been introduced without allocation of the budget to maintain the environment and to purchase equipments. Lack of management support to provide necessary equipment for quality patient care. Negative attitude by some of he management due to their religious and cultural beliefs

- **Poor infra structure**

The programme has been introduced after the hospital was build. The programme was not planned, hence it is difficult for the management to allocate conducive environment for the programme. Midwives provide TOP services in a one small room which makes it difficult for the midwives to maintain privacy to their clients. The clients have a right to privacy.

- **Poor management support**

Midwives feels they are not supported by management since two midwives have been trained to provide TOP services but only one midwife is allocated at the TOP clinic. TOP guidelines on staffing is not adhered to by management which says two midwife to be allocated to render the service not one. The cultural and religious belief of the management contributes not supporting the programme.

- **Lack of support by colleagues**

In all the facilities doctors are not interested in assisting a woman who volunteers to perform TOP. Very few midwives volunteer to go for training on TOP. Midwives fail to adhere to TOP policy guideline which says in a day, a midwife should perform procedure to three to four clients. Due to high number of clients requesting TOP, midwives perform procedures sometimes to five clients.

- **Negative attitudes by community members**

Community members were not keen to utilize the TOP service since according to African culture is a taboo to perform TOP. Community did not have information related to CTOP Act No 92 of 1996. Church and traditional leaders had negative attitudes towards TOP until midwives came up with the strategy of educating communities utilizing broadcasting in the radio station of Munghana Lonene and radio Phalaphala.

Although the law tries to change attitudes of traditional society, it is not surprising also when the nurses and medical doctors are not interested in assisting women who want to do TOP. Survey done amongst South African doctors shows that about 80% are not willing to assist in rendering TOP (Keninger, 1986).In all the three hospital at Bohlabela doctors are not interested in assisting a women who volunteer to perform TOP if is above 12 weeks where a midwife cannot perform that procedure according to TOP Act No 92 of 1996.

At present almost two thirds of the women throughout the world, live in countries where abortion is legally obtainable for social, economic and for personal reasons or benefit. In all the countries where abortion is liberal it cannot be assumed that women have equal opportunity of getting an early safe abortion if she needs one. In all countries there are still some problems like lack of medical facilities or personnel, women's low status in the society, cultural taboos regulations and financial constraints for the procedure and for the transport to the facility since only designated facilities are permitted to perform TOP on request by the client (Althaus, 2000).

There is a need for all governments, relevant inter govern mental and non-governmental organisation to strengthen their commitment to women's health and deal with the unsafe abortion. There is a need for the government to revisit the TOP policy, which is supported by the increasing statistic, which proves that, there is a need for the service to be provided. The present designated hospital does not cope with the workload. Clients are travelling long distances for TOP procedures (http://www.cbctrust.com/history law religion.php) accessed 12 June 2006.

Management should support the programme by making sure that proper staffing is allocated according to the policy TOP guideline. Budget should be allocated for equipment and furniture. Provision of conducive environment to

render the service need to be considered when allocating accommodation / space. Since the statistics is increasing, staff establishment need to be reviewed. Improvement of infrastructures should be done to improve quality patient care and to boost morale of the midwives,

The community does not have full information on TOP services since women come to the hospital already above 12 weeks and give the reason that they were still waiting to get money to pay at the hospital for the procedure. There is a need for campaign / awareness about the service to be utilized by everyone and to be accessible. Midwives have proven that they can provide high quality TOP services and they are more acceptable by the clients and accessible to the clients. The health status of women in South Africa has really improved because if women see that she cannot afford to rise
the baby due to social problems or health status she may perform TOP without permission of the second person. (Makofane, 1999).

Some South African midwives who have been involved in providing TOP have found their challenges and obstacles to be insurmountable. Some of them had stress and left the service because of the workload and lack of support from the management. TOP services have a lot of challenges which include lack of support by management's failure to provide sufficient equipment according to the needs. There is a need for midwives to be supported by the government and the hospital managements to give them courage to the wonderful work that they are doing to raise the standard of South African women by rendering TOP services (Makofane,1999).

The department to come up with a plan for continuous monitoring of TOP service. Improvement of quality patient care and accessibility of service even in rural communities. Review of midwifery training curriculum to include TOP procedures. Review of policy to have a limit on how many times is a person is allowed to do TOP. To review policy on giving consent that if a client is a

minor, parents need to be involved to give consent. Staff establishment for TOP services to be adhered to by all facilities dedicated to render TOP services. Support by management in all the facilities is needed to give midwives courage to continue with the good work that they are doing. Budget allocation for the programme for medical equipment and furniture (Makofane, 1999).

The midwives found it difficult to take as much responsibility as the doctors for carrying out the procedure. They have minimal information since they are only trained for two weeks and doctors are trained for seven years but they are not willing assist women who volunteer to perform TOP. Valuing midwives and recognising the areas that cause trauma could alleviate a considerable amount of stress for midwives and ensure that the woman is cared for in a supportive and sensitive manner (Turyomumazima, 2000).

5.4. RECOMMENDATIONS

The following are recommended for the development and improvement of TOP services:

The programme to have its own staff establishment. Rest day for he staff need to be taken as right of the midwife since they work under bad condition on daily basis to boost their morale. In the clinical setting support of colleagues is very much vital. Sharing positive and negative experiences with peers twice a year can be useful (Turyomumazima, 2000). Therefore support visit to be done by National and Provincial government to see the real picture of the implementation of the programme is crucial.

Special budget for TOP services to be allocated in all facilities. Midwives to be given certificates or awards after completion of training as a token of appreciation to have volunteered to render the TOP services.

TOP services need to be accessible to all South Africans even in rural areas there is a need for TOP services. To make community understand about the service needs continuous service education and value clarification workshops even to school children since they also volunteer for TOP services. There is a need for teenagers to be educated about the advantages and disadvantages of TOP.

Community leaders like church leaders, Chiefs and Induna's need to be involved in health matters to participate in decision making concerning health matters. Because of lack of knowledge and negativity by traditional leaders, this contributes to clients reporting very late in their pregnancy where midwives cannot perform TOP after 12 weeks. This needs doctors to do and they are not accessible and are not interested in assisting to perform TOP services. Clients end up resorting to street abortions which is a risk to their lives.

TOP guidelines should be revised by first consulting service providers more especially midwife. Value clarification workshop to be conducted to all health workers and community members and even at high schools since the statistics indicate the need to the youth or teenagers who utilise TOP as family planning method instead of using contraceptives.

Support system to be developed and provided to the health workers who conduct TOP services twice a year not annually as it is done for psychological counselling. Midwives to be paid scarce skills allowances like other professionals since most of the professional nurses are not willing to perform

TOP services. Midwives have proven that they can provide high quality TOP services (Makofane, 1999).

Improvement of infra structures where TOP services are rendered. Clients need privacy and service providers also need more space to move freely to prevent medico legal hazards. The programme needs sufficient staffing, therefore staff establishment is important for the programme to function 24 hours instead of telling clients to come the following day due to time constraints since presently the clinic is open from 07:00 to16:00 and it is closed on weekends.

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