ABORTION:

Social implications for nurses conducting termination of pregnancies in East London

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by

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Finally, to my greatest source of comfort and strength, my gratitude to my Creator, Jesus, the Christ, who has graciously given me the ability and the Breath of Life to see this study through.

DEDICATION

To the God of this Universe, whom I am privileged to know, for allowing me the gift of being born... a gift I have until now, taken for granted.

For you created my inmost being;
you knit me together in my mother's womb.
I praise you because I am fearfully and wonderfully made;
Your works are wonderful,
I know that full well.
My frame was not hidden from you
when I was made in the secret place.
When I was woven together in the depths of the earth,
your eyes saw my unformed body.
All the days ordained for me were written in your book
before one of them came to be.

Psalm 139 vs 13-16

ABSTRACT

Abortion is a highly controversial subject that has again come into the spotlight in South Africa due to the legalisation of abortion on demand in 1996. The results of various studies conducted since the Choice on Termination of Pregnancy Act 92 of 1996 was implemented, have indicated that abortion providers have met with a great deal of negativism and ostracism. This study focussed on the implications of abortion work on nurses' social relationships with family, friends, colleagues and their communities. Recent literature was reviewed on the subject. The researcher however, found little information on this specific aspect of abortion. The study was conducted with abortion nurses from two government designated hospitals in the East London area responsible for abortion services. Thus, results cannot be generalised. This is a qualitative study that aimed at obtaining first hand information regarding the personal experiences of abortion nurses. A non-probability sampling technique was used viz. criterion sampling. The Interview Guide Approach was used whereby in-depth, semi-structured interviewed were conducted with the guidance of a set of questions in the form of an Interview Schedule. The ten respondents were asked to share their recommendations as to possible measures that could address the challenges mentioned during their interviews.

The researcher came to the conclusion that nurses' social relationships and lives are definitely impacted by abortion work. This impact is largely negative as the majority of respondents experience labelling, stigmatization and ostracism from family, friends, and their colleagues. Abortion nurses also experience a lack of social support, ambivalent feelings with regard to abortion, and a range of negative emotions ranging from stress and depression to frustration and anger. A number of repeat abortions are being done and there seems to be a general lack of contraception. The need exists for nurses to go to Value Clarification Workshops and also to get support in terms of compulsory, continuous, counselling. Separate wards should be set up for abortions whilst sex education should be included in school curriculums at both primary and secondary schools. Family planning and facts about the abortion process should also be included in these sex education programmes. Overall, the need exists for family planning initiatives to promote contraception and deter women from using abortion as a means of contraception. As this study reveals, conducting abortions has come at a great cost for the majority of nurses who lack social support and bear the brunt of anti-abortion sentiment expressed by significant others in their lives. The latter being the people who would normally be the one's they would turn to for help, counsel, support and assistance.

Chapter One

Introduction

1.1. RATIONALE FOR THE STUDY

Abortion has always been a topic of interest to me because of the controversy that surrounds it. A literature review of the subject in preparation for a paper last year produced a wealth of information. Many questions arose however, as a result. This research project will seek to explore one of the areas in which I found little available information.

Abortion became legally available on demand in South Africa (S.A.) in 1996 with the Choice on Termination of Pregnancy Act 92. Since this Act came into effect, various research projects have been undertaken. The focus of some of them have been on nurses experiences, and perceptions of abortion, as well as possible solutions to some of the dilemmas experienced by them. My area of interest however, is one of the more far-reaching consequences of 'abortion work' on Termination of Pregnancy nurses, specifically in terms of the social costs or implications.

My study is of an exploratory nature. I have targeted the Termination of Pregnancy nurses (hereafter referred to as TOP nurses) at two government designated abortion facilities in the East London area for the purposes of this research.

1.2. CHOICE OF RESEARCH TOPIC

Initially I chose the topic "Abortion: a qualitative study of women's experiences". However, a preliminary reading of the literature indicated that research had been done on this topic previously by different researchers. Thus, I refocused my attention on the experiences of abortion providers only to find that several studies have been conducted in S.A. since the implementation on the Choice of Termination of Pregnancy Act 92 of 1996, on the above topic. Further reviewing of the literature indicated that the implications of TOP for abortion providers' social lives were not the subject of any of the studies. Thus, a further refining occurred and the following topic emerged "Abortion: Social Implications for nurses conducting termination of pregnancies in East London".

Salient information from the literature reviewed is included in the following paragraphs to provide the context within which this research study was conducted. (Please note that a more detailed discussion of the literature reviewed will follow in Chapter 2).

1.3. BACKGROUND

Abortion is a subject that evokes very strong emotions and arguments. There is ongoing debate between pro-choice and pro-life activists. Pro-choice activists advocate the right of a woman to determine whether to carry a pregnancy full-term or not. An article in CRLP (Centre for Reproductive Law and Policy) publications in 1999, said that "The call for women's human rights would ring hollow if such rights did not guarantee women the freedom to make crucial decisions regarding their reproductive lives. Because the ability to control reproduction lies at the core of reproductive rights, these rights are rendered meaningless when women cannot determine whether or not to continue a pregnancy" (http://www.crlp.org/pub_fac_abor2icpd.html).

Pro-life activists on the other hand, advocate the right of the foetus to life. They regard abortion as murder.

Mundigo and Indriso (1999:23) state that induced abortion is an ancient practice, experienced by women of all backgrounds in every part of the world. They go on to say that abortion carries a heavy burden of stigmatization, including moral and religious condemnation. The exact incidence of abortion and abortion-related mortality and morbidity is still difficult to establish. The legalization of abortion on demand in South Africa however, means that abortion can now be monitored and more accurate statistics drawn up. Whether abortion services are accessible to and are being utilized by women in the remote areas is however, still to be determined.

Many reasons exist for abortion e.g. poverty, rape, incest, deformation of the foetus etc. A common reason presented for abortion is lack of availability of contraception. Kulczycki (1999:3) states that

the high abortion rates characteristic of Poland, Mexico and Kenya, the wider regions of Eastern Europe, Latin America and other parts of Sub-Saharan Africa reflect the unmet need for family planning and the common recourse to abortion in the absence of contraceptive failure. Abortion is one of the most important means of birth control in some countries e.g. East Asia and the former Soviet bloc (Ibid). There are however, high levels of unwanted pregnancy and unsafe abortion even in Western countries. This has been found to be true in South Africa as well.

1.4. METHODS OF ABORTION

There are various methods which are used to terminate a pregnancy. The method used depends largely on how far the pregnancy has developed.

Medical Termination:

Termination through the use of drugs such as RU486/Mifepristone/Mifegyne which are used in combination with prostaglandin. The foetus is expelled as a result of a combination of these drugs.

Surgical Terminations:

Menstrual aspiration: A sterile, narrow, flexible cannula (or tube) is inserted through the neck of the womb. The other end of the tube is attached to a vacuum source; sometimes simply a large syringe. The uterus is then emptied by suction.

Vacuum termination: The cervix is dilated and a sterile plastic tube is inserted through the cervix and suction is done. Womb is then scraped out with a sterile metal instrument called a curette.

1.5. ABORTION AND THE LAW

In many countries in the developing world, induced abortion is illegal and therefore largely unsafe.

55 countries allow abortion, which is about 62% of the world population. According to the Abortion Centre for Reproductive Law and Policy in New York, approximately 38% of the population have abortion laws that make it illegal. Among the countries that have legalized abortion are: France, Britain, Switzerland, Denmark, Hungary, Romania, Italy, Russia, United States of America, China, Australia and South Africa (http://www.crlp.org/pub_fac_abor2icpd.html).

1.6. ABORTION LAW IN SOUTH AFRICA

South Africa enacted the Choice on Termination of Pregnancy Act (hereafter referred to as the Choice Act) in 1996, making it's abortion laws one of the world's most liberal. The Act determines the circumstances in which and conditions under which the pregnancy of a woman may be terminated, which are as follows:

2.(1) A pregnancy may be terminated-

(a) upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;

(b) from the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that

- the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
- there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or
- the pregnancy resulted from rape or incest; or
- the continued pregnancy would significantly affect the social or economic circumstances of the woman; or

(c) after the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy -

- would endanger the woman's life;
- would result in a severe malformation of the fetus; or
- would pose a risk of injury to the fetus

(http://www.polity.org.za/govdocs legislation/1996/act96-092.html).

The Act specifies the following :

The termination of a pregnancy may only be carried out by a medical practitioner, except for a pregnancy referred to in subsection (1)(a), which may be carried out by a registered midwife who has completed the prescribed training course. Surgical termination of pregnancy may only take place in a facility as designated by the Minster of Health. The State promotes the provision of non-mandatory and non-directive counseling before and after the termination of pregnancy.

The termination of a pregnancy may only take place with the informed consent of the pregnant woman.

- In the case of a minor, she must be advised to consult with her parents, guardian, family members or friends before the pregnancy is terminated. However the pregnancy shall not be denied if she chooses not to consult them.

- Consent of the pregnant woman may be dispensed with in the following situations:

  - if the woman is severely mentally disabled to such an extent that she is completely incapable of understanding and appreciating the nature or consequences of a termination of her pregnancy; or

- she is in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy in terms of section 2, her pregnancy may be terminated during the first 12 weeks of the gestation period, or from the 13th up to and including the 20th week of the gestation period on the grounds set out in section 2(1)(b)

- upon the request of and with the consent of her natural guardian, spouse or legal guardian

- if such persons cannot be found, upon the request and with the consent of her curator personae: provided that such pregnancy may not be terminated unless two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course consent thereto (http://ww.polity.org.za/govdocs/legislation/1996/act96-092.html).

The Choice Act seems to have placed power over their reproduction firmly in the hands of women. I have difficulty in understanding and accepting that such power has also been placed in the hands of minors. Minor children are generally considered not mature, or responsible enough to make certain important decisions. Hence, for example, licences to drive automobiles are not given to minors. It is interesting though that we trust them to make the correct decision regarding abortions without consulting with their parents, but consider them too young to make other decisions of similar magnitude like for example the decision to get married. (Those under the age of 21 still require parental consent in order to get married).

1.7. RESEARCH DESIGN AND METHODOLOGY

1.7.1. RESEARCH DESIGN

A qualitative research design was used due to the sensitive and exploratory nature of the topic. According to Rubin and Babbie (1993:362), qualitative inquiry involves the attempt to understand those whom we observe from their own perspective - to understand their feelings, their view of reality, and to convey the special meanings of what we observe to them.

1.7.2. RESEARCH METHODOLOGY

The General Interview Guide Approach was used whereby the issues to be covered in the interview were listed as possible questions, ensuring that the interviews were focused whilst remaining conversational and free to probe into unanticipated circumstances and responses (Rubin and Babbie 1993:374). Semi-structured in-depth interviews were conducted.

1.7.3. SAMPLING

A non-probability sampling method was used viz. Purposive Sampling. Dooley (in Taylor 1997:50) says that in purposive sampling (also known as judgmental or theoretical sampling) researchers choose respondents because of certain characteristics. Criteria for inclusion in the study were:

- nurses had to be employed at a government designated abortion facility in East London, who are currently involved with TOP patients.
- nurses who consented to be a part of the study.

A sample of 10 subjects were selected. (A more detailed discussion of the sampling process can be found in Chapter 3).

1.7.4. RESEARCH TOOL

Semi-structured, in-depth interviews were conducted with each of the 10 respondents. The Interview Guide was structured according to the different areas of nurses' social relationships that were the focus of this study. This was done to facilitate the data analysis process. (See Appendix 1 for Interview Schedule).

1.7.5. DATA COLLECTION AND ANALYSIS

A dicta phone was used to record the interviews, with the permission of the respondents. This information was then transcribed and thoroughly perused so that 'preliminary trends in the scanned data could be identified to facilitate the organization of the data into meaningful 'chunks'' (Vithal and Jansen 1997:27). Williams, Unrau and Grinnell (1998:287) say that the primary purpose of a qualitative data analysis is to sift and sort the masses of words we have collected from our research participants in such a way that we can derive patterns related to our research question to identify the similarities and differences presented by individuals and the possible links between them. The data has also been summarized in tables (See Appendices 5 -11 for Tables 1 - 7).

1.8. PROBLEMS EXPERIENCED WITH THE STUDY

A major problem experienced with this study was respondents very busy work schedules and the different shifts they work. Some nurses also went on leave during the course of the study. This led to delays in the research as some nurses could not be contacted for an entire month. Thus I had to wait until they returned to work in order for them to read transcripts etc. Therefore, data collection took almost four months, longer than I had anticipated.

With regards to the literature, I had difficulty in obtaining some of the literature I had wanted to

consult for the purposes of this study. I found no information on other research projects that had been conducted where the focus was on how Termination of Pregnancy impacts nurses social lives. Thus, no comparisons could be made in this regard with other research projects of a similar nature.

As discussed in point 1.10 below, a great deal of effort went into clarifying my own values and beliefs with regards to abortion before commencing with this study. Thus, I am satisfied that no bias entered into the study throughout the research process. I however, experienced great difficulty in writing up the final chapter of this thesis due to my personal convictions and religious view point. I have found it difficult to advocate any recommendation that I felt is contrary to my own values as I believe it would be hypocritical to do so. I have nevertheless attempted to be as objective as possible in Chapter 5 and to avoid bias from creeping into this study at the final stage. The reader is at liberty to draw his/her own conclusions from this study and also to utilize the information from the study to make further recommendations.

1.9. KEY CONCEPTS

- **Abortion:** refers to termination of pregnancies that are induced and not spontaneous.
(The terms 'Termination of Pregnancy' and 'Abortion' will be used interchangeably in this study).

- **TOP:** will be used as an abbreviation for the 'Termination of Pregnancy'.

- **Abortion work/ TOP work:** refers to the act of caring for TOP patients or conducting abortions on patients as a part of respondents' nursing duties.

- **Unsafe/Backstreet abortions:** refer to unwanted pregnancies terminated by persons lacking the necessary skills and/or in an environment lacking the minimum medical standards (Kulczycki 1999:9).

- **Social Implications:** This definition was developed by me for the purposes of this study. It refers

to any effect that 'abortion work' has on nurses' relationships and interactions with family, friends, colleagues, and members of the community.

1.10. POINT OF DEPARTURE

Before proceeding I would like to clarify my own viewpoint on abortion. I believe it is very important to have insight into one's own feelings and beliefs regarding a topic as controversial as abortion in order to avoid judgment and bias entering into the study.

My personal opinion is that ideally all life should be protected i.e. both that of the mother and that of the foetus. I, however, recognize that circumstances sometimes makes it necessary for people to choose the rights of one over the other. The stance that I take is one of being non-judgmental and choosing rather to understand, as individuals, each pregnant woman that has to make a decision regarding termination of her pregnancy.

As a woman, I understand both pro-life and pro-choice arguments. Personally, whilst valuing human life greatly as a gift from God, I can also understand the turmoil a woman goes through in certain situations, like pregnancy as a result of rape etc. Thus, I prefer not to judge any woman who plans to have an abortion, or who has had an abortion. Review of the literature found me often questioning whether I would continue to hold onto my pro-life values if faced with a situation as traumatic as some women had experienced, and hoping that I would have the courage to do so.

1.11. ORGANIZATION OF THE STUDY

This thesis will be set out as follows:

Chapter 2: Literature review: consists of a review of the current literature available on aspects

relevant to the topic. Books, journals, newspapers, theses, the internet and a personal interview were the sources of information used.

Chapter 3: Research Design and Methodology: provides information on the particular research design used and gives a description of the manner in which the research was conducted.

Chapter 4: Presentation and Findings: sets out the data that had been collected and discusses the findings.

Chapter 5: Conclusions and Recommendations: contains the conclusions drawn up and the proposed recommendations. Suggestions for further research are also included in this chapter.

The thesis ends with appendices and a bibliography of the sources quoted in the text.

1.12. CONCLUSION

Abortion, although it has been legalized in South Africa, and many other countries in the world, still evokes a lot of debate. In our country emotions still run high among pro-lifers. Our new Constitution and our movement towards freedom for all and especially the rights of women however, means that the latter will continue to make the ultimate decision regarding their reproduction unless a change in government policy states otherwise. Researchers have focused on the impact of abortion work on providers. Problems encountered by abortion nurses and possible interventions to address these problems have been identified. The focus of these studies however, have not been the implications of abortion work for nurses' social relationships. Thus, this research study was embarked on to explore this aspect of abortion.

Chapter Two

Literature Review

2.1. INTRODUCTION

An attempt was made to obtain information specific to the topic, viz. the impact, if any, of TOP work on nurses' social lives and relationships with family, friends, colleagues, community members etc. Literature on this specific aspect of abortion however, was not readily available. This literature review will commence with the history of abortion, the differing viewpoints, current world views on abortion, as well as our South African society's views regarding this controversial topic. Attention will also be given to the South African legislation regarding abortion, as this determines the abortion scene in S.A.

An attempt has been made to describe the context within which this research is to be conducted. Reference will be made to other recent research projects in South Africa regarding relevant aspects of abortion. As mentioned above, attempts at obtaining information regarding the impact of abortion work on abortion provider's social relationships proved frustrating as very little information was found in this specific area. Information was nevertheless found on our society's views and responses to abortion. This is relevant to this study as a community's views on abortion would directly influence their attitudes towards abortion workers and also the manner in which they interact with them.

A review was also done of the available literature regarding social relationships, their value, the impact of relationships in the work environment, the unique working conditions of nurses in South Africa and man as a social being. The latter will be relevant for the purposes of this study to establish how one is affected by one's environment.

2.2 ABORTION

Luker (1984:1) questions what it is about abortion, amidst many other moral issues we face daily that makes it so troubling, and so difficult to deal with. She hazards an answer to this question by stating that different beliefs about the roles of the sexes, about the meaning of parenthood, and about human nature are all called into play when the issue is abortion. Abortion also gives us a rare opportunity

to examine closely a set of values that are almost never directly discussed. Because these values apply to spheres of life that are very private (sex) or very diffuse (morality), most people never look at the patterns they form. For this reason, the abortion debate has become something that illuminates our deepest, and sometimes our dearest beliefs (Luker 1984:158). That abortion affects people deeply is evident from the ongoing debate in the different countries...a debate that has existed over centuries and still has not been resolved, even in our own country today.

2.2.1. HISTORY OF ABORTION

Abortion seems to have been around for almost as long as mankind has been. Chandrasekhar (1974:24) says that all civilizations for which we have any records at all show that abortions have been in vogue for thousands of years. In fact, it is possible that abortion might have been the first kind of "surgery" ever attempted by man. Man's attitude towards abortion have ranged over a wide spectrum, from approval, bordering on encouragement, to total prohibition and condemnation, all the way from early civilization - Assyrian, Babylonian, Hindu, Greek and Roman, to the present day. Most of the Greek philosophers, particularly Plato & Aristotle approved of it and even encouraged it (Ibid).

Abortion has been resorted to by almost all societies, at different periods of history, for a variety of reasons. Some of these reasons are cases of incest, cases of rape, pregnancy in an unmarried girl, pregnancy in a girl below the age of consent, pregnancy in a sick or emotionally disturbed woman, to ensure the physical health or sheer survival of a woman, when pregnancy showed lack of spacing, when pregnancy occurred during the lactation period, for certain eugenic reasons, and contraception failure due to lack of knowledge amongst women and men about human reproduction and about the characteristic, correct use and possible side effects of contraceptive methods (Chandrasekhar 1974:22).

Many societies have found it easier to accept abortion as a necessity in cases of rape and incest i.e.

where a father impregnated his daughter through unlawful sexual relations. Traditionally, births to unmarried mothers were not accepted in most societies (The State of South Africa's Population Report 2000:44). In our society today however, unwed mothers are not frowned upon or rejected as in previous generations.

Abortion for eugenic reasons i.e. abortion of foetuses deemed to be weak or not good enough or healthy enough with the view of producing only fine offspring, is, I believe, a violation of human rights. During 300 to 400 BC only healthy men and women were allowed to have children. Every bride and groom needed to have a health certificate. Men were allowed to reproduce between 30-45 years, whilst women had to be between 20-40 years. Offspring born of unlicenced matings or deformed were exposed and left to die (Chandrasekhar 1974:24). The above orders were advocated by the Greek philosopher, Plato. I feel that such practices were cruel and barbaric.

Other reasons for abortions are the desire for smaller families, shifts from rural to urban residence, and the increase in non-marital sexual activity (Mundigo & Indriso 1999:28). The latter seems to be a major reason for abortions currently as there is an increase in sexual relations between people outside of marriage. The resultant unwanted pregnancies are aborted.

2.2.2. HISTORY OF ABORTION IN SOUTH AFRICA

Interestingly, the issue of abortion has evolved over time in South Africa (S.A). In the 1820s, white observers realized that Xhosa women were swallowing herbs to induce miscarriages (Bradford 1990:2). Bradford (in McCulloch 1996:3) traces the evolution of the various abortion practices in S.A. From 1840, she states that the swallowing of poisonous roots and herbs was the most common abortifacient method practiced by the black population of S.A. Colonial officials and missionaries in Transkei were dismayed rather than impressed by the popular awareness of abortifacients, which were largely provided by female doctors.

McCulloch (1996:3) gives the following account of abortion in S.A.:

> *"In the period between 1910 and 1960, there was a shift in legal abortion practice towards more medicalised procedures, such as the penetration of the womb with instruments in order to rid women of unwanted pregnancies. This was partly due to world-wide improvements in medical technology and the discovery of the antiseptic in 1865. These surgical procedures were practiced mainly by white medical doctors operating under vaguely defined common law. Access to abortion for wealthier white women were relatively easy, whereas black women still relied largely upon herbal methods. From the time of the advent of Apartheid in 1948, there was increasing opposition to abortion, not only on moral and religious grounds, but also on racial-political grounds. The easy access white women had to abortion became an issue to the Nationalist government. Their concern was the decreasing birth rate of the whites and the increasing birth rate of the black population. Therefore the practice of abortion in S.A, particularly among the white population became a progressively more controversial issue. It was under these circumstances that, in 1974, an exclusively white, male commission was appointed to provide the guidelines for the legislation to be introduced in 1975 (viz. The Abortion and Sterilization Act 2 of 1975)".*

Van Rooyen (1998:296) states that under this Abortion and Sterilization Act 2, legal abortions were possible under very specific circumstances and tight substantive and procedural curbs placed on the availability of legal abortions, which could be performed only at state institutions or those designated by the Minister of Health. Specific circumstances under which abortions could be permitted by the Act (2-1975) included the following:

- where pregnancy was seen to endanger or constitute a threat to the life of the pregnant woman; or
- where the pregnant woman's mental health would be permanently damaged by the

continued pregnancy; or

- if a serious risk existed that would result in the child in utero suffering from a mental or physical defect that would result in the child being irreparably and seriously handicapped; or
- if a woman had been raped, provided that the rape had been reported to the police and where after investigation, a magistrate is convinced that the pregnancy was a result of the rape; or
- where a woman was subject to permanent mental handicap or where there was an incestuous relationship such that sexual intercourse was unlawful.

(Van Rooyen 1998:296).

The Abortion and Sterilization Act of 1975, excluded the majority of women from seeking legal abortion (Suffla in Ndhlovu 1999:2). Therefore women were forced to seek 'back street' or illegal abortions. It was estimated that approximately 200 000 to 300 000 illegal abortions took place in South Africa each year. A Natal gynaecologist said the following with regards to 'backstreet' abortions: 'The undeniable fact remains that any South African woman finding herself unwillingly pregnant, can, if she so chooses, obtain the services of an abortionist, with the greatest of ease'. In short, abortion on demand already exists in this country (Westmore 1977:57). McCulloch (1996:80) says that abortion was a socially unacceptable alternative for dealing with unwanted pregnancy in many circles, and may be particularly unacceptable amongst African groups, as well as in religious communities. The alarming increase in the population with it's subsequent social problems (especially amongst the poor black people), has however resulted in restricting the number of children born per year in S.A. Children were no longer regarded as essential to an African marriage (Chidammodzi in Sono 1994:131). It is saddening that children who were previously considered a blessing and enjoyed such status, are now often considered burdens and are unwanted.

Westmore (1977:55-56) conducted an exploratory study into the attitudes of Natal medical practitioners towards the Abortion and Sterilization Act. She found that the majority of medical practitioners in her study called for more liberal legislation in South Africa. During 1990, the

Department of National Health and Population Development, decided to reconsider legislation regarding abortion and called on interested parties to 'make representation for possible changes' to the existing Abortion and Sterilization Act (Van Rooyen 1998:297). The result was a great call for liberalization of existing abortion laws.

Arguments in favour of liberalization of the existing abortions laws appeared in many publications. The following article by Cope (1993:1) describes the situation:

> *"Abortion law reform in Apartheid South Africa, presents the picture in Baragwanath Hospital prior to the Choice on Termination of Pregnancy Act where of 22 000 babies born each year, half are to mothers who have no male support. It is an aspect of the social breakdown taking place in S.A. today. It is an aspect of the law which denies South African women control over their fertility. Up to 30 abandoned babies are cared for by Baragwanath Hospital at all times. Each week at least five dead infants are brought to the government mortuary abandoned by mothers who have taken care to leave their children to die where they as mothers cannot be traced. Reality of this nature is often overlooked by those who support the ideal of life from conception. For them it is difficult to accept that abortion is a fact of life, a fact that no woman seeks to experience or promote, but one which can be dealt with in 2 ways, either legally and skillfully or illegally and dangerously.*
>
> *S.A's restrictive legislation creates an industry of 'backstreet' abortions. Gynaecological wards are crowded with it's victims. Some of the women die; those who survive are nursed back to health to be exposed to the same risk on their return home. Their vacated hospital beds are immediately filled. Hospitals across the country, particularly those in urban areas suffer from an overload on their nursing and financial services caused by this pressure*

on gynaecological wards, pressure which is a direct result of a law which denies a basic human right: the right to early, safe and low-cost medical care for women faced with unwanted pregnancy."

This very descriptive account by Cope clearly indicates her reasons for supporting a more liberalized abortion policy in the hope that the above problems would be eliminated.

With the democratization of South Africa and the change of government during 1994, the emergence of a strong culture of rights became evident. The process of constructing a new constitution for South Africa and the ability of the general public to give input into issues related to the Constitution, stirred up emotions and debate about the promise of constitutionally entrenched rights to privacy, freedom of choice, equality and an entire range of basic human rights, opened up a space for a stronger lobby and argument for change in abortion legislation (Van Rooyen 1998:297). Not all South Africans, however favoured a changed abortion legislation.

This is reflected by events just weeks prior to the Choice Act coming into effect. East Londoners staged an anti-abortion protest march. Their efforts however, were met with counter-demonstrations by supporters of abortion. Dr. Bennie Steyn, who practices medicine at a community hospital in the border region joined the pro-abortion supporters sharing that the hospital encountered a steady stream of women every month who were desperate for safe - but illegal- abortions (Daily Dispatch. 4 January 1997:page unknown). Despite the demand for legalized abortion, anti-abortionists state that 80% of S.A reject abortion. A fact that is apparently known to government (http://www.hli.org/issues/reports/sabil.html). The abortion debate again surfaced and resulted in the Choice of Termination of Pregnancy Act 92 of 1996.

As stated above however, not all South Africans felt the need for more liberalized abortion laws. As the battle loomed over the passing of the Choice Act, a newspaper, the Citizen quoted Claude Newbury of the Pro-life Association who stated: 'we do not make it a developed country by killing people' (The Citizen 16 July 1996: page unknown). The Citizen also quotes Abe Nkomo, chairman

of the parliamentary portfolio committee on health that drafted the Bill who gives an opposing view: '...the Act is needed to curb the suffering often caused by illegal abortions which are largely a problem of the poor black majority' (The Citizen 16 July 1996: page unknown).

HLI Africa released a press statement in response to the possibility of the Choice Act on 30 October 1996. They stated: 'The Choice on Termination of Pregnancy Bill is the most undemocratic law, ignoring the views of 80% of all South Africans who are totally against the killing of defenseless, innocent, unborn babies. The evil of the silent abortion holocaust against the unborn is not debatable'. They further state that they are appalled at the decision to go ahead with this diabolical legislation which will result in the death of millions of our babies and many mothers. The latter refers to breast cancer which is said to result from abortions (http://www.hli.org/issues/reports/sachoice.html). There are however, conflicting reports with regards to whether breast cancer is a result of abortions or not.

2.2.3. RELIGIOUS VIEWS ON ABORTION

In a study Van Rooyen (1998:303) found that religion was the most influential factor in responses to abortion. (35,3%) of respondents selected religion as the most influential force in informing their responses and attitudes towards abortion. The notion of moral and religious conservatism as an influential factor in South African society is one that has received recognition elsewhere. In a recent publication, Leggett (in Van Rooyen 1998:303), for example, identified this 'conservatism' as 'one of the most striking facets of South African culture' . Haffajee (in Ndhlovu 1999:121) observed that religious beliefs emerged as being associated with negative attitudes towards termination of pregnancy both within the general population and amongst health professionals. The above seems logical as religious and pious people are generally more conservative and preoccupied with issues of righteousness and morality. According to Statistics South Africa, the country's population estimates in the year 2000 stood at 43 686 million (South African Yearbook 2001/2002 2001:1). Of this number, 80% are Christians. Other major religious groups are the Hindus, Muslims and Jews (South African Yearbook 2001/2002 2001:2). Thus, the following paragraphs will briefly discuss these major religions in South

Africa.

a. THE CHRISTIAN VIEW

Chanrdasekhar (1974:26) traces the Christian view of abortion back to the 13th century:

> *"St. Thomas Aquinas (1225-74), the Italian theologian, stated that anything that interfered with procreation was a sin against nature. The influence of Aquinas was so compelling that the Catholic doctrine on contraception and abortion became rigid, irrational and cast iron. These Catholic views became the foundation for various laws on the matter in Europe in the 18th and 19th centuries. The Catholic Church alone, among all the great religions, through many years of acrimonious comment and controversy has always taken the stand of absolute prohibition of abortion".*

John Paul II, the Pope of the Roman Catholic Church, contends that abortion is a particularly heinous crime because it kills an innocent human being who has yet to be born. He maintains that human life begins the moment an ovum is fertilized, and that every human being has a sacred and inviolable right to life (Paul in Roleffe 1997:17; Chandrasekhar 1974:26).Dissension however exists even in the Christian camp with different denominations holding differing views on abortion.

This is evident from a 1995 Anglican Church discussion paper on abortion which states:

> *"Few moral decisions are absolute. Most have to be made in the context of conflicting demands. Often in an agonizing and pressing moment. The question then becomes: 'under what situation may the perceived good of the mother be given the greater weight than the perceived good of the foetus, and who will make the decision'. This is the crux of the issue from the*

Anglican perspective - we accept the possibility of abortion as the lesser of two evils under certain circumstances" (The Sowetan 10 October 1996:11).

Thus, the Anglican Church places a greater value on the 'perceived good' of the mother. Similarly, Bishop Sigqibo Dwane, the president of South African Council of Churches, says that he believes that a woman should have the final say over her body and have the right to choose whether she wants to carry a child to birth. His organization has no firm stand on abortion as the members have differing opinions. He stated that people are guided by their consciences (Singata 1996:8). In a similar vein, Rev.Otto Ntshanyana of the Methodist Church of South Africa in Khayalitsha, Western Cape said his church stands for life of every person, but understand that there are instances like rape, and health hazards that need to be considered. On a different note, Rev. Rubin.S.Nyobole, of the Pentecost Baptist Church in Khayalitsha, feels that abortion must not be legalized, as it is against the law of God (Ibid).

Thus, the Christian camp is as divided as the rest of the country and indeed the world, on the issue of abortion.

b. HINDU VIEW AND MUSLIM VIEW

Whilst Hinduism and Islam are not major religions in S.A., a small percentage of the population follow these religions, hence they are mentioned here briefly. Hindu law givers have treated abortion as a crime and ranked it among other crimes such as murder, incest and adultery with the wife of a guru (teacher) etc. (Chandrasekhar 1974:44).However, the Hindu view has adjusted itself to altered world conditions and changed economic and social needs (Chandrasekhar 1974:45). Today in over-populated, poverty stricken India, abortion is permitted. Indians' outlooks and viewpoints on the topic have thus changed not only with the times, but also in accordance to the needs and circumstances of the people.

Pumzile Nkanyani of the Eastern Cape interviewed Mufti Siraaj, a member of the Port Elizabeth Muslim community regarding abortion. According to Siraaj, the Islamic law regards all human life as sacred. Abortion is only permissible before 120 days of pregnancy as Muslims believe this is when the soul enters the foetus. Abortion is only permissible, according to the Islamic faith, in certain circumstances viz. when the mother's physical or mental health is in danger, when there is danger of an inherited disorder manifesting in the offspring, or when pregnancy is the result of rape (Nkanjeni 1996:7).

c. JEWISH VIEW

Judaism is another religion followed by a minority of South Africans, hence mention is briefly made about the Jewish view on abortion in this literature review. Sheler (in Cozic and Petrikin 1995:19) states that the Jews have a much more tolerant position with regards to abortion. Abortion is con - sidered a matter of individual conscience and they oppose most government restrictions on abortion - a position with roots in ancient Jewish writings. Interestingly, the Talmud suggests that the foetus is not fully a person, but, rather, is 'as the thigh of it's mother'. Nonetheless, it is worthy of protection as a potential human being. The Mishna, a compilation of Jewish law from the 3rd century AD, explicitly approves of therapeutic abortions if the mother's life is endangered. Orthodox Jews today allow abortion only in strictly defined cases involving the health and survival of the mother.

2.2.4. THE PRO-LIFE STANDPOINT

Pro-lifers or Anti-abortioners believe in the right to life of the foetus. Abortion is considered murder and is seen as immoral. Reiman (1999:9) states that exclusive focus on the right to life is unsatisfactory for 2 reasons.

> *"Firstly, because there could be ways in which it is wrong to kill a foetus*

other than because they possess a right to life. We should have a duty not to take fetuses' lives even though they do not have a right to life in the same way that we seem to have a duty not to be cruel to animals though it would be odd to think that animals have a right to non cruel treatment. Secondly, a right to life is normally understood as a right not to be killed, and thus as a negative requirement that we refrain from taking life. But it is also possible that fetuses have rights to positive assistance or protection just as small children have rights to positive assistance from adults (and not just from their parents) to protect, feed and educate them".

The author here clearly views the foetus as a living being that should be protected.

Interestingly, traditional feminists have been pro-choice, however, many feminists have recently become pro-life. Kennedy (1997:4) says that her disapproval of abortion relates to the certain killing of a pre-born child, and the possible, often probable physiological and psychological harm inflicted on a woman.

Pro-lifers argue that abortion is murder and that it is wrong because the foetus can feel it. They state that the foetus is a person and even, if for argument sake, the foetus is not a person in the full moral sense, it is undeniably a potential human person. They also state that widespread abortion dulls the public conscience towards other assaults on the sanctity of life. A valid argument they make is that foetuses today, have more rights than ever to be protected as premature babies of as little as twenty two weeks can now survive in specialist units (Hadley 1996:56-57).

I agree with the fact that foetuses are potential human beings and that public conscience can become dulled to other assaults on the sanctity of life as a result of abortion. I will venture here to repeat what a colleague recently shared with me. The story is about a man who, when he finally dies and meets God in Heaven, questions Him as to why He did not provide a cure for AIDS (Acquired Immune Deficiency Syndrome) to the world. God's reply was: 'I sent you the cure, but you aborted it!' As

much as the latter is fictional, it made me wonder about the potential of the foetuses that are aborted. We will probably always remain ignorant as to the great rulers, scientists, artisans, artists etc. we just may have denied the opportunity to live as a result of abortion.

2.2.5. THE PRO-CHOICE STANDPOINT

In the opposite camp we have the pro-choicers who advocate women's rights to decide whether to carry a foetus to full term or not. The pro-choicers believe that a woman's right to control her body overrides any claim made by the foetus. Muller (in Roleffe 1997:23) argues that abortion can be a moral choice when the foetus has a birth defect or when the pregnancy is unwanted. She further asserts that when abortion is an available option, most children who are born will be healthy and wanted.

In defense of abortion pro-choicers argue that abortion is not murder because foetuses are not persons and it is therefore not morally wrong to destroy them. They admit that the foetus is potentially a person but state that this does not tell us the moral value of that potential being at a given moment in it's development. They firmly believe that it is impossible in practice to grant equal moral rights to foetuses without denying the same rights to women (Hadley 1996:61-63).

As mentioned in Chapter 1, whilst I believe in empowerment of women, I feel that to support choice with regards to reproduction would be to condemn millions of potential human beings to an early death. In my opinion, there are circumstances however, which may necessitate abortions, for example cases of rape and incest.

2.2.6. ABORTION IN DIFFERENT COUNTRIES

According to legislation currently in force, twenty-five percent of the world's women live in parts of

the world where abortion is permitted only to save a woman's life or is prohibited altogether. There is a marked difference in favourable legislation between the first world and third world context. Eighty-six percent of women in the first world live in countries with liberal abortion laws, whereas in the third world, only fifty-five percent of women live in countries that permit abortion on socioeconomic grounds (Supporting the right to choose 1999:1).

Evidence that abortion is constantly a contentious issue for governments can be seen currently in the United States of America where President George W. Bush enacted the 'Global Gag rule' recently which prevents any foreign organization that receives funding from the US Agency for International Development from supplying legal abortions (Daily Dispatch 28 March 2003: page unknown). The issue of abortion moved to the fore again when President George W. Bush, a devout Christian who sides with opponents of abortion, replaced Democrat Bill Clinton in the White House in early 2001 (Daily Dispatch 9 January 2003: page unknown).

Anti-choice groups regularly harass clinic staff, intimidate patients at clinics, and use graphic language designed to punish women e.g. 'Abortion is murder' and 'Women are baby killers' (Sheler in Cozic and Petrikin 1995:19; http://www.prochoice.org/facts/postab.html). Between 1977 and 1990, the total number of reported incidents of violence and disruption against abortion providers was 829 in the USA. These incidents involved bombings, arson, attempted bombings or arson, invasion, vandalism, assault and battery, death threats, kidnaping, and burglary. The above figures excludes hate mail and harassing calls, bomb threats, picketing and clinic blockades. The latter numbered 419 between 1987 to 1990 (Costa 1991:140-141). Anti-abortion sentiment is thus actively demonstrated in America.

This state of affairs was reported by a weekly newspaper, Revolution Worker, published by the Revolutionary Communist Party in Chicago, Illinois:

> *"The staff of facilities that provide abortions learn to live with bricks through their windows, threats towards them and their children, and*

gauntlets of jeering picketers and blockades surrounding their cars as they come to work. From bullet proof vests to electrified fences, bomb-threat drills, floodlights, and elaborate security systems, the simple act of providing health care becomes one requiring the most extensive precautions and protections" (Cozic and Petrikin 1995:204).

The situation in America is particularly interesting and provides a good example of a country where the abortion debate rages on.

This unremitting fury and stridency aroused by abortion in the US baffles outsiders. Besides the words, a low-intensity civil war has been conducted for almost 20years, the battleground reaching from the Supreme Court to Congress and the State legislatures, out to the pavements outside abortion clinics where women have been systematically terrorized and doctors have been gunned down and killed (Hadley 1996:1). Abortion has been legal in USA and most of Europe for 10,15, 20 years and yet it is as explosive an issue as ever (Hadley 1996:xii).

Similar movements can be seen in other parts of the world e.g. Poland. The new law allows abortion only when a woman's life is in danger, after rape, incest or if there is a proven history of genetic disorder on the family (Hadley 1996:40). Anti-abortion activists say that a push to ban abortions in Slovakia has revitalized their efforts to outlaw the procedure in the Czech Republic (http://www.praguepost.com/P03/2003/Art/0410/news8.php).

The data that are available demonstrate that induced abortion is very prevalent in the developing world as well (Mundigo & Indriso 1999:23). They state that this was largely as a result of lack of contraception.

As can be seen, the different countries are constantly moving from liberalizing abortion law to making them more restrictive or vice versa. Thus, it is a constant tug-of-war between the two strongly opposed groups i.e. the pro-lifers and the pro-choicers.

2.2.7. SOUTH AFRICAN RESPONSES TO THE CHOICE ON TERMINATION OF PREGNANCY ACT 92 OF 1996

The Choice on Termination of Pregnancy Act 92 of 1996 was enacted in South Africa setting out the circumstances and conditions under which pregnancy make be terminated on demand. Under the Choice Act, any woman with a less than 12 week pregnancy will be allowed to obtain an abortion on demand. Girls under 18 are allowed to have abortions without their parents' knowledge or consent. A 20 week pregnancy may also be terminated if the life of the woman or child is in danger. Abortion is also permissible when a pregnant woman believes she cannot continue the pregnancy on grounds of poor economic or social situation (http://www.africaonline.co.ke/Afri...tand/weeklyrvu/970207/africa4.html).

Whilst many rejoiced at the passing of the new Choice Act, others geared up to challenge the new legislation. The Choice on Termination of Pregnancy Act was successfully defended in the Pretoria High Court in May 1998 and according to some represented a victory for women's rights and health. In July 1997, 3 Christian groups (The Christian Lawyers Association, Christians for Truth and United Christian Action) issued summons against the Minister of Health. In it they claimed that the Choice Act violated the right to life of the foetus, and accordingly should be struck down as unconstitutional. They sought to lead evidence on a variety of matters, including the issue of when life began (Legal Update 1998:20). Their efforts, however were unrewarded.

Van Rooyen's study of final year social work students from 2 universities in Kwa Zulu Natal revealed that over half of the sample (54,3%) agree to varying extents that abortion on demand should be available, whilst almost one third (32,8%) expressed that they 'disagreed' or 'strongly disagreed' that women should be allowed access to abortion on demand (Van Rooyen 1998:300). A study conducted amongst doctors and nurses in the Eastern Cape, showed that almost two thirds of the participants felt uncomfortable with the concept of abortion or were unsure of how they felt (Marais in Van Rooyen 1998:300).

The Barometer provides an overview of media coverage of termination of pregnancy in 1999. That many South Africans view the Act negatively was apparent from media covering the following:

> *"Religious critiques on abortion especially from the Catholic Church and Islam.*
> *On the controversy of the implementation of the Act (1st February) the religious lobby cited the day as a national disgrace for which Christians should repent.*
> *In February: media covered demonstrations outside the Marie Stopes Clinic in Cape Town and a feature article in a Eastern Cape newspaper was on alternatives to abortion.*
> *March and April: Some South African political parties openly criticized the Choice Act. Pan African Congress called for the law to be more restrictive, while the African Christian Democratic Party (ACDP) called for the abolition of the Act. The New National Party added their objection to the law.*
> *May and June: The growing political dissatisfaction with the Act continued with the ACDP's call to Christians to suspend payment of their taxes until the law is abolished. Religious undertones dominated the debate and the Act was cited as a cause for the moral decay of South Africa".*
>
> *(The Barometer 1999:15)*

Further evidence that many South Africans are not in favour of the Act is also reflected in the fact that many demonstrators picketed outside the Marie Stopes Clinic in Durban after it opened it's doors in 1996 (Maduray 2003). Another incident was reported in Durban on 13 May 2000, where more than 1000 people demonstrated outside an abortion clinic in Isipingo, South of Durban. They were led by an anti-abortion organization called the Isipingo Ministerial Fraternal. The organization claimed that young school children were flocking to the clinic for abortions, which were allegedly performed by nurses instead of doctors. The organization's chairman, Danny Frank, said the legislation on abortions

did not make them right (City Press 14 May 2000: page unknown). Some South Africans have been very creative in conveying their anti-abortion sentiments... on 2 February 2001, about 40 pro-life supporters took part in what they called a funeral procession to parliament to mark the fourth anniversary of legalized abortion in S.A. (The procession being for the babies 'murdered' by abortion since the Choice Act was implemented). (Daily Dispatch 2 February 2001:page unknown).

In Durban Andy Maduray, Regional Co-ordinator of the Marie Stopes Clinic states that whilst they initially met with a lot of opposition, society seems to have changed. Not only is there an absence of demonstrations now, but even people's responses to abortion has become less extreme and less negative. She says that she has experienced a gradual increase in the number of people who are supporting 'choice' as they are increasingly being exposed to abortion either personally, or through a friend or a family member. Hence this has led to a changed perspective i.e. people are less fervently opposed to abortion. She states however, that abortion is still a sensitive issue and that the majority of the community are still anti-abortion, largely due to religion. (The major religious groups she encounters in Durban are Christians, Muslims and Hindus) (Maduray 2003).

With regards to TOP services in the Eastern Cape, the Barometer (1998:8) states: 'The initial opposition, vocal and vehement, has dwindled and TOP now excites little discussion and attracts little attention amongst staff who were very hostile at the start. It is striking how nurses in particular have come to accept and indeed support the service, despite their former antagonism.'

A recent article in the Daily Dispatch hailed the implementation of the Choice Act as 'one of the first significant health interventions by the newly elected African National Congress, three years after South Africa's first democratic elections in 1994 (Daily Dispatch 26 September 2003:16). The article further states that deaths and complications from unsafe abortions have been significantly reduced since abortion was legalized in S.A. more than six years ago (Ibid).

It seems that South Africans have come a long way in terms of their views on abortion. However, from the above paragraphs it is evident that many South Africans are dissatisfied with the Choice Act

and view it negatively. Thus, the abortion issue has not yet been laid to rest in S.A.

2.2.8. SOCIAL IMPLICATIONS OF ABORTION WORK FOR NURSES

Andy Maduray of the Marie Stopes Clinic in Durban shared that her husband's initial response to her work was negative. He had apparently battled with the idea of what she does for a living. He has, however, since adjusted and worked through his feelings so that he is now understanding and supportive. Maduray says that her work does not impact her social relationships significantly. Although she does admit that she steers away from telling people about her work at the Clinic, especially when she meets new people or is in a social setting (Maduray 2003). Abortion however, had a different impact on the following nurse, who, in discussing the impact of abortion work stated: 'I find it draining and exhausting, I become tired to the point where I do not want to relate to anyone, especially my family who may be in need of emotional support....' (Brien & Fairbairn 1996:169). Thus, the social cost for her is the lack of energy she has to invest in other relationships viz. relationships with her family who may also need her emotional support.

With regards to relationships with colleagues, one nurse suggested that ward staff get together, support each other and be non-judgmental, not only to their patients but also towards their colleagues (Brien & Fairbairn 1996:177).

Health care providers who are involved in rendering services (TOP services) are, in some instances feeling isolated, vulnerable and targeted, particularly in institutions where management and the bulk of staff are against TOP (Braam in Shete 2001:91). Researchers, Gmeiner, Van Wyk, Poggenpoel and Myburgh (2000:75) advise that nurses who have made the choice to work with women who choose to terminate a pregnancy have to learn to care more for each other and give more support to one another. Such support from their colleagues is especially important in view of the fact that TOP nurses do not get assistance or support from predominantly anti-abortion staff.

Doctors and nurses, in the Eastern Cape, continued to refuse to conduct abortions. Daily Dispatch Reporter, Zamuxolo Feni gives the following report:

> *"They continue to refuse on moral, cultural or religious grounds, and because some are at times afraid of harassment from local communities and colleagues. Some of the staff members are developing 'strange attitudes' towards them, they say." (Daily Dispatch 12 July 2000: page unknown).*

The above indicates that TOP nurses in the Eastern Cape are often overworked and get no assistance from their colleagues.

Carte Blanche, a documentary programme aired on Mnet in June 2002, showed that TOP nurses at the Philadelphia Hospital in Mpumalanga, are being stigmatized as "satanists who kill babies" by their rural communities (http://www.mnet.co.za/Display/Display.asp?Id=1992). Shete (2001:96-97) stated that all the respondents in her research (i.e. TOP nurses in Eastern Cape) voiced that they would like to see a change of the negative attitudes towards TOP by their colleagues. All the respondents felt abused by their friends because in public they passed silly remarks to them (Ibid).

Thus, it seems that TOP work has had some negative effects on abortion providers in S.A. TOP work has also exposed abortion nurses to harassment and victimization.

2.2.9. HOW ABORTION CHALLENGES AND AFFECTS OUR SOCIETY

One way to view any society is in terms of a 'network of norms' about behaviour. In this view, the stability of any society depends upon consensus about what is expected of individuals within that society. If people agree on what is appropriate and inappropriate behaviour, the society is stable and the people should be well adjusted. But, when the consensus breaks down for some reason, when the existing rules of behaviour no longer holds and are not replaced by new rules, or when the existing

rules are challenged by a new set of expectations, the society is said to be in a state of social disorganization (Lauer 1982:16). Presently the abortion issue has torn our society apart. The South African society is very divided on this issue as we have discussed at length in the preceding paragraphs. This can also be attributed to a difference in values. The following discussion illustrates this point.

Lauer (1982:19) states:

> *"Any societal condition becomes a social problem when there are 'value clashes' about the condition. The conflict of values with resulting power struggle is well illustrated by the continuing abortion controversy. Those who argue in favour of abortion believe, among other things, that a woman has the right to control her own fertility, and that the physical and emotional well-being of the woman is at least as important as any rights of the unborn child. Those who argue against abortion believe, amongst other things, that the foetus is a living human being and, therefore, abortion is murder. The unborn child, they say, has the same rights as anyone else. Both groups share a value about human life, but they differ about whether the life of the pregnant woman or the life of the unborn child takes precedence".*

Therefore, our society faces a great challenge when it comes to abortion and how this debate can be resolved.

2.3. MAN: A SOCIAL BEING

Man is not 'immune' to his environment, nor does he function in isolation from other people. He is a part of the environment, not just the physical, but also the social environment. Discussion on this topic is important to get an idea of how and why employees, in this case TOP nurses, are a part of a

work environment and a social environment.

Literature reveals that man is a social being. He needs to be seen in the context of his environment (including the social environment) which exerts an influence over him. The environment is also influenced by him. Broderick (1993:37) puts it in a slightly different way: as an open system the family receives input from the environment and output is that which it gives back to the environment. The basic fact in social psychology is that individuals both seek and avoid one another. The need to associate with others is universal and overriding and may be considered as a basic human need or motive (Lindgren 1969:23). The universality of this drive can be explained in terms of learning that takes place during infancy when dependency on others is reinforced and rewarded; the need for other's help in accomplishing tasks and coping with the environment, instinctual drives and a need for stimulation (Lindgren 1969:37). The drive to interact with others can also be explained in terms of a need for attention which in turn relates to the need to be aware of one's own reality.

The idea of inter-relatedness and interdependence of man was emphasized by the great Christian missionary of the 1st century, Paul, who used the image of the 'body' stating that the body is one but has many members, each with a specific function. He further explains that the eye cannot say to the hand 'I have no need of you', nor can the head say to the feet, 'I have no need of you' (Broderick 1993:7). Thus, Paul's metaphor refers to the fact that we need each other in this world.

We also derive a sense of meaning from our association with others. Knowing what events mean enables us to resolve puzzling and disconcerting ambiguities, which otherwise would cause anxiety. Through associating with others we learn to impart a degree of structure or meaning to our experiences, and this in turn enables us to learn whom we resemble (identity) and whom we do not resemble (definition) (Lindgren 1969:38). The rewards we receive from our association with others have a price: we must work for them. In reinforcement theory terms, we pay for our rewards through learning modes of behaviour that enable us to continue receiving reinforcement (Lindgren 1969:102).

According to Lauer (1982:13) behaviour is social in the sense that we behave as we do because of our

experiences with other people and because of the social context in which we behave. Behaviour is the result of social forces and environmental contingencies rather than personality traits, character, will power, or other qualities of individuals (Zimbardo in Lauer 1982:15). Human life then, is social life. An individual's attitudes are not something unique to that individual, something created or developed in isolation from others. Rather, an individual's attitudes develop through interaction with others and are shared with the groups of which he or she is a part. Likewise, norms are social and behaviour is social in the sense that everything we believe and do is a function of our relationships with others (Lauer 1982:15). Thus, investigating the impact of a social phenomenon on individuals social lives is important.

Somerville (1972:39) states that the individual is a product of his society...the child becomes a social being and develops a concept of self through interaction in small, intimate groups. Thus, it is evident that man is very much a social being. He is molded, shaped, affected, influenced, and developed by others in his environment, be it his work or social environment.

2.3.1. SOCIAL SUPPORT

As a social being, man is reliant on support from social systems. Social support includes size and density of one's social network, availability and responsiveness of individuals within the network, and an individual's ability to make use of the network's resources (Derlegon et al in Hendrick 1995:66).

Wortman and Dunkel-Schetter (in Hendrick 1995:66) proposed the following important social support behaviours: expression of positive emotion towards someone, support of their feelings and beliefs, encouraging them to express feelings, offering information or advice to them, providing them with material aid, aiding them with particular tasks, and helping them feel a part of a group of people who will support each other. From this list it is apparent that social support may be offered in emotional, cognitive or behavioural terms. Nzimande (1996:47) defines social support in terms of the following interpersonal features of a person's life: emotional support i.e. information that one is loved and cared

for, esteem support i.e. information that one is valued and esteemed, network support i.e. information that one belongs to a network of mutual obligation and socioeconomic support.

In considering social support, it is extremely important to assess not only the support that may be available to an individual but also how supported that individual actually feels. The term 'perceived social support' has been used to refer to 'the belief that if the need arose, at least one person in the individual's circle of family, friends and associates would be available to serve one or more specific functions' (Cutrona, Suhr and MacFarlane in Hendrick 1995:66). The importance of perceived social support should never be underestimated. Most therapists have probably had clients in situations in which the knowledge that they have a safety net (perhaps consisting of only one person) was enough to keep them balanced on their particular tightrope. The net may not have to be used - but the client had to know that it was there (Ibid).

Many studies have found that social support can alleviate the effects of stress on health and mental health. There is quite a lot of support for the 'buffering hypothesis', that is that social support comes into action when it is needed, when there is stress (Argyle and Henderson 1985:27). Therefore, having social support is vital to the healthy functioning of individuals.

2.3.2. THE FAMILY

The family is an important social support system. A family 'is created when two or more people construct an intimate environment that they define as a family, an environment in which they generally will share a living space, commitment, and a variety of the roles and functions usually considered part of family life (Vosler 1996:13). Despite widespread family breakdown, parents, children and other close relatives continue to work together for each other's benefit. Most people turn to family networks when things go bad. Close relatives provide emotional support by listening to each other and offering encouragement (Riker and Brisbane 1988:268). Caplan (in Nzimande 1996:47) refers to the family as an extended network of relationships through birth and kin which functions as an

important social support structure.

Different investigations conducted research on family-kin-friend networks. These studies demonstrated that kin turned first to one another in time of need. Their help included physical assistance, material support and emotional support (Broderick 1993:148). Holman (1983:40-41) in discussing assessment of a family's social network states that important people in the family's environment provide the means for relatedness, identification, affirmation, socialization to belief systems, norms and cultural values. Such people function as the natural helpers in a mutual aid system (Holman 1983:41). Argyle and Henderson (1985:29-30) state that the wider social network can be a source of different kinds of help in times of crisis. They also say that those people who have children tend to live longer (Ibid). The reason for this could possibly be the benefits derived from this social contact.

The healthy family is responsive to outside input and experiences, whether these are negative or positive. Yet it should also be stable enough to offer a sense of security and continuity in a context of continuing change (Fine 1995:12). A healthy family has a clear and shared belief system. This includes a set of values and givens about the way each family member should live their lives. It may include a set of religious beliefs, and provides a framework for understanding and relating to previous and future generations (Fine 1995:19). The external stresses on today's family is vital in providing support and security for it's members attempting to cope with high stress levels (Fine 1995:96). Adler (in McCulloch 1996:63) comments that research literature within the coping and stress model suggests that both perceived and actual support can act as a buffer to some of the adverse psychological effects from the experience of stressful events. According to Chiddamodzi (in Sono 1994:125) the family provides the nursery for the development of human warmth and sympathy conducive to harmonious social living.

Respondents in a survey were asked to define family values. They defined such values in terms of love, emotional support, respect for others and authority and responsibility for one's self, family members, co-workers and society at large (Mellman, Lazarus and Rivlin in Zimmerman 1995:11)

Ranking highest in this list were love and emotional support (Ibid).

The environment is highly complex, interactive, and turbulent and has become increasingly important for effective system performance (Terreberry in Zimmerman 1995:183-184). The environment constantly presents families and other organizations with sudden and unpredictable changes that continually threaten to upset their equilibrium and adaptive capacities; it also threatens their ability to predict the future and control the consequences of their actions. Thus, families as systems are vulnerable to disequilibrium not only because of changes internally induced by members and their own development but also because of the turbulent and changing nature of their external environment as well (Ibid).

The family is an important source of support for an individual. It both influences the environment and is influenced by it. This is clearly indicated by the family structure and support experienced by South African Black families. The most significant feature of the traditional Black family is the importance of the larger kin group when compared with the nuclear family. Amongst the black people, the extended family was ranked as the primary source of social support (Phorie 1989:10). Barnes says that we can only understand African marriage and family life in the context of the kinship system of society (Kanjo in Sono 1994:22) . Martin (in Phorie 1989:11) says that the extended family has an important role within the Black community as a social unit for providing psychological, emotional and material support to it's members. The extended family also provides moral support in difficult times, resulting in a sense of emotional security (Phorie 1989:13). Thus, the larger kin group provides a number of benefits to the traditional Black family which serve to strengthen it.

Ubuntu is a metaphor that describes the significance of group solidarity, on survival issues, that is so central to the survival of African communities, who, as a result of the poverty and deprivation have to survive through brotherly group care and not individual self-reliance (Mbigi and Maree1995:1). Thus, reliance and dependence on social support systems is very important to Black South African families. In fact, it can be said that social support systems are important to all families. One realizes the importance of family when one takes stock of the numerous occasions that one approached one's

family for assistance with problems, for advice and counsel, for love and attention, for baby sitting and to run errands, and sometimes just for company.

2.3.3. FRIENDS AND NEIGHBOURS

There are people who do not have family networks. They often have to turn to friends when in need. Many neighbours stand ready to help each other, whether in an emergency or not (Riker and Brisbane 1988:268). In urban areas it is the non-family support system that prevails above the extended family (Phorie 1989:13).

The Shorter Oxford Dictionary defines a 'friend' as 'one joined to another in mutual benevolence and intimacy'. Friends are people who are liked, whose company is enjoyed, who share interests and activities, who are helpful and understanding, who can be trusted, with whom one feels comfortable with and who will be emotionally supportive (Argyle and Henderson 1985:64).

Social support is one of the main things we need friends for - talking to them about our problems and receiving advice or amateur psychotherapy. On a more everyday level, simply comparing notes, and sharing experiences is important to us, to build a shared cognitive world, to put our private experiences into words and compare them with those of others (Argyle and Henderson 1985:84).

Contact with friends has been shown to be important for the young and the old. What is important is not the quantity of social interaction with friends, but it's quality, the level of intimacy, the amount of self-disclosure, the pleasantness of contact and the satisfaction derived from it (Argyle and Henderson 1985:29-30).

Argyle and Henderson (1985:30) say that neighbours and local organizations are the weakest kinds of relationships, and provide the least in the way of benefits. Nevertheless, good contacts with neighbours and belonging to churches or other local organizations do have some effect on health and

well-being. The local network of neighbours, friends and acquaintances, is an important source of help.

2.3.4. THE VALUE OF RELATIONSHIPS

'Relationships', 'personal relationships', or 'long term relationships' refer to regular social encounters with certain people over a period of time. Carter and McGoldrick (1999:9) explain that human identity is inextricably bound up with one's relationships with others....human beings cannot exist in isolation, and the most important aspects of human experience are relational. The main reason for psychologists' interest in relationships is the strong link with health and happiness. Furthermore, those who are married, who have lots of friends or who in other ways have a supportive network, are happier, in better physical and mental health, and live longer (Argyle and Henderson 1985:4-6; Gelles 1995:442). Argyle and Henderson (1985:7) say that women provide more social support than men do. They also form closer same-sex relationships than men and keep up closer contacts with kin. It has been suggested that the reason women live longer is that they are able to form closer and more supportive relationships.

Argyle and Henderson (1985:18) state the following:

> *"The more strongly attached we are to others, the longer we are likely to live. In a famous study in California, 6 900 adults were followed up over a 9 year period. Within each age group, those with the fewest social attachments were more likely to have died. An index based on marriage, friends and other links was devised. In each age group, individuals who were 'most connected' in their social relationships had lower mortality rates than those who were 'least connected'".*

Therefore, building a good social network is advantageous to individuals

Stress is a typical feature of most, if not all of our lives. Stressful life events make us ill, but if we have a good spouse or other forms of social attachment and support, the effects of stress are greatly reduced (Argyle and Henderson 1985:23).. It is found that these people who are happier, and in better physical and mental health, tend to have good relationships of all kinds. Marriage, cohabitation and similar relationships are found to be most important (Argyle and Henderson 1985:28).

There are a number of different ways in which social support from relationships can work viz. intimate close attachments provide caring, trust and empathy. There is a lot of evidence that having a confiding relationship with a spouse or friend is good for mental and physical health. The process which involves disclosure and discussion of personal problems - may be akin to psychotherapy. Social support also takes the form of affirmation, giving confidence, increasing self-esteem, and the belief in one's ability to cope. Favourable evaluation from others may lead to the expectation of similar evaluation and confidence in getting our own way; and belief in one's ability to cope results in confidence to tackle problems. Social networks are also one of the main sources of information. They also provide tangible help e.g. help at work by workmates. Social integration i.e. being accepted by a group of friends, and being able to participate in regular social activities, may be a distinctive form of social support (Argyle and Henderson 1985:30-31).

There is evidence that stress makes people ill by weakening the immune system, the natural defense against germs. It seems very likely that by reducing stress, social support can help to keep the immune system operating. Another possibility is that the relaxation response is activated by social support. This in turn reverses the biochemical effects of stress (Argyle and Henderson 1985:31). Hence, social support is vital for one's physical and mental health and to increase one's coping abilities.

2.3.5. THE WORK ENVIRONMENT

Most people spend hours at work. In fact the better part of our day is spent at work. Due to the prolonged exposure, the work environment can have a cumulative effect on adult development. Work

exerts a multi-faceted influence on us simply as a context (Pillari 1988:235). According to Pillari (1988:232) there is no meaningful alternative to work. Work defines our position in society and is the context in which we act out in areas such as competition, territoriality, creating and achieving, and bonding and nurturing i.e. associating with people in order to achieve (Pillari 1988:233).

People at work are in better mental and physical health, and experience a greater sense of well-being than the unemployed or women who are housewives. This however, is only true for working people when they have good relationships with their work superiors or colleagues. Relationships with both work mates and supervisors can be sources of stress or of social support and satisfaction. Work superiors are in a position to solve problems directly, workmates can back the individual up and add to pressure to solve problems, as well as listening to troubles and offering advice. When a person at work sees that he has social support this dampens the perceived level of stress (Argyle and Henderson 1985:29-30). Thus, social support at work has definite advantages for individuals. The main advantage or benefit being to serve as a buffer against stressors in the work environment.

2.3.6. THE INTER-RELATION BETWEEN THE FAMILY AND THE WORK ENVIRONMENT

Perhaps no two sets of social systems in our society have more obvious mutual impact upon each other than the family system and the various occupational systems in which it's members are involved on a daily basis. At least three types of reciprocating effects have been identified. First, family and occupational systems compete head on for the limited time, energy and loyalty of the same individuals. Second, we have 'spillover', which is the transfer of mood, style and interaction, and acquired skills between work and home settings. Third, in addition to these two types of direct effects, we have indirect effects that are of at least equal importance: the family living space, material possessions, life-style, educational opportunities and social standing in the community are all substantially determined by family members occupational placement and income; these in turn influence that placement and that income (Broderick 1993:152-3).

With regards to the two spheres, namely family and occupation, research has shown that support in one sphere may translate into better performance in the other. For example, when spouses of either sex actively support their mate's career, both the mate and the career prosper (Broderick 1993:154).

Real life offers a continual intermixture and confrontation between these two supposedly segregated realms (namely the family and occupational spheres) (Broderick 1993:155). Broderick (1993:155) cites Bolger and his associates (1989) who illustrated this point; they found that for both sexes, the best predictor for getting into a quarrel with one's spouse was having already had a quarrel with co-workers that same day. Hence, the work and family environments influence each other constantly.

2.4. THE WORKING CONDITIONS OF NURSES IN SOUTH AFRICA

As mentioned above, people spend a considerable amount of time at work and work conditions also exert a significant influence, either positive or negative, on people. In South Africa, the working conditions of nurses have led many to leave the country to take up nursing posts elsewhere. South Africa currently faces a crisis as more and more nurses leave the country every year. Between 1995-1999, 2 543 nurses requested that their qualifications be verified which they needed to go abroad (Independent Newspapers 28 March 2001: page unknown).

Some of the reasons for this exodus of nurses to other countries are the poor working conditions and the fact that they are being underpaid. Other problems are the unequal distribution of nurses with the bulk being in urban areas and the fact that nurses are being excluded from policy making. Thus, lucrative offers made to nurses by overseas countries are very enticing to them (Independent Newspapers 28 March 2001: page unknown; Sunday Times 26 May 2002:1).

In South Africa nurses have to work 12 hour shifts including most public holidays and weekends due to the serious shortage of staff. Nurses are also required to carry heavier work loads to meet the needs of the many patients as the nurse:patient ratio has increased dramatically in the last few years.

Overcrowding at provincial hospitals worsen the situation. Low salaries and the fact that they are not consulted during policy making further frustrates nurses with the result that thousands of nurses have left the country over the past few years to go to countries like Saudi Arabia and the United Kingdom where they are offered far better salaries.

The extent of the nursing drain in South Africa can be seen from the fact that a Durban hospital, R. K. Khan Hospital was left with 62 vacant posts after nurses left for jobs in Saudi Arabia (Sunday Times 26 May 2002:1). Matron Bathmasani Gounden, the Assistant Director for nursing services said that nurses were booking off sick daily because of stress and exhaustion. Matron Rachel Sami said that South Africa's nursing drain would not stop until the provincial health department raised salaries and improved working conditions (Ibid).

Thus, nursing in South Africa, especially those in the provincial hospitals face the stressors of being underpaid, poor working conditions, and being overworked due to a serious shortage of staff.

2.5. CONCLUSION

Abortion, in South Africa, as in many other parts of the world, is still a very sensitive, emotive topic. The legalizing of abortion on demand in S.A. in 1996, has caused many changes. One of these being that nurses have to administer abortions and also care for the patients thereafter. This has different effects on nurses. The South African society has reacted in different ways to the new legislation. Some have welcomed it as an important milestone in advocating women's rights, whilst others regard it as a shameful act that has placed S.A. on the road to demoralization. Thus, the pro-life and pro-choice supporters keep the debate alive. TOP nurses are a part of families, social relationships and communities. This being the case, they are, like everyone else, affected by these various social systems and the views that they hold, as well as by their work. Thus, this research project explores the social implications of abortion work for TOP nurses.

Chapter Three

Methodology

3.1. INTRODUCTION

In the following chapter, the methodology of this study will be discussed. Reasons will also be presented for the choice of research design, methodology, sampling procedures, research tool used etc. The chapter will be concluded with a discussion of the limitations of the study and ethical considerations.

3.2. RESEARCH DESIGN

A qualitative research design seemed the most appropriate for this study due to the exploratory nature of the research and because it attempts to understand those being observed from their own perspective. Sherman and Webb (in Ely, Anzul, Friedman, Garner and Steinmetz 1999:4-5) say that qualitative research aims at understanding experience as nearly as possible as it's participants feel or live it.

3.3. RESEARCH METHODOLOGY

The Interview Guide Approach was used and a semi-structured interview guide was opted for. Semi-structured interviews seemed the best option for this type of research as it meant having the advantages of both a questionnaire to guide the interview but also the freedom to ask additional questions if I needed to. Patton (in Rubin and Babbie 1993:374) suggests that the interview guide strategy is one way to provide more structure than in the completely unstructured informal conversational interview, whilst still maintaining a relatively high degree of flexibility.

3.4. THE RESEARCH TOOL

(See Appendix 2 for Interview Schedule)

Lauer (1982:3) states that any task demands the proper tools and he quotes a Chinese philosopher who said "One should not attempt to open clams with a crowbar". I believe that I have selected the appropriate tool to elicit the information that was needed for the purposes of this research.

An Interview Schedule was drawn up and a pilot study conducted with a member of my family who was a general nurse a few years ago. After this pilot study the interview schedule was revised. The Interview Guide was divided into different areas/categories and the questions were formulated so that they were more specific. Jones (in Allan & Skinner 1991:204) says that she found it helpful to begin writing out the questions in full. She said 'Although I may not use the questions as written, this exercise allows me to think about the way I might phrase questions...'. Apart from the categories aimed at explaining respondents' social relationships, two additional categories were included in the study viz. Relationship with Self and Relationship with God. These categories were included for a more comprehensive study of the implications of TOP work on nurses. The last category on the Interview Schedule allows for respondents to provide recommendations with regards to the challenges experienced by them as a result of TOP work.

The first few interviews found me 'clinging' to the Interview Schedule as if it were a lifeline. This can be attributed to my initial anxiety as I had never done this type of interviewing before. However, as I became more sure of myself and also more familiar with TOP work, the jargon used etc., I found myself becoming more confident so that I relied less on the Interview Schedule and used it merely to check that the different areas had been covered. In other words, it was use as a *guide*, as it supposed to be used in semi-structured interviews.

The Interview Guide/Schedule started with identifying particulars of respondents and the length of time they have been doing general nursing and TOP nursing. Every interview commenced with me

informing respondents of the reasons for the research, the potential costs and benefits of the research, emotions that could be evoked as a result of the research and how this will be handled, the measures taken to ensure confidentiality and anonymity, what would happen with the transcripts etc. The interviews then proceeded with identifying details, and often the decision regarding a pseudonym, accompanied at times with laughter. The interviews were purposely structured in this manner with the aim of commencing with straightforward, easy questions to set respondents at ease in the interview. More sensitive issues or topics were positioned later in the interview in order to first set respondents at ease during the interview.

Where a particular area was explored eg. relationship with family, less intense questions regarding their family's reactions and responses when they started general nursing, were asked first, before the interview proceeded to explore their family's reactions when they started TOP work. The same pattern was followed throughout. This is especially important with the situation as it exists in South Africa at present where TOP services are still a controversial subject.

Ten in-depth interviews were conducted with TOP nurses at two different hospitals in the East London area. Before proceeding with the study, permission had to be obtained from the Medical Superintendents of both hospitals. (See Appendix 1 for letter submitted to the Medical Superintendents of both hospitals). I was then referred to the Matrons-in-charge so that I could explain the purposes of the research and what it would entail. The Matrons-in-charge at both hospitals then introduced me to the Sisters working with TOP. Further information was given to them regarding the research study.

Some interviews were conducted by appointment whilst a few were conducted immediately upon my introduction to the nurses. This was largely as a result of the lack of availability of nurses due to their busy schedules. The latter proved to be a major difficulty with this research study. TOP nurses were usually very busy due to the large number of TOP patients and a shortage of nursing staff.

The interviews ranged in duration from 30 to 90 minutes. Some respondents proved to be more

verbose than others, so shorter interviews were not necessarily less informative. Interviews were recorded on audio-cassettes with the permission of respondents and then transcribed. Respondents then read their transcripts to ensure that the correct information had been captured from the interviews.

3.5. THE SAMPLING PROCEDURE

(Please refer to "Sample Profile" in Chapter 4).

Due to the fact that a very small number of nurses perform TOP, non-probability/ purposive sampling was used in this research. In purposive sampling researchers choose respondents because of certain characteristics (Dooley in Taylor 1997:50). The type of purposive sampling used was Criterion Sampling. The respondents targeted had to meet the following criterion:

- They had to be qualified TOP nurses currently performing TOP.
- They had to be willing to be interviewed.

3.6. ANALYSIS OF DATA

The interviews were recorded by means of a dicta phone and were transcribed. Williams, Unrau and Grinnell (1998:230) describe the use of audiotape as the most reliable way of recording interview data. Debbie Goldberg (in Ely et al 1999:82) states that transcribing interviews helps to recall the experience, expands the details and often provides a fresh perspective on the material. I found this to be true. Apart from the above, I also found that there were certain pieces of information that I had missed in the interview that were thankfully, captured on the cassettes. Note- taking during the course of the interview meant that I was not always fully focussed on what the respondent was saying, especially with those respondents who spoke fast. Thus, transcribing was valuable in proving to me just how much one can miss when one isn't actively listening. Note taking served as a back-up should

I encounter problems with the dicta phone. Note taking however, proved to be a distraction for me as it is not something I am accustomed to during the counselling interviews which I conduct daily.

Respondents were then asked to check the transcripts. Member checking ie. getting feedback from our research participants about our interpretation of what they said is a means of assessing the trustworthiness and truth value of the text data (Williams et al 19998:231). The difficult task of breaking the transcripts up into meaningful units then began. Although the Interview Schedule had been divided according to the different areas I wanted to explore, the interviews did not unfold neatly according to those categories. However, being in-depth interviews this was anticipated. What was not anticipated was how exhausting it would be rearranging the almost 70 pages of transcribed notes into different themes and 'hunting out' the patterns or categories. Ely et al (1999:87) say that at it's most useful, the process of establishing categories is a very close, intense conversation between a researcher and the data that has implications for ongoing method, descriptive reporting, and theory building. Therefore, many solitary hours were spent interacting with the data in order to achieve this.

Williams et al (1998:230) advise that because the interviewing approach to data collection is based on the interaction of the interviewer and the research participant, both parts of the discussion are included in the transcripts. They further state that the interviewer must also keep notes on the interview to record impressions, thoughts, perspectives etc. (Ibid). Unfortunately, I neglected to do the above. Thus, only respondent's discussions were transcribed verbatim. In hind sight I believe that recording my part of the interviews as well as recoding my impressions, thoughts and perspectives on each interview could have lent a richness and depth to the data.

With regards to reliability and validity, I am satisfied that this study has taken these concepts into consideration. Mason (2002:39) says that if your research is valid, it means you are observing, identifying or 'measuring' what you say you are. Various measures were taken in this study to ensure validity. A clear statement of the purposes of the study was formulated and presented to hospital authorities as well as to the respondents prior to commencement of the research. Only relevant questions were asked and were phrased in simple language to ensure that respondents would

understand the questions. A pilot study was also undertaken in order to test the research tool to ensure that it aims at obtaining the information that is relevant for this research study.

Reliability is sometimes measured by observing the consistency with which the same method of data 'collection' produce the same results (Mason 2002:187). In terms of reliability I am satisfied that should this study be replicated, it would yield similar results.

Williams et al (1998:301) speak of the 'dependability' of qualitative studies rather than 'reliability'. They say the following with regards to the dependability of the data:

> *"If we have been consistent in such things as interview procedures and developing rules for coding, and if we have obtained dependable data through a rigorous recorded process, then another researcher should be able to follow the same process, make the same decisions and arrive at the same conclusions. Also, if we ourselves redo part of the analysis at a later date, the outcome should be very similar to that produced in the original analysis".*

The following issues were taken into consideration in order to ensure reliability i.e. if this study could be duplicated , it would yield similar results. Data was obtained first hand from TOP nurses. Such data was offered voluntarily whilst participants were in their natural work environments. Member checking was done i.e. feedback was obtained from research participants about my interpretations by presenting interview transcripts to them for comment. Williams et al (1998:301) state that obtaining feedback from research participants is a credibility technique that is unique to qualitative studies.

Thus, I believe that the criteria for reliability and validity have been met in this study.

3.7. LIMITATIONS OF THE STUDY

A limitation of this study is that the results cannot be generalised to the wider population of TOP nurses, due to the fact that the sample obtained is not representative of the population.

Another limitation was that it was not possible to explore the implications of TOP work in certain areas of respondents' lives as some had not informed members of their families, or their friends, or communities about their work. Thus, I was unable to obtain a full picture of the extent to which TOP may or may not impact nurses socially, this being one of the main objectives of this study. (Although, I must admit that a lot of valuable information was nevertheless gleaned from respondents, as will be discussed in the next chapter).

Upon reflection, I feel that nurses responses may have been restricted due to the fact that interviews were conducted in English. English was the second language of the majority of the respondents. Although all respondents were proficient in English, I nevertheless wonder whether having the interviews conducted in their first language would have yielded a different, perhaps better result.

3.8. ETHICAL CONSIDERATIONS

3.8.1. ENSURING CONFIDENTIALITY AND ANONYMITY

Great care was taken to ensure that confidentiality was not breached. Lee (1993:164) says that attention paid to confidentiality helps to legitimate the research process and convinces potential respondents that researchers are to be trusted, and presumably encourages accurate reporting. Respondents were assured that pseudonyms would be used and that even audio tapes and transcripts would be anonymous. Lee (1993:171) says that an obvious solution to the problem of confidentiality is to obtain data which are anonymous at the point of collection or which are made so soon afterward. Almost all the respondents chose their own aliases. Respondents were also assured that taped

interviews would be erased after they were transcribed to further protect their identities.

Certain identifying details have also been omitted from the transcripts and the research to prevent identification of respondents. Further measures taken to protect respondent's identities include placing identifying particulars in categories eg. ages were categorized as between 20-30 years, 30-40 years etc. Renzetti and Lee (1993:9) say that while research participants should in general expect their rights to privacy, anonymity, and confidentiality to be protected, maintaining confidentiality of research data is especially important where informants or respondents are being asked to reveal intimate or incriminating information. Some of the information shared by the respondents in this study could be deemed to be incriminating. All respondents were called on to share intimate details with me, thus the need for confidentiality.

3.8.2. ENSURING VOLUNTARY PARTICIPATION AND INFORMED CONSENT

I conferred with the TOP nurses, informing them of the research and asking their permission to interview them. There was only one nurse who declined to be interviewed. Thus, nurses were given a choice regarding becoming a part of the study.

Prior to every interview, respondents were also informed of the potential for certain feelings to be evoked as a result of the interview. I also clarified what would happen should such a situation arise viz. that an appointment would be set up for her with a counsellor to assist her with those feelings. With regard to the above, Strydom (in Vos 2002:65) states that emphasis must be placed on accurate and complete information so that subjects will fully comprehend the investigation and consequently be able to make a voluntary, thoroughly reasoned decision about their possible participation.

After every interview contact was made with each respondent to see how they had experienced the interview. Although some of the respondents said that they had thought of the interview afterwards, none of them mentioned experiencing negative emotions as a result of the it. Two of the respondents,

Lucy and Theresa expressed that the interview had cathartic value for them. Both expressed that it had been good to speak to someone about their work and that it had been a relief. Lucy in particular said that she had become less irritable as a result of the interview. Renzetti and Lee (1993:9) say that permitting research on the private sphere might reveal that in many instances, particularly in sensitive areas, research participants desire catharsis, rather than sanctuary. Research on sensitive topics may produce not only gains in knowledge but also effects that are directly beneficial to research participants (Ibid). Lee (1993:107) similarly states that the depth interview can often be a cathartic experience for interviewees.

3.8.3. ENSURING PROTECTION FROM HARM

The criterion of avoiding harm is a basic ethical principle: inflicting harm is unethical and contrary to rights and welfare (Holloway and Jefferson 2000:86). To avoid harm to the respondents, I remained sensitive to the respondents and did not probe too much into negative feelings expressed by them. Whilst such information would have been good for the purposes of this research, I felt it unethical to risk causing emotional trauma to a respondent merely for the sake of this study. I was also sensitive to the fact that many of these nurses have experienced or are still experiencing conflicting thoughts and emotions as a result of their work. Some are using defence mechanisms like rationalising and isolation of affect, in order to cope with the incongruence in their thoughts, feelings, actions, beliefs etc. Realizing this meant that I was careful not to bring respondent's attention to these. Thus, in certain instances I did not clarify when such discrepancies arose because to do this could mean alerting respondents to the existence of such incongruence if they do not already know of it's existence.

This would mean leaving a respondent exposed, naked and vulnerable, with all their defences broken down; certainly causing them harm. Thus, I sacrificed a measure of depth in some of the interviews in order to protect the respondents from harm.

3.8.4. RESPECT

Respect was shown to respondents by ensuring that I went to great lengths to ensure confidentiality. I agree with Strydom (in Vos 2002:70) who says that objectivity and restraint from making value judgements are part of the equipment of a competent researcher. Therefore, I was also non-judgmental in my interactions with the respondents having resolved my own feelings about TOP before commencing with the research. Grinnell et al (1996:61) state that the process of ridding yourself of your own biases and assumptions is known as 'epoch'. They advise that before talking to research participants, one's goal should be to achieve as much epoch as possible so that one does not impose one's own beliefs on the interviewees (Ibid).

Respect was also shown to respondents in practical ways eg. being punctual, courteous and understanding when they were too busy to talk to me.

3.8.5. ENSURING THAT SUBJECTS ARE INFORMED OF THE RESULTS OF THE RESEARCH STUDY

Arrangements were made with respondents so that the results of the research could be conveyed to them on conclusion of the study. I will meet with each respondent individually in like manner as the interviews were conducted so that a printed copy of the results of the research could be given to the respondents. Holloway and Jefferson (2000:90-91) state that the products of research should be fed back into the groups or community from which the data derived.

3.9. CONCLUSION

In this chapter I have provided what I hope is a clear description of the manner in which this study was conducted. The nature of the study necessitated the use of a qualitative research design where

a Semi-structured Interview Guide was used. Criterion sampling was used and data was analysed thematically. Reference has also been made in this chapter to the limitations of the study. I am convinced that any researcher who wishes to replicate this study will arrive at similar conclusions as attention was paid to reliability. Validity was also taken into account. This chapter also discussed ethical issues that were considered during the study. Having set out the methodology of the study, I will now proceed to present and discuss the research findings.

Chapter Four

Presentation and Findings

4.1. INTRODUCTION

In the following chapter the findings of this study will be set out and discussed with reference to the available literature. The chapter is set out according to the different themes identified in the data viz. Nurses' rationale for doing TOP work, Nurses' perception of TOP work, Stigma and Labelling experienced by TOP nurses, Implications of TOP work on relationships with family members, Implications of TOP work on relationships with friends, Implications of TOP work on relationships with colleagues, Implications of TOP work on relationship with the community, De-motivating factors experienced by TOP nurses, Implications of TOP work on nurses' relationships with God and the Implications of TOP work on nurses. The chapter will commence with a description of the sample. A special note should be made that not all the themes that emerged are relevant for the purposes of this study. They are however included in this chapter as findings of the research as it will be unethical to overlook them. Such themes are:

- Theme 1: Nurses' rationale for doing TOP work
- Theme 2:Nurses' perceptions of TOP work, and
- Theme 9:Demotivating factors experienced by TOP nurses.

4.2. SAMPLE PROFILE

(Appendix 5: See Table 1 for Identifying Particulars of Nurses)

A sample of 10 nurses were drawn from two different government designated hospitals providing TOP services in the East London area. Five respondents each were interviewed from the two different hospitals. The sample consisted of nurses doing first trimester terminations, as well as nurses doing second trimester terminations.

Nurses' ages ranged from between 20 to 50 years. The sample consisted of 7 Black women, 2 Coloured women and 1 White woman. (The race groups respondents belong to are not reflected on

the tables to protect respondent's identities). The period of time respondents had been doing general nursing ranged from between 1-5 years to 20-25 years. Whilst the period of time respondents had been doing TOP nursing ranged from as little as a few months to between 5-6 years. (The Choice Act came into effect in 1997 ie. six years ago).

Only one respondent from the 10 interviewed, did not have children. The other respondents had from a minimum of 1 child to a maximum of 3 children. Six of the respondents were married, whilst four were single. (Please note that widows were also categorised as 'Single'. Again, this was to prevent respondents from being easily identified).

4.3. FINDINGS AND DISCUSSIONS

4.3.1. THEME 1: NURSES RATIONALE FOR DOING TOP WORK

Seven of the respondents provided reasons why people come for TOPs and why TOPs are necessary. However, Theresa and Lucy see TOP as merely a part of their job. Rose believes that patients should have the right to decide that they do not want children and that their rights should be respected. This is in line with the pro-choice standpoint ie. that a woman's right to control her body overrides any claim made by the foetus. CRLP press, a publication of the Centre for Reproductive Law and Policy, stated the following with regards to the latter in their February 1999 issue: "The call for women's rights would ring hollow if such rights did not guarantee women the freedom to make crucial decisions regarding their reproductive lives. Because the ability to control reproduction lies at the core of reproductive rights, these rights are rendered meaningless when women cannot determine whether or not to continue a pregnancy (http://www.crlp.org/pub_fac_abor2icpd.html).

Judy, Bee and Blanche point out that they are not encountering septic patients from backstreet abortions anymore as they used to when TOP was not legalised. Similarly, the TOP nurses interviewed by Shete (2001:78) felt that being directly involved with TOP has been a positive step

to try and minimise the problem of backstreet abortions. Cope (1993:1) commented on the former restrictive Abortion and Sterilization Act 2 of 1975 saying that it creates an industry of 'backstreet' abortions. She stated that gynaecological wards are crowded with it's victims, some of whom have died (Ibid).

Blanche, Bee, Amber and Judy, all mentioned the issue of teenage pregnancies. Children as young as ten are having abortions and they see TOP as necessary in order to help these school-going children with these unwanted pregnancies. As Blanche explained to her child regarding the above problem "...some are still at school... others are too young to have children." Betty and Bee also saw TOP as a means of curbing the number of unwanted children. Betty stated that when the TOP Clinic opened there were many street children "...and street children are unwanted". Economic reasons were also given for TOPs . In her study, Shete (2001:76) also found that the respondents (TOP nurses) mentioned that the common reason cited by clients for wanting to terminate their pregnancies was due to economic problems.

Most of the respondents view TOP services as a means of helping the community. Lovely sees it as serving her community, especially the HIV positive pregnant women. The rate of HIV infection is high in S.A. South Africa is second only to India in the numbers of people living with HIV and AIDS. Yet India has 20 times the population of S.A. (The State of South Africa's Population Report 2000:61).

Linda, Lucy and Amber had personal experiences with teenage pregnancies. Either they themselves, or a family member had fallen pregnant in their teenage years. However, Lucy is not sympathetic toward pregnant teenagers wanting TOPs. Rather, she states "...sometimes you just cannot understand why people do this, because when I was young there wasn't such things. You had to suffer for the consequences of your deeds". Linda and Amber, on the other hand, were motivated by their past experiences to become abortion providers. Linda said that she became an abortion provider "...to give other women the opportunity they deserve. Professionally, I feel I'm giving these people, the women in the community, a second chance".

Thus, nurses' rationale for doing TOP work ranged from their belief in a woman's right to choose, to providing a service to avoid backstreet abortions, unwanted and unplanned children and teenage pregnancies.

4.3.2. THEME 2: TOP NURSES' PERCEPTIONS OF THEIR WORK

Judy sees her job as a "cleaning of the uterus". As she explained "We are just cleaning the uterus.... they go out with the tablets and abort at home and come back, and we just clean the products that are left in the uterus".

Both Lovely and Bee felt that they are not directly responsible for TOP patients. Bee says "...the doctor's see to the TOP patients, the nurses only look after them". Lovely clarified that she's "...not hands on. Here, in the ward, we admit above 12 weeks. They are doctor's patients. So, I just care for them... we just do observations, cut the cord and clean her up".Theresa seems to have a similar perception of TOP work. When asked by her friends how she copes with TOP work, she replied "I don't have a problem because it is not me that's doing the termination. It's not me that's pregnant... I'm just looking after the patient... she's the one that made the decision.... I'm not the one that's actually pregnant and asking for TOP." So Bee, Lovely and Theresa see their role with TOP patients as one of just doing observations and helping the patients abort. However, despite these perceptions, as will be discussed later on, Lovely and Theresa still experience TOP negatively.

The responses of Blanche, Betty, Lucy and Amber in the interviews indicate that they see TOP as part of their duty. Lucy told her children that she just sees TOP as a job "...something I have to do to bring in an income and because of these nice hours".

Half the respondents (viz. Bee, Linda, Rose, Amber and Judy) view their work positively. They see it as a necessary service that they are rendering. Linda, however, still questions whether the work she's doing is morally acceptable. Interestingly, Betty also started off at the TOP Clinic with a

positive view of TOP but has gone from being pro-abortion to anti-abortion. Lauer (1982:15) states that an individual's attitudes develop through interaction with others. Betty's attitude towards TOP has changed drastically in the last few years as a result of her interaction with the TOP patients. Betty now experiences TOP work negatively, as does Blanche, Lucy, Lovely and Theresa.

Rose and Bee had to first resolve their personal feelings about abortion before experiencing their work positively.

4.3.3. THEME 3: STIGMA AND LABELLING EXPERIENCED BY TOP NURSES

Off the 10 respondents, only 2 (Rose and Theresa) did not experience labelling from people in their social network. Labels ranged from titles like 'Murderers' and 'Killers' to being called 'Osama Bin Laden'. Sister Lydia Motsapi was interviewed by Carte Blanche for a documentary aired on M-Net on 23 June 2002 with regards to abortion in South Africa. She stated that TOP nurses are stigmatised in rural communities. She said "So everybody is just looking at them as those satanists - they are killing babies. Some people chase them on streets. People want to beat them up because they are killing babies" (http://www.mnet.co.za/CarteBlanche/Display/Display.asp?Id=1984).

Anti-abortion sentiment have been expressed overseas as well. In USA for example such sentiments have been expressed through bombings, arson, vandalism, assault and battery, death threats, kidnapping, burglary, hate mail, harassing calls, picketing and clinic blockades (Costa 1991:140-141). Respondents in this study have experienced a lot of stigma and labelling since they have started TOP work. However, not to the extent that the above abortion providers.

Betty stated emphatically "It isn't an easy thing to accept. It doesn't matter which way you look at it, termination of pregnancy has a stigma attached to it. It will always have a stigma attached to it!" One cannot do other than agree with Betty in light of the fact that abortion has been a contentious issue for centuries in most civilisations. Chandrasekhar (1974:24) says that man's attitude towards

abortion have ranged over a wide spectrum, from approval bordering on encouragement to total prohibition and condemnation, all the way from early civilisation to present day.

Some people became less prejudiced and more accepting of TOP when their relatives needed TOPs or when the respondents gave them more information about TOP and the need for it. Betty, Lovely and Judy experienced a change in attitude in previously anti-abortion colleagues, community members and friends when their relatives had to have TOPs done. As Judy said with regards to her colleagues "They were initially negative. Now they are coming to me with their relatives for TOPs....they're so friendly now because I'm helping them!" Thus, personal experience challenged some people's prejudiced views and feelings. Andy Maduray of the Marie Stopes Clinic in Durban also mentioned that there was a gradual increase in the number of people supporting abortion after being initially anti-abortion, due to their experience of a friend or family member needing an abortion (Maduray 2003).

4.3.4. THEME 4: IMPLICATIONS FOR RELATIONSHIPS WITH FAMILY MEMBERS

(See Appendix 6: Table 2)

Respondents' family members varied in their responses to them starting TOP work. Betty expressed that her child hates TOP work and asks her often "Mom, how many babies did you murder today?" Betty's other close family members did not comment on her choice of work. So Betty is confronted often with her child's negative attitude towards abortion. This, however, has not impacted negatively on their relationship.

Blanche also experienced difficulties with her family. Her children told her that it was wrong taking the life of another person. She says "I've just tried to convince them that we're not killing!" Linda's mother was displeased when she started TOP work and said to her that she's killing babies. Her husband however, is supportive of her. She has no extended family. Lucy's children were shocked that she had chosen to work at the TOP clinic and asked "Mommy, you go to church. Doesn't this

affect your conscience?" Lucy's extended family do not know where she's working. She fears being ostracized and therefore has withheld this information from them.

Lovely, Bee and Judy have also not informed their families that they are doing TOP work. Judy's husband is aware of it and is supportive of her decision. He's especially appreciative of the better working hours at the TOP Clinic. Judy did not tell her children as she feels it will affect their family life. She says "I did not tell them because they will not approve of it... they will say 'Oh, my mother is killing people!'" She says that her children are very religious. Van Rooyen (1998:303) found that religion was the most influential factor in responses to abortion. Both Bee and Lovely describe their families as stigmatised and are hence reluctant to disclose to them that they are working with TOPs. Bee, however, states that TOP work did affect her family life initially as she was still stressed when she got home as a result of TOP work ie. the 'spillover' effect. Broderick (1993:152-153) speaks about this 'spillover' effect which is a transfer of mood, style and interaction, and acquired skills between work and home settings. The effect of TOP work on Bee is similar to that on the following nurse who, in discussing the impact of abortion work stated "I find it draining and exhausting. I become tired to the point where I do not want to relate to anyone, especially my family who may be in need of emotional support..." (Brien & Fairbairn 1996:169).

Theresa, Amber and Rose have been open with their families concerning their work. Theresa, however, hasn't disclosed the fact that she is doing TOP work to her family of origin. These three respondents experienced the support of their families, rather than being ostracized. With regard to the inter-relation between the family and work environments, Broderick (1993:154) states that when spouses of either sex actively support their mate's career both the mate and the career prosper. Theresa further states that she does not discuss her work with her husband. Thus, she states that her work does not have any effect on her relationship with him. Amber's family supported her decision to do TOP work as they had experienced a teenage pregnancy in their family.

Hence, it can be seen that the implications of their work on those nurses who have informed their families of their involvement in TOP have been largely negative. Although some family members were

supportive and accepting of respondents decisions to do TOP work.

4.3.5. THEME 5: IMPLICATIONS FOR RELATIONSHIPS WITH FRIENDS

(See Appendix 7: Table 3)

Whilst some respondents faced an inquisition regarding TOP work, others' friends could not reconcile TOP with their own views and beliefs and their strong convictions resulted in a breakdown in their friendships with the respondents. Lovely and Betty were unfortunately faced with this situation. Their friends broke contact with them after they started TOP work. Lovely has being doing TOP work for a few months only but has already lost friends as a result.

However, whilst the majority of the respondents (ie. eight of them) received very negative reactions from their friends when they started TOP work, not all of those friendships were negatively impacted. Some respondent's friends were able to express their disapproval of TOP whilst still maintaining their friendships. Blanche's friends for example, told her that she was doing something wrong and that they disapproved. The reactions of Judy, Betty and Linda's friends varied. Some were understanding whilst others were totally negative. Linda says "They were totally against what I'm doing. They think it's killing babies!" Lucy has not informed her friends of the work she is now doing as she fears their reactions will be negative.

Lovely's friends went as far as calling her a killer and "Osama Bin Laden". Judy also had to face ostracism at the hands of her friends (who happen to be her colleagues as well). She describes a particularly upsetting incident "When I went to the ward the nurse introduced me to other nurses and said that I'm a killer. I felt so upset!" She afterwards expressed these feelings to the nurse in question. Theresa's friends however, are just concerned about how she is coping with TOP work.

Whilst the majority of the respondents experienced labelling, criticism and ostracism from their friends

when they started TOP work, only two respondents lost friendships as a result. The other respondents' friendships have not been negatively affected as a result of TOP work. Although most of their friends disapprove strongly of TOP, they nevertheless accept the respondents and have maintained their friendships with them.

4.3.6. THEME 6: IMPLICATIONS FOR RELATIONSHIPS WITH COLLEAGUES

(See Appendix 8: Table 4)

Nine of the respondents received very negative responses from their colleagues when they started TOP work. Only Rose did not experience negativity from her colleagues. The fact that the majority of nurses feel very negatively about TOP is supported by a study by Poggenpoel, Myburgh and Gmeiner (1998:4) who found that the majority of nurses who were interviewed were of the opinion that the woman as well as the health services delivery staff involved with abortion are murderers. Shete (2001:92) similarly found that most professional nurses were very negative towards TOP and did not want to be associated with it.

Half of the respondents experienced conflict with their colleagues as a result of TOPs. Respondent's colleagues both voiced their negative sentiments and acted them out. Betty said that her colleagues passed very nasty comments when she started TOP work. Blanche stated that her colleagues would say when they came into the ward "This is the Killer Ward, where they are killing people!" Similarly Judy and Amber's colleagues also said that they are killing people.

Lucy's colleagues were shocked at her decision to do TOP work and asked her what possessed her to do this type of work. They also told her that they would never do such work. Bee's, Lucy's and Linda's colleagues tried to dissuade them from starting TOP work.

Amber stated that her relationship with her colleagues have changed since she started TOP work

"Especially with the nurses in the ward where we admit the patients who're above 12 weeks.... the relationship between them and us are so strained. They don't want to give us beds for these patients. They reserve the beds for the other patients who're not TOP patients". There is conflict between the staff at the clinic and the staff at the wards. In her study, Shete (2001:72) also found that gynaecological patients were given first priority over TOP patients.

Theresa, Lovely, Linda and Blanche stated that their colleagues do not want to admit or treat TOP patients. Lovely shared the following "Here at work when the patient comes, they take the folder and say 'Oh, it's a TOP. It's your patient!' They take it as if that patient is yours...TOP is yours...and you have to attend to them. Even if the patient has aborted, they say 'Just call that nurse to see to this patient!' It's not fair because everybody here must accept the patient and help her. One day I cried because there were so many patients for TOP. The ward was full and they were all passing their patients onto me. They were shouting at me and I cried. The other nurses don't want to have anything to do with TOP patients!" TOP patients have confirmed the above and have reported that people directly involved in providing TOP, related to them in a positive way but other staff (eg. ward staff, referring staff) were negative (http://www.hst.org.za/sahr/99/chap26.htm).

Theresa mentioned that they are working under abnormal circumstances viz. they are short-staffed, their salaries are low, they don't get appreciated and conflict sometimes arises with the nurses due to the proper procedures not being followed. They are always taking 'short-cuts' in order to save time. Conflict also arises because her colleagues do not want to admit TOP patients. In her study Shete also found that work over load and staff shortages affected nurses negatively. There is, however, a general shortage of nurses in South Africa at present with a resultant work overload on existing staff (Sunday Times. 26 May 2002:1).

Betty's relationship with some of her colleagues were also strained when she first started TOP work. Thus, respondents decisions to start TOP work were largely met with negativism from their colleagues and impacted negatively on some respondents relationships with their fellow nurses.

These findings are contrary to the assertions made in The Barometer (1998:8) which stated that initial opposition to TOP services have dwindled in the Eastern Cape and TOP excites little discussion and attracts little attention amongst staff who were very hostile at the start. They continue to say 'It is striking how nurses in particular have come to accept and indeed support the service despite their former antagonism'(Ibid). This study did confirm that opposition to TOP is not as intense as it was a few years ago. However, it also revealed that respondent's decision to do TOP work whether a few years ago, or as recently as a few months ago, occasioned negativity, labelling, ostracism, as well as conflict amongst colleagues. In fact, the majority of the hospital staff still remain very negative about TOP and have not yet accepted it. This is confirmed by Dr. Eddie Mhlanga, head of maternal and women's health in the national Department of Health, who stated that TOP providers are often overlooked for promotion, enjoyed little support and faced constant victimisation and intimidation by managers and the community (Daily Dispatch 26 September 2003:16).

4.3.7. THEME 7: IMPLICATIONS FOR RELATIONSHIP WITH COMMUNITY

(See Appendix 9: Table 5)

Half of the respondents (viz. Bee, Blanche, Judy, Lovely and Lucy) said that their community is not aware of the work they do. They have not specifically shared this with their communities. Although, there may be people who know they are doing TOP work. Lucy had to disclose to a lady from her church that she is doing TOP work. The extremely negative reaction she got from her, deterred her from sharing this with anyone else.

Betty got mixed reactions from her community when she started TOP work. Some reacted positively whilst others were disapproving. However, her church has supported and accepted her. Rose has also had a positive response from her church and her community. People, especially the young people, approach her for advice regarding family planning, TOPs etc. The issue of TOP is taboo in her community but she states that they accept TOP. Her church, like the rest of her community has not

taken a stand on TOP. They are however, accepting of her. The church minister has prayed with her and she has also opened up to the congregation regarding her work. Rose says "I think in my community it is much easier because they accept it more easily. I think the problems come with the rural areas because the people have got set standards and ways of living. But in the urban areas they accept it more easily".

Theresa also provides information and advice to people in the community. She especially targets the young people when she goes to social gatherings, to give them the correct information about contraceptives, safe sex, and TOP, it's complications etc. Linda states that many churches in her community say that TOP is wrong and that it is killing and everyone has a right to live, even the unborn child. This is in line with the pro-life standpoint which focusses on the right to life of the foetus and consider abortion to be murder (Hadley 1996:56).

4.3.8. THEME 8: IMPLICATIONS OF TOP WORK FOR THE NURSES

(See Appendix 10: Table 6)

Half of the respondents (viz. Linda, Theresa, Lucy, Lovely and Blanche) question if they are doing the right thing when it comes to TOPs. Theresa, Blanche, Lucy and Lovely experience guilt as a result of TOP work. Linda experiences her work positively but still has not settled within herself, whether it is morally acceptable or right.

Stress, depression, confusion, anger, resentment and frustration were other negative emotions experienced by TOP nurses. Lovely, who has been doing TOP work for a few months, says she has negative feelings about herself and doubts if she is really doing the right thing. She also mentioned that she feels a depression that she believes is associated with TOP work. TOP work is also affecting her psychologically. Lovely shared the following with me "One night I dreamt that I was resuscitating the babies...and that the mother was saying 'I want my baby now!' So I was just running around

trying to resuscitate this baby! So it's very stressful!"

Theresa experiences a lot of conflicting emotions. She constantly questions herself regarding whether what she is doing is right or not. Her conscience troubles her a lot and she feels guilty. Theresa's also concerned about the negative effect that TOP work has had on one of her colleagues and wonders whether it will have a similar negative effect on her. Blanche also experiences guilt. Although she understands why people have TOPs, she nevertheless feels guilty after conducting a TOP.

Lucy confessed that she feels guilty and ashamed as well, due to TOP work. She said "This sits on your conscience!" Lucy is uncomfortable with the work she is doing, which has definitely brought about a change in her. She has developed respect and admiration for pregnant women who give birth to their babies, and for those taking contraceptives. She has also developed a love for babies and does not take them for granted anymore. Lucy has also become impatient and angry towards women who come repeatedly for TOPs. She has become judgmental. Brien and Fairbairn (1996:168) say that surveys have consistently pointed out the low levels of empathy and the judgmental attitudes among TOP nurses. Lucy said "...every time they're pregnant they just come and kill the baby. We nurses must help them kill the baby.... you wonder how they can do it...because when you're lying on your bed at home, thoughts come to you!" Lucy's own feelings of guilt are reflected in her negative, judgmental, attitude towards the clients, especially those coming for repeat TOPs. Ndhlovu (1999:123) quotes Webb who noted that attitudes can leak through into behaviour and inadvertly influence care given by nurses to patients.

In this sample, it is Betty who seems to have experienced TOP work most intensely. Compared to the other respondents, it seems that TOP work has had the greatest impact on her. She initially was pro-choice, promoting TOP. She was sympathetic towards TOP patients and says "I felt desperately sorry for those women who really did not want to have another child". She has however become frustrated and angry with TOP patients who have used TOP as a contraceptive. She feels that they abuse the service and she feels abused as the service provider. Respondents in Shete's study also expressed their feeling that TOP was being misused ie. being used as a means of contraception (Shete

2001:94).

Betty stated that TOP has affected her psychologically making her become a 'hard' person. Dartington (in Brien and Fairbairn 1996:175) says that hospital nurses need to mobilise appropriate defences against pain and anger as when these are not available breakdown or breakout symptoms like sick leave or psychosomatic symptoms result. A common alternative is the unconscious development of a 'protective shell' which serves to deflect and anaesthetize emotion. Dartington goes on to say however, that if such a shell becomes a permanent feature of the personality, it is at great cost to the individual who can no longer be fully responsive to his or her emotional environment (Ibid). Betty has built up resentment over the years and it manifests in impatience, anger and emotional detachment from TOP patients which serves as a psychological defence mechanism to protect her from emotional pain. The result has been her decision to leave TOP nursing. A month after our interview, Betty informed me that she'd got the transfer she had wanted to a different ward and that she will no longer have to work with TOPs. Lovely and Theresa have also confirmed that they sometimes feel like leaving . Lovely stated that she feels like leaving the TOP ward sometimes, whilst Theresa shared that she occasionally feels like leaving nursing altogether.

Judy and Amber experience TOP positively. The effects on them both were different to those on the other respondents. Amber says that TOP work had resulted in her being more empathic with others. She is pleased with herself and proud that she is doing TOP work and helping others. Similarly Judy stated that she "feels great" because she did TOP work despite the negativity of her colleagues. She feels proud of herself for doing TOP and says she's not ashamed at all. It is worth noting that Amber and Judy work closely together presently and that Judy recruited Amber to TOP work. Lauer (1982:15) states that an individual's attitude develops through interaction with others and are shared with groups of which he/she is a part. Judy and Amber's constant interaction with each other even before Amber started TOP work could well be a reason for the similarity of their perceptions of TOP, and the positive way in which they experience their work. TOP work seems to have enhanced both these respondent's self esteem.

TOP work has given Rose an appreciation of her family and the life she has led. She is grateful she has never had to experience what the patients do and she has become appreciative of the supportive parents she has. She also states that she feels she knows herself better as a result of TOP work.

In this study, it was found that many of the TOP nurses use psychological defence mechanisms in order to protect themselves emotionally. Many use rationalization viz. Blanche, Lovely, Judy, Bee and initially Betty as well. Betty for example spoke to her critics about the large number of street children when she first started abortion work. She was pro-choice at the time and argued that the number of children ending up on the streets could be reduced through TOPs for unwanted pregnancies. In the years following however, Betty has become 'anti-abortion'. She has been using a different defence mechanism to protect herself emotionally viz. 'isolation of affect' where she literally switches off emotionally and is emotionally detached from her job and the patients. Isolation of affect occurs when an individual separates feelings from actions (Halgin and Whitbourne 1997:110) According to Freud, everyone uses defence mechanisms on an ongoing basis to screen out potentially disturbing experiences. However, when defence mechanisms are used in a rigid or extreme fashion, they become the source of psychological disorder (Halgin and Whitbourne 1997:109-110). (Thankfully Betty has been transferred to a different department). Other studies have also indicated that TOP nurses resort to psychological defence mechanisms as shields to protect them from emotional pain (Ndhlovu 1999:118; Gmeiner, Van Wyk, Poggenpoel and Myburgh 2000:72).

The effects of TOP work on respondents spiritual/religious lives will be discussed under the heading: Implications on relationship with God.

4.3.9. THEME 9: DE-MOTIVATING FACTORS

A de-motivating factor for some of the nurses when they started general nursing (not TOP nursing) was the conflict that arose as a result of differences in qualifications. Four of the respondents viz (Lovely, Amber, Linda and Lucy) expressed that they had experienced negativity from their

colleagues when they first started general nursing due to the differences in qualifications or seniority. Conflict exists between those who are more qualified and those who have a lower qualification but years of experience. The older staff seem to feel threatened by the new comers who had higher qualifications than they did. In the past, it seems that junior nurses were also in a subservient position to the more senior staff. This also created unhappiness for those just entering the nursing profession.

We have dealt with the conflict between respondents and their colleagues due to TOP work and the resultant stressors viz. the lack of co-operation or teamwork especially when it came to admission of second trimester TOP patients; holding TOP staff solely responsible for the care of TOP patients; not assisting TOP staff; and projecting their anger and negative sentiments with regard to TOP onto TOP staff.

Apart from the above, other unique work conditions make the work of TOP staff more difficult. Betty, Lovely and Theresa mentioned staff shortages. Betty had to be called in from leave every year since she started TOP work as there were no other staff available. Theresa puts things into perspective by saying "...we are working under very abnormal circumstances... it's very bad... we're short staffed... it's very hard work and you don't get appreciated! Our salaries are low... You don't even get a 'Thank You' to motivate you. So, that's what depresses you at times....that you feel you want to resign!" As mentioned above, the abnormal circumstances Theresa describes viz. staff shortages, low salaries etc. exist in other hospitals in South Africa (Sunday Times 2002:1; Independent Newspapers 2001: page unknown). Shete (2001:72) also found that staff shortages and unwillingness of staff to assist TOP nurses affected them negatively.

Argyle and Henderson (1985:29) state that people at work are in better mental and physical health, and experience a greater sense of well-being than the unemployed or women who are housewives, when they have good relationships with their work superiors or colleagues. In light of the findings of this study I would venture to state that this greater mental and physical health and sense of well-being is also dependent on people doing jobs that are not in conflict with their own values and beliefs. Where confusion and ambivalence regarding the morality or ethics of their job arises, people's mental

and physical well-being is threatened, as is evident from the discussion in the previous section. Another de-motivating factor Lucy experiences is the difficult patients. Some patients are very demanding and TOP nurses have to put up with "...a lot of unpleasantness from the clients..." Some of them do not co-operate with the nurses. They do not take their medication on the appointed date and arrive at the clinic on the wrong day, throwing their schedule off. (The clinic only books a certain amount of patients every day as there are limited beds available). This puts pressure on nursing staff when more patients than were scheduled arrive at the Clinic, and they cannot turn them away after they've ingested the Misoprostol tablets that start the abortion process.

Bee mentioned that she had experienced TOP work very negatively in the beginning as she had been totally unprepared for it. She'd received no training for TOP work so she was unaware of how to handle and care for TOP patients or the foetuses. She feels that she should have received training to adequately prepare her for the experience of TOP work. Results of Shete's (2001:91) study also revealed that the nurses working with TOP clients were not prepared psychologically and that this had a negative effect on them and on their clients (Shete 2001:91).

Four of the respondents (viz. Lovely, Betty, Theresa and Lucy) expressed that second trimester pregnancies (especially during the latter part of the term) are far more difficult for them to cope with. Brien and Fairbairn (1996:176) confirm that late terminations evoke powerful feelings in staff and that nurses find handling the foetus extremely distressing. Both Lovely and Theresa experienced guilt when the aborted foetus resembles a baby. The negative effect of seeing the aborted foetus on nurses has also been confirmed by Ndhlovu's study (1999:115) where it was found that nurses were disturbed during the TOP procedure by the sight of the aborted foetus or foetal parts, and the born alive foetus (Ndhlovu 1999:115). (The reader is referred to the pictures of foetuses at 12 weeks and 18 weeks old, as well as their actual sizes, at the end of this chapter).

Theresa expressed that it is very emotionally upsetting to her when the aborted foetus is still alive, because it means that *she* has to sever the cord, cutting off it's oxygen supply. At times like these, she feels very guilty and her conscience plagues her. She says "It's now and again that the baby will

still be alive...maybe once in six months. So, there's time to recover. I'm sure if it had to happen on a regular basis, I won't be able to cope with it!" Bee also expressed that she finds it difficult when the aborted foetus is still breathing. Lucy said that the aborted foetus sometimes gives a last cry. She also related an incident when a woman aborted twins and she could not help but say to her "You know you've just destroyed two lives". Thus, TOP work seems to be more difficult for nurses to deal with when the foetus has the appearance of a baby rather than being a mass of tissue and blood clots.

Clients using TOP as a means of contraception also de-motivates some respondents who mentioned that TOP is now being used as a substitute for contraception. Other TOP nurses in the Eastern Cape expressed their concern that clients were misusing TOP and were being careless with their contraception as they were coming for repeated TOPs (Shete 2001:79; Ndhlovu 1999:118). Respondents in this study echoed this concern. Available data demonstrates that induced abortion is very prevalent in the developing world (Mundigo & Indriso 1999:23).

Betty, Lucy and Linda stated that women are using TOP as a contraceptive. Betty stated that a lot of time is spent counselling the patients about contraception etc. Therefore, it angers her and Lucy when some patients come in for repeated TOPs. She feels they are abusing the service and abusing her as well.

Blanche and Theresa also said that women should be using contraception rather than going through the painful process of TOPs. Both felt that contraception would be far easier for patients and as Blanche mentioned "It is free!" This view is supported by Meidany, Pucherdt and Rohde (in Shete 2001:94) who found in their study conducted in the Eastern Cape that 96.4% of the communities regard TOP service mostly as a method of limiting unwanted births because of social and economic reasons. They also point out that services of family planning should be improved and be more efficient as they are more cost effective than TOP. An article by Varkey and Fonn summarised the results of 86 studies conducted in South Africa since the Choice Act was implemented. They found that between 25-80% of women accessing abortion services were not using contraception (http://www.hst.org.za/sahr/99/chap26.htm). Thus, the lack of contraceptive use seems to be a contributing factor

to the ever increasing number of repeat TOPs. This frustrates and de-motivates TOP providers.

4.3.10. THEME 10: IMPLICATIONS FOR RELATIONSHIPS WITH GOD

(See Appendix 10: Table 6)

Whilst nine of the respondents were church goers, they differed with regards to the depth of their spirituality. Nevertheless, half of the respondents (viz. Linda, Lucy, Betty, Theresa and Blanche) questioned whether they were doing the right thing from a religious perspective. Many respondents prayed to God about TOP and also to ask His forgiveness if they are doing wrong by providing TOP services.

Only one respondent reported that she did not have any relationship with God viz. Lovely. Linda expressed that she is not a regular church-goer and attends church only when she feels she needs to or when she wants to go. She expressed that many of the churches and the church goers say that TOP is wrong. Linda however questions whether what she is doing is right from a religious point of view.

Lucy's children questioned her involvement with TOP because she is a church goer. She even had someone say to her that she shouldn't even go to church because she is a murderer! She says "I still want to be close to my Creator, but at the same time I feel I don't need people to tell me that I shouldn't go to church!" Lucy often prays to God about TOP and her job. She believes that He is an understanding God who will not punish her for what she is doing. Her relationship with God has not changed since she started TOP work, as she continues to speak to Him about her work.

Similarly Amber, Judy, Bee and Rose did not experience changes in their relationships with God. Amber says "I still see God as the one who has created me. I still respect Him....I still go to church and pray like I used to. So there's no change!"

Judy believes it is right to help people and that God knows what is happening and He understands.

She is a regular church goer and although her minister criticizes TOP, she's still doing it because she believes it is right. Her family is very religious and she says that if she had to tell them that she is doing TOP work, it will have a negative effect on her family life.

Bee constantly prays to God for the ability to cope with TOP. She states however, that TOP work has not brought about any changes in her relationship with God. This is in line with other TOP nurses in the Eastern Cape who felt that their religious beliefs did not affect their decision to be involved with TOPs (Shete 2001:77). Rose, uniquely felt that TOP work has improved her relationship with God. She believes that God would have stopped TOP work a long time ago if He did not want it to happen.

Blanche however, has experienced changes in her relationship with God. She prays to God daily for forgiveness for her involvement in TOP work. Whilst she says she understands people's need for TOPs, she believes that the child being aborted has also been created by God. Theresa's family and friends have been concerned about her ability to cope with TOP as she is a regular church goer but she also prays to God about her work.

Being involved in TOP work has brought about a drastic change in Betty's relationship with God, although it has not affected her church life. In fact, her church has been supportive of her. According to Argyle and Henderson (1985:30), belonging to organisations in society, like churches, have a beneficial and positive effect on people's health and well-being. Being involved in TOP work has caused Betty to question the existence of God. She shared the following:

"When you see a nations decline to thinking that termination of pregnancy is a normal procedure; that if you fall pregnant it doesn't matter, you just have an abortion...it makes me wonder if there actually is a God up there. I never used to doubt my Christian beliefs...I never doubted them for a minute! Now! How can there be a God who allows women to use it as a method of family planning? Because that's what they're doing. I'm now beginning to question 'Is there really a God?' I've always believed in the ten commandments, but now...what do I do everyday when I come to work? I basically commit murder. Whether they want to argue that it hasn't got a soul until it's born or whatever... I question the existence of God because I wonder: How can He give children to people who do not want them?'

Findings from previous studies conducted since the implementation of the Choice Act, have shown that religion and frequency of religious attendance affect attitudes to abortion. There was slightly higher support amongst non- or very infrequent religious service goers (http://www.hst.org.za/sahr/99/chap26.htm). This study did not confirm this as the infrequent church goers did not necessarily have a more positive attitude towards TOP and vice versa. Van Rooyen (1998:303) found that religion was the most influential factor in responses and attitudes to abortion. This also was not confirmed by this study.

In summary, from the nine respondents who have relationships with God, TOP work has only brought about a positive change in one respondent's relationship with God. Two respondents felt that TOP had negatively impacted their relationship with God. Whilst, the remaining respondents felt that their relationships with God had not changed as a result of TOP work. The majority of the respondents involve God in their work lives by praying to Him often about TOP.

4.3.11. THEME 11: RECOMMENDATIONS OF NURSES

(See Appendix 11: Table 7)

More than half the respondents (viz. Betty, Amber, Bee, Lovely, Rose and Theresa) felt that counselling should be offered to TOP nurses to help them cope with their stressful occupation. Theresa and Betty emphasized that counselling should be made compulsory for nurses working with TOPs. Rose however believes that counselling should be made available, more especially to those nurses who are affected negatively by working with TOPs. Betty further specified that counselling should be provided by a psychologist or someone that the staff trusts and respects. Lovely suggested that such counselling take place at least once a month. In their study, Gmeiner et al (2000:72) also found that TOP nurses felt they needed support...one nurse suggested "a kind of meeting" where they could go to talk about their experiences and ventilate. The need for counselling services were also reflected in Ndhlovu's study where she found that only one of the nurses in her study had received

some form of counselling to help her cope with her work (Ndhlovu 1999:124).

Training for TOP nurses was also a recommendation made by more than half the respondents (viz. Judy, Betty, Linda, Amber, Lovely and Bee). Betty stressed that specialised staff needed to be involved in TOP and that nurses should be well informed of what the job entails, what they are getting into and must be thoroughly educated and trained. Linda felt that TOP should be included in the nursing curriculum so that when student nurses qualify they will all know how to do TOPs. Judy also expressed that a need exists to recruit and train new TOP staff. Increasing the number of trained midwives is a national goal. Thus far 90 midwives have completed the theoretical training and 22 physicians have been trained in the manual vacuum aspiration technique to serve as provincial resource persons, who in turn have trained 124 other physicians (http://www.hst.org.za/sahr/99/chap 26.htm).

Amber and Lovely believe that in-service training should be provided for nurses at the hospitals. Lovely believes that such training is the key to prevent staff from being judgmental and negative towards TOP patients especially the young patients. Bee strongly emphasized the need for training for any nurse involved in TOP work especially to prepare them for situations like dealing with the born alive foetus during second trimester abortions etc. Respondents in Shete's study also suggested that in-service training and education be given at hospitals in order to teach the whole hospital community about TOP and it's benefits so that they could be more accepting of it (Shete 2001:97).

Raising public awareness regarding contraception and TOP was also recommended by half the respondents (viz. Theresa, Betty, Linda, Amber and Lovely). Betty, Theresa and Linda felt strongly that a greater emphasis should be placed on family planning and contraception in order to prevent TOPs and Linda stressed, 'more especially repeat TOPs'. Betty believes that teenagers should be targeted at the school and that sex education and family planning should be introduced into their school curriculum.

The need to educate the public on TOP was also emphasized. Lovely and Linda stated that

communities should be educated to come for TOPs early ie. below 12 weeks pregnant. Amber and Judy also felt that the public needed to be informed of TOP and what is going on at the TOP Clinics etc. Similarly, all the respondent's in Ndhlovu's study felt that not much has been done in terms of educating the public especially women and teenagers on issues concerning abortion and family planning (Ndhlovu 1999:123). They suggested massive campaigns to educate teenagers in schools on the prevention of unwanted pregnancies and the complications of abortions (Ibid).

Both Theresa and Lovely suggested that separate wards be set up for TOP patients. Theresa expressed that it was extremely difficult for nursing staff to work with mothers with babies and TOP patients in the same ward. It is her belief that separate TOP wards would also be beneficial to TOP patients as nurses would be able to spend more time with them caring for them and counselling them etc. A respondent in Ndhlovu's study expressed her mixed emotions due to nursing different types of female patients in the same room. She also suggested a separate room for TOP patients so that nurses can be comfortable to give care to them accordingly (Ndhlovu 1999:121). Nurses in a study by Poggenpoel (in Ndhlovu 1999:122) likewise verbalized that they experience inner conflict because they work in 'a hospital where babies are born in one unit and murdered in a unit directly opposite the first one'.

Blanche suggested that TOPs should be done at Clinics to ease the pressure off the hospitals' TOP staff. Separate clinics were recommended by respondents in a study by Poggenpoel et al (1998:5) Tancred (in Poggenpoel et al 1998:5) states that the government is aware that they will have to create abortion clinics to relieve the extensive pressure on hospitals and that they plan to extend abortion services to local clinics. However, this plan has not yet been implemented.

Linda and Bee felt that TOP nurses should be given incentives eg. salary increases, appraisals and recognition for the work they are doing. Bee especially felt that nurses doing second trimester abortions should not be overlooked and should get further incentives like stress days etc. All the respondents in Shete's study felt that it would be nice if they would be given some incentives like salary increases and a day off for the work they are doing. They also felt that they needed some

recognition from the government as people who were having a positive impact on the lives of childbearing women (Shete 2001:98).

In light of the fact that some second trimester TOP patients remain in the hospital for several days before aborting, Blanche suggested that second trimester TOP patients be given tablets and sent home to abort and only return to the hospital for Dilation and Curettage.

Lucy's suggestions differed considerably from the above. She felt strongly that the Choice Act should be amended to restrict the number of abortions to one per woman for her lifetime. She feels that the Act as it stands now, does not promote family planning. She also felt that the Act should be amended to prevent married couples from having abortions unless there is an abnormality in the pregnancy. Lucy also believes that mothers of pregnant teenagers should discourage them from abortions and encourage them rather to keep their babies instead of accompanying them to abortion clinics. Lucy's radical approach to addressing TOPs gives a clear indication of her anti-abortion stance.

After observing the negative impact that TOP has on some nurses, Rose recommended these nurses who are being negatively affected by TOP should not be permitted to do TOP work.

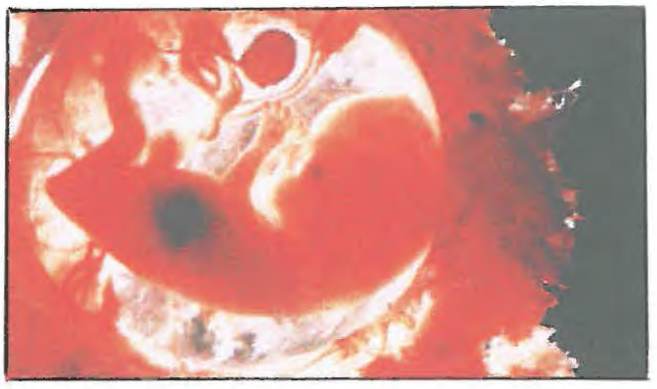
As can be seen, nurses had many suggestions on the measures that can be put in place in order to address the problems faced by abortion providers.

4.4. CONCLUSION

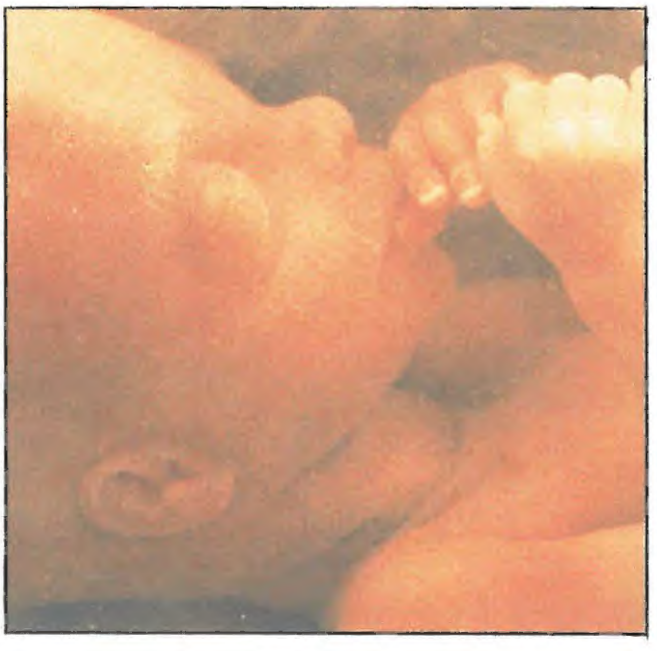
In the above chapter, the findings of the research study were set out according to the different themes that emerged from the data provided by the respondents. Insights were obtained into nurses' rationale for doing TOP work, as well as their perceptions of their work. De-motivating factors were also identified. Important findings for the purposes of this study however, were that TOP nurses experience stigma and labelling as a result of their work and that abortion work has different impacts

on their social relationships (which has been largely negative). Abortion work has also impacted some respondent's relationships with God and self. References have also been made to the literature where appropriate. I could find no literature that was available on certain sections of the study dealing with the social implications of TOP work, thus very few references are made to literature or previous studies in these sections.

FOETAL DEVELOPMENT



First Trimester: Foetus at 12 weeks
Approximately 8.5 cm



Second Trimester: Foetus at 18 weeks
Approximately 20 cm

(Sabbagh and Barnard 1987:192)

Chapter Five

Conclusions and Recommendations

This section contains a summary and discussion of the salient points mentioned in the previous chapters. Recommendations are also included in this chapter. The chapter is concluded with suggestions for further research.

5.1. CONCLUSIONS

The following conclusions can be drawn from the preceding chapters:

- The pro-choice versus pro-life struggle is ongoing in our country. TOP nurses fall into either of these categories. Being social beings, nurses' work environment has impacted on their social environments. The impact on nurses' social relationships have been largely negative i.e. they have experienced stigma, labelling, criticism from friends, colleagues, and even family members. This indicates that the majority of people in the East London area who are a part of TOP nurses' social networks are pro-life. As a result, TOP nurses are deprived of social support behaviours as listed by Wortman and Dunkel-Schetter (in Hendrick 1995:66) viz. the expression of positive emotion towards someone, support of their feelings and beliefs, encouraging them to express feelings, offering information or advice to them, providing material aid to them and aiding them with particular tasks, as well as helping them feel a part of a group of people who will support each other.

  As Ruda Landman, presenter of the television documentary programme, CarteBlanche, says '...although the law may have changed, attitudes haven't' (http://www.mnet.co.za/CarteBlanche/Display?Display.asp?Id=1984). Thus, lack of such social support from one's family, friends, colleagues and community seriously disadvantages TOP nurses, making them vulnerable to high stress levels.

Some respondents had not informed family members or their communities and friends about their involvement in TOP work. Despite this, sufficient information was obtained to draw the following conclusions regarding the social implications of TOP work for nurses.

- Conflict has arisen between nurses and their colleagues as a result of TOP work which has resulted in strained relationships and a lack of co-operation and teamwork amongst staff. Evidence of this has been found in other studies. Poggenpoel et al (in Shete 2001:93) found in their study that although nurses were happy with their involvement with TOP, they were unhappy and experienced some discomforts as most people were against it due to the controversy surrounding TOP. One of the reasons for this unhappiness was the fact that they were rejected by their friends and the rest of the hospital staff. Respondents in Shete's study listed non-acceptance by their colleagues as one of the problems they are faced with (Shete 2001:97).

- In extreme cases friendships broke down when nurses started TOP work. The friendships of the majority of respondents however, remained intact despite very negative responses and views of abortion which friends expressed to them.

- No significant changes were noted in respondents' relationships with family members after they were informed of their involvement in TOP work. Some family members however, reacted negatively to respondents when they learned of them doing TOP work. Such reactions involved them labelling and criticizing respondents.

- Conclusions could not be drawn regarding any repercussions of TOP work on respondent's relationships with the community due to the fact that many respondent's communities were unaware of their involvement in TOP work. What did emerge from the interviews however, is the fact that communities and the organisations eg. churches within them hold very different views on abortion. Some accept abortion, others regard it as a taboo subject, whilst a few consider it totally unacceptable.

Reactions to abortion providers are dependant on the particular community and it's view on abortion.

Other conclusions drawn from the findings of this study are as follows:

- Many TOP nurses feel ambivalent about their work and experience negative emotions like guilt, depression, confusion, resentment, anger, frustration, and stress. Repeat TOPs, born alive foetuses, working with mothers with babies as well as TOPs simultaneously and the sight of foetal parts during second trimester abortions make their work experience traumatic for nurses. Conflicting emotions as a result of having to work with TOPs and other gynaecological patients at the same time was expressed by respondents in other studies (Shete 2001:70; Ndhlovu 1999:121; Poggenpoel et al 1998:5).

- Some nurses resort to the use of psychological defence mechanisms like rationalisation and isolation of affect to help them cope with TOP work. (Examples can be found in Theme 8: Implications of TOP work for nurses, in Chapter 4). Other studies have confirmed TOP nurses' use of psychological defence mechanisms (Gmeiner et al 2000:70; Ndhlovu 1999:118).

- Abortion services are being increasingly used in East London. The many repeated abortions by patients, show a lack of contraception use. This is confirmed by other study which revealed that nurses felt that TOP is being used as a form of contraception, especially since patients came for repeat abortions (Shete 2001:94; Ndhlovu 1999:118). Meidany, Puchert and Rohde (in Shete 2001:94) revealed that 96,4% of the communities included in their study, regarded the TOP service mostly as a method of limiting unwanted births because of social and economic reasons. Whilst Varkey and Fonn found in their study that 25-80% of TOP patients had not been using contraception (http://www.hst.org.za/sahr/99/chap26.htm).

- TOP patients as young as 10 years old indicate that children are becoming sexually active at an earlier age. Hence, the need exists for sex education that must more aggressively target primary-, as well as secondary- school children. Teenage pregnancies are a major concern in South Africa. In 1998, 35% of all teenagers had been pregnant or had a child by the age of 19 (The State of South Africa's Population Report 2000:44).

- TOP patients being treated in the same ward as other gynaecological patients has a negative effect on the nursing staff, as well as both TOP and other patients. A respondent in Shete's study described her dilemma created by the situation by saying that she has to attend to a patient with infertility who has been trying to conceive for years and then has to work with a patient who has just terminated a pregnancy (Shete 2001:70). This understandably creates a dilemma for nurses. Other studies have also revealed that working with TOP and gynaecological patients in the same ward, or worse, in the same room, has the effect of creating mixed emotions in nurses (Ndhlovu 1999:121; Shete 2001:69,70; Poggenpoel et al 1998:5).

The above are the conclusions drawn from the findings of this study. In the following paragraphs recommendations will be made in order to address the above issues.

5.2. RECOMMENDATIONS

In light of the above findings of this research study, the following can be recommended:

- Compulsory, continuous, counselling in order to help nurses cope with their own ambivalent feelings with regard to TOP work, as well as stressful situations like ostracism from others and the traumatic experience of a born alive foetus etc. Two of the respondents experienced catharsis as a result of the interviews indicating their need to talk about their experiences and to vent pent-up emotions. Both hospitals have social workers who would be able to provide

counselling and possibly also start support groups for TOP nurses. One of the hospitals also has a Psychological Service Centre which could provide professional counselling services to the nurses. Gmeiner et al (2000:73) recommended support groups for TOP nurses where they might receive debriefing, verbalise their experiences, listen to others experiences, decrease isolation and provide support for others.

- Value Clarification Workshops should be set up in order for nurses to clarify their personal values with regards to abortion. Those whose personal beliefs and values are contrary to the concept of abortion, should not be permitted to do abortion work. Thus, avoiding the situation were nurses are left with conflicting, negative feelings like guilt, stress etc. which results in them relying excessively on psychological defence mechanisms. Brien and Fairbairn (1996:165) state that anyone involved in abortion should have a clear idea of their own beliefs and feelings about abortion. They also state that nobody should work in the abortion field unless they feel comfortable with the reality of abortion, both for their own sake and for their clients (Brien and Fairbairn 1996:167).

- Together with the above, nurses should also be well informed of the emotional, psychological and social demands of TOP work. They should be made aware of possible traumatic experiences like a born alive foetus, the sight of foetal parts etc. Brien and Fairbairn (1996:174) state that carrying out terminations may cause problems for some health care professionals which is related to their beliefs and also the reality of the procedure. Marwick (in Brien and Fairbairn 1996:176) advises that nursing staff who care for women undergoing medical abortions should be carefully recruited and should be committed to this method. He further advises that they should receive specific instructions on dealing with their own feelings (Ibid). Part of their preparation should be to sensitize them of the possible impact that TOP work could have on their relationships with family, friend, colleagues and their social lives in general.

- Rigorous, age-appropriate, sex education programmes should become a part of the

curriculums at both primary and secondary schools with the aim of delaying sexual activity, preventing teenage pregnancies and the resultant abortions, as well as informing children of the realities of abortion. This is especially important in light of the fact that S.A. has a very youthful population with 33,9% of the population younger than 15 years and 44,2% younger than 20 (The State of South Africa's Population Report 2000:29). The need to increase public awareness, especially targeting teenagers, with regards to issues of abortion and family planning has also been echoed by TOP nurses in other studies (Ndhlovu 1999:123; Shete 2001:94).

- In addition to the above, family planning should be fervently promoted in all communities in order to prevent unwanted pregnancies. Such campaigns should also inform the public of the TOP procedures during first and second trimesters, and also the possible complications of abortions. Thus, women should be helped to make informed decisions. Family Planning should be promoted in order for women to realise that contraception is the far easier option than abortion. Meidany, Puchert and Rohde (in Shete 2001:94) pointed out that family planning services should be improved and be more efficient as they are more cost effective than TOPs.

- A separate ward should be set up for TOP patients in order to protect them from ostracism, as well as to protect other gynaecological patients from any distress as a result of being in the same ward or room as TOP patients. This would also resolve the problem of TOP staff having to work with unco-operative colleagues who are 'anti-abortion'. Further, it would serve to prevent nurses from experiencing conflicting emotions having to work with TOP and other gynaecological patients at the same time. As a respondent in this study (Theresa) said, in a separate TOP ward nurses would be able to spend more time with TOP patients and provide more intensive counselling on family planning etc. with the view to preventing repeat TOPs.

5.3. SUGGESTIONS FOR FURTHER RESEARCH

1. Longitudinal studies should be done to investigate the long term implications of TOP work on nurses. This is suggested especially with Betty in mind, who radically changed over a period of a few years from being pro-choice to anti-abortion, after several years of TOP nursing.

2. Research should also focus on investigating repeat TOPs, and the general lack of contraception in East London, in order to provide guidance for future family planning initiatives.

3. Research should also be done to investigate the effects second trimester abortions have on physicians. Recent research in South Africa seems to have focussed largely on TOP nurses.

4. A question that arose in my mind during the course of this study was the impact of the current abortion rate on the future demography of South Africa. I believe that this will be an interesting study especially if viewed in the wider context of the AIDS pandemic. Since February 1997 when the Choice Act was implemented, 272 602 women had legal abortions at public health facilities (Daily Dispatch 26 September 2003:16). The number of abortions seem to be on the increase and it is my belief that this is bound to impact on the demography of S.A. The question is what the impact will be.

5.4. CONCLUDING COMMENTS

This study provides evidence of the still very controversial nature of abortion in South Africa. Anti-abortion sentiment has been greatly 'watered down' since the implementation of the Choice on Termination of Pregnancy Act 92 of 1996. Despite this, abortion providers still have to deal with ostracism, labelling, stigma and criticism from family, friends and their colleagues. Exploration into

the repercussions of TOP work on nurses' social relationships yielded important insights. What emerged was the fact that people in TOP nurses' social networks were largely 'anti-abortion'. Thus, TOP nurses are unable to rely on them for social support. In addition to this, many nurses' own ambivalence regarding their work meant that they are very vulnerable to the effects of stress. Overall, one could conclude that nurses experience feelings of isolation, frustration, anger, and resentment in addition to stress due to lack of social support. Therefore, doing TOP work has cost nurses a great deal, impacting their relationships with self, others and in some cases, even with God. Thus, implementing abortion on demand in S.A. has brought it's own challenges. One of these being to support, care for and assist nurses who are a very valuable and scarce resource in our country.

Appendices

APPENDIX 1

6 Rocky Place
Braelyn
5201

8 August 2003

The Medical Superintendent
Frere Hospital
East London, 5201

Sir/Madam,

RE: RESEARCH PROJECT - TERMINATION OF PREGNANCY NURSES

I am a Social Work Master Student at Rhodes University. My area of study is termination of pregnancy with specific interest in the implications of termination of pregnancy work for nurse's social relationships. This is a subject that I have not found information on, therefore my desire is to explore it.

The findings of this study could be valuable in informing and sensitizing different role-players on possible wider implications of termination of pregnancy work on nurses' social relationships. It could also be valuable in leading to possible interventions to minimise any negative social implications of termination of pregnancy work.

I hereby request your permission to approach those termination of pregnancy nurses who would be willing to be a part of this study. I will observe all the ethical protocols relevant to this type of research, which will be supervised by Rhodes University. I hope to hear from you soon and am willing to meet with you to discuss any further queries you may have.

My contact details are as follows:
Tel: (w) 742 5011
(Fax) 742 5014
(Cell) 084 4006 355

Thank you.

Yours faithfully

S. Naicker (Miss)

APPENDIX 2:INTERVIEW SCHEDULE

1. Identifying Particulars

Name: Age: Race: Marital status: Children:

How long have you been doing general nursing?

How long have you been doing TOP work?

2. Relationship with family

2.1. Describe your family's reactions (ie. their opinions, feelings and attitudes towards you) when you started general nursing. *(Family refers to your spouse or boyfriend, children, parents, extended family (ie. cousins, grandparents, uncles, aunts, family in law, nieces, nephews etc.)*

2.2. When you first started general nursing, were your relationships with these family members affected in any way? Please elaborate.

2.3. What were the reactions (ie. opinions, feelings and attitudes toward you) of your family when you started TOP work?

2.4. If your relationships have changed since you started TOP work, please describe these changes.

2.5. Would you say that TOP work has any other effect on your family life? Please elaborate.

3. Relationship with friends

3.1. Describe your friends reactions (ie. their opinions, feelings and attitudes toward you) when you started general nursing.

3.2. When you started general nursing was your relationship with your friends affected in anyway? If yes, please elaborate.

3.3. What were the reactions (ie. opinions, feelings and attitudes towards you) of your friends when you started doing TOP work?

3.4. If your relationships with your friends have changed since you started TOP work, please describe these changes.

3.5. Would you say that TOP work has any other effect on your friendships? Please elaborate.

4. Relationship with colleagues

4.1. Describe the reactions (ie. opinions, feelings and attitudes) of your colleagues towards you when you started general nursing. *(Colleagues refers to social workers, doctors and other nurses at the hospital.)*

4.2. When you started general nursing was your relationship with your colleagues affected in any way. Please elaborate.

4.3. What were the reactions (ie. opinions, feelings, and attitudes) of your colleagues toward you when you started TOP work?

4.4. If your relationship with your colleagues have changed since you started TOP work, please describe these changes.

4.5. Would you say that TOP work have caused any other effect on your interactions with your colleagues? Please elaborate.

5. Relationship with community

5.1. Describe the reactions (ie. opinions, feelings and attitudes) of members of the wider community towards you when you started general nursing. *(Members of the wider community refer to neighbours, members of the same church congregation, and others living in your community).*

5.2. When you started general nursing was your relationship with these people affected in any way? If yes, please elaborate.

5.3. What were the reactions of these members of the community when you started TOP work?

5.4. If your relationship with these members of the community have changed in anyway since you started TOP work, please describe these changes.

5.5. Would you say that TOP work has affected your community life in any other way?

6. Relationship with Self

If TOP work has brought about any changes in your relationship with self (ie. Your communication with, opinion, feelings and attitude towards yourself), please describe these changes.

7. Relationship with God

If TOP work has brought about any changes in your relationship with God (ie. Your communication with, opinion, feelings and attitude towards God), please describe these changes.

8.General

Would you say that TOP work has affected your life in any other way? Please elaborate.

9. Recommendations

APPENDIX 3

INTERVIEW NO. 1: BETTY

1. Identifying Particulars: ***

How long have you been doing general nursing?

Between 20-25 years.

How long have you been doing TOP work?

Between 5-6 years.

2. Relationship with family

2.1. Describe your family's reactions (ie. their opinions, feelings and attitudes towards you) when you started general nursing.

(Family refers to your spouse or boyfriend, children, parents, extended family (ie. cousins, grandparents, uncles, aunts, family in law, nieces, nephews etc.)

My family were surprised because I had never shown any interest in nursing. They didn't even think I'd get through the training. They were more than happy that I'd started nursing... they just didn't believe it...they thought I'd drop out after six months.

2.2. When you first started general nursing, were your relationships with these family members affected in any way? Please elaborate.

No, except my mother was very proud that I'd become a nurse because she was a nurse.

2.3. What were the reactions (ie. opinions, feelings and attitudes toward you) of your family when you started TOP work?

My one brother didn't say anything... he's a very non-judgmental type of person. My other brother doesn't tell anyone what I do... My parents say "It's my choice"... My child hates it... and says 'Mom, how many babies did you murder today?' I think the reason being, I introduced sex education

everywhere along the line..... My child is also very religious and goes to church and youth groups and things like that, and doesn't really approve of it.

2.4. If your relationships have changed since you started TOP work, please describe these changes.

I think my child grew up a lot when I took on the job...because we had lots of discussion about why I do it, why women have to do it, why this thing happens...so I think *** grew up a lot. But *** and I have always had a very close friendship relationship... I don't think it's a parent/child relationship... it is... half and half; in that *** expects me to look after ***. *** is brought up asking.... if I shout at ***, *** asks 'Why are you shouting?' The relationship with *** has not deteriorated in anyway but has changed only in that *** has had to grow up and ask more mature questions due to this type of work.

2.5. Would you say that TOP work has any other effect on your family life? Please elaborate.

No, none whatsoever, other than the hours. Before I came to the clinic I was working half days, and seven sevens and night duties and weekends and public holidays. I suppose working in the clinic, my home life has improved...I'm home for weekends and public holidays, I'm home at 4 o' clock in the afternoon...so I would say, hours-wise, my life has improved

3. Relationship with friends

3.1. Describe your friends reactions (ie. their opinions, feelings and attitudes toward you) when you started general nursing.

I think they were as shocked as my parents were. I was a **** student.. I was very into*** and when I went into nursing everybody thought I must be mad.... they all laughed, they thought it was a big joke. The only person who didn't treat it as a joke was myself. But then I've always enjoyed nursing...I do enjoy nursing. I think my main reason for wanting to get out of the clinic is because I've lost contact with real nursing...this doesn't feel like real nursing to me! It's like problems that you solve...it's not like real nursing!

3.2. When you started general nursing was your relationship with your friends affected in anyway? If yes, please elaborate.

No.

3.3. What were the reactions (ie. opinions, feelings and attitudes towards you) of your friends when you started doing TOP work?

Well, most of the friends I had when I was nursing I've lost contact with. I've got some of my school friends left who also couldn't believe when I started nursing. They're not really affected by it... you know, as far as they are concerned it is just part of the work I do. The people who have been affected by it, I haven't seen for *** years. The people who were really against the fact that I was going to do the job, I just haven't seen for *** years. They've broken contact... it happens... it's bound to happen! It isn't an easy thing to accept. It doesn't matter which way you look at it... termination of pregnancy has a stigma attached to it.... and it will always have a stigma attached to it. Well, I still see those friends and we say 'Hello' and 'Goodbye' but we never visit each other.

3.4. If your relationships with your friends have changed since you started TOP work, please describe these changes.

No other changes except some have broken contact.

3.5. Would you say that TOP work has any other effect on your friendships? Please elaborate.

No.

4. Relationship with colleagues

4.1. Describe the reactions (ie. opinions, feelings and attitudes) of your colleagues towards you when you started general nursing. ***(Colleagues refers to social workers, doctors and other nurses at the hospital.)***

It's such a long time ago... I don't remember.

4.2. When you started general nursing was your relationship with your colleagues affected in any way. Please elaborate.

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4.3. What were the reactions (ie. opinions, feelings, and attitudes) of your colleagues toward you when you started TOP work?

There were some very nasty comments passed and things like that but it's all disappeared. And my biggest critic is the one who says 'Good morning' to me every morning... I suppose people's attitudes change, you know. I think they thought that I would leave you know. Initially there were quite a few people who were very anti... then a lot of them... then their relatives came, and then the situation was very much altered.. Obviously, everything at this clinic is highly confidential. If people 'phone and say 'Is so and so there?'We say it's is a confidential clinic, we cannot give out any information. What goes on here is very confidential. No names are given over the telephone.

I think the other factor is that at that stage when we opened the TOP clinic there was many street children... and I turned around to my biggest critic who has two children and I asked 'How many street children do you look after.... how many of the street children have you taken into your home...given them love, care and attention, other than your own children. I said "You've got to think about it not only from the women's views wanting the abortions but you've got to think about it from the child's point of view as well". Most street children come from unwanted pregnancies. We've had quite a lot of discussions. I used to do quite a lot of in-service at the lecture room and explain what the law was about. I mean abortion is not a new thing ... it was only that people who could afford to have abortions had abortions and the people who couldn't afford it, took back street and things like that. So, you know attitudes have changed. But I do not have a problem with anybody.

Initially, my relationship with my colleagues was a bit strained.

4.4. If your relationship with your colleagues have changed since you started TOP work, please describe these changes.

Not that I can think of.

4.5. Would you say that TOP work have caused any other effect on your interactions with your colleagues? Please elaborate.

5. Relationship with community

5.1. Describe the reactions (ie. opinions, feelings and attitudes) of members of the wider community towards you when you started general nursing. ***(Members of the wider community refer to neighbours, members of the same church congregation, and others living in your community).***

I was staying at res. I was staying at East London and I was doing my *** at ****, so there's not very much I can say because I moved around.

5.2. When you started general nursing was your relationship with these people affected in any way? If yes, please elaborate.

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5.3. What were the reactions of these members of the community when you started TOP work?

Some people said it was good. Some people said it wasn't so good...so it was a mixed reaction. I've had a lot of support from the people in my church... they haven't had a problem with me doing it at all...so it hasn't affected my church life.

5.4. If your relationship with these members of the community have changed in anyway since you started TOP work, please describe these changes.

I find that the sympathy has actually dissipated. I'm now getting angry at the situation because I think the service is being abused. And when a service is being abused, the people providing the service also feel a certain amount of abuse. You can't help it. It's merely a reaction. That's why I say, my attitude has completely changed. I worked in the *** ward for many years and I used to feel so desperately sorry for those women who really did not want to have another child. But having worked here now for *** years and knowing family planning, the amount of counselling we go into with each patient,

and they keep coming back. You know I've done one women once a year for *** years... and she thinks it a joke. I'm doing a patient now who was here in February of this year, and she's back again and it's not even five months. Then your attitude towards your patient changes, and then you start to lose your humanity. I must be honest with you...I deal with the patients but I'm like a robot. I don't ask them questions that will give me any part of their social or family history. I used to be very involved with the patients, but the more involved I got with the patients the more patience I lost with the patients. Therefore, you need to be careful when you make a person provide a service that they've had enough of and want to get out of, and nobody's trained to take over. So that person has to stay in that job.

5.5. Would you say that TOP work has affected your community life in any other way.

No.

6. Relationship with Self

If TOP work has brought about any changes in your relationship with self (ie. Your communication with, opinion, feelings and attitude towards yourself), please describe these changes.

As I stated I started with sympathy but I now have very little sympathy...that has been ground out of me. The thing is that I now hate what I do. It has a drastic effect on my feelings and emotions but I try to limit it to work situation only. I really do hate this job...I hate the patients... I hate the job ... and I hate everything to do with the situation which will have an effect on me. Except that I have learnt to say "OK, I've come to work. I dislike my patients. I dislike my job", but I get it done and I go home and that's the end of the story...it's just a job. When I walk in here, I switch off, the emotions etc, do my job and go home. It's how I deal with the job I now do. Yes, it has had a very drastic effect on me, because when I started I was a very nice person. Now I don't mind what I say to the patients, or how I say it. It's been too long, it's been too intensive for too long...without the support, without the assistance, without the extra staff. In my leave...for *** years I was asked to

come and do procedures whilst on leave.

It's not just the nature of the work but also being given total responsibility, and no support. It's very frustrating. That's why I've built up such a resentment towards the job and towards the patients. I think that anybody would. I don't think that anyone would say 'No, it doesn't matter! Call me whilst I'm on leave!" And I've done this every year for *** years.

7. Relationship with God

If TOP work has brought about any changes in your relationship with God (ie. Your communication with, opinion, feelings and attitude towards God), please describe these changes.

Yes, if I have to be honest I must say that there has been. When you see a nation's decline to thinking that termination is a normal procedure that if you fall pregnant, it doesn't matter, you just have an abortion, it makes me wonder, if there is actually a God up there. I never used to doubt my Christian beliefs...I never doubted them for a minute. Now! ... How can there be a God who allows women to use it as a method of family planning, because that's what they are doing. I'm now beginning to question, "Is there really a God?" I've always believed in the ten commandments, but now "What do I do everyday when I come to work?" I basically commit murder, whether they want to argue that it hasn't got a soul until it's born or whatever. Especially when you get to second trimester pregnancies and the foetus is formed except for the eyes and the ears and things. I really am becoming an anti-abortionist. That's the reaction. I look at these women and I think that there cannot be this lack of family planning in this country. There must be something more. As I said, I'm definitely leaving this job. I question the existence of God because I wonder how He could give children to people who do not want them. If we were an emergency service then it would be different. When we first started the clinic we used to see people with tears streaming down their faces because they really were desperate . We no longer have desperation. We might get one desperate patient in a month if we are lucky. We get the patients who will come in here and say "I want an abortion" or "Give me

an abortion". There doesn't even appear to be remorse there. You look at these patients and you think , "Is this your method of family planning?" When you do repeat after repeat after repeat, you realise that this is their method of family planning. They have no conscience about the fact that they can do an abortion every three or four months.

8.General

Would you say that TOP work has affected your life in any other way? Please elaborate.
No, I come to work, I do my job and I go home. I used to actually think about the patients that came, I used to feel sorry for them. I used to think of any way that I could help them. But I no longer do that. I no longer think about the patients that come here. I don't even look at their faces anymore. I actually don't even want to look at them, because when I start recognizing them as repeats, I become extremely angry. So now I don't even bother to look at their faces. This job affects you psychologically. You become a hard person!

9. Recommendations

TOP staff need to be specialised. They should know what they are getting into before they take the job. They should know exactly what the job entails. Staff should also be well educated. We should improve on family planning clinics. There should be more sex education for teenagers, including information on family planning. This should actually be introduced into the schools. Compulsory counselling sessions should be provided for TOP nurses with a trained psychologist...someone whom the staff respects. This should be part of the deal...part of the service provided.

Note to the reader: The above is not the full transcription of the interview. Many details have been omitted due to the fact that the information had the potential to lead to identification of the respondent. Asterisks have been used in the place of certain information for the same reason.

APPENDIX 4

INTERVIEW NO. 10: Theresa

1. Identifying Particulars: ***

How long have you been doing general nursing?

Between 15-20 years.

How long have you been doing TOP work?

Between 5-6 years.

2. Relationship with family

2.1. Describe your family's reactions (ie. their opinions, feelings and attitudes towards you) when you started general nursing.

(Family refers to your spouse or boyfriend, children, parents, extended family (ie. cousins, grandparents, uncles, aunts, family in law, nieces, nephews etc.)

My parents always wanted me to become a nurse. Nursing was actually my second choice. I wanted to become a teacher. I applied for nursing and teaching. The first response I got was from the hospital. In December I started here and then in January I got a reply from the College, but I was already here, so I continued with the nursing.

2.2. When you first started general nursing, were your relationships with these family members affected in any way? Please elaborate.

Not at all.

2.3. What were the reactions (ie. opinions, feelings and attitudes toward you) of your family when you started TOP work?

I can't say much about my family. My entire family is in ***. . I know my mother and the others know I'm working in the Gynae Ward but they don't actually know that I'm working with TOPs.

My husband does not have a problem with it. It's maybe because I don't discuss it a lot at home with him... "I've done a TOP today" but with the others....like with my sisters-in-law....I will discuss it with them.... I will mention the stats...48-56 a month.... that is just second trimester...first trimester is also about 32-40 a month... so if you count, it comes to about a hundred babies a month that... I don't want to even use the word!

When it come's to extended family: some of them asked me how I cope.... I'm a regular church goer and all that. They don't know how I cope with that. The main thing now is that I really promote family planning. I talk to people outside about it....even in social gatherings, if there's young people, I tell them about it, I even tell them about the patients who come in.... I won't mention the names or whatever, but I will tell them about the incidences and then I will tell them about the complications that the patients suffer.... to prevent them from doing it. I tell them about family planning and not to listen to the stories outside. There's a lot of stories outside, that if you use the injection your libido will drop etc...and nowadays the children like to listen to all these funny stories. So I give them the correct information what does Depo do...what happens.... the blood is not accumulating in your body... some of them think that...where is this blood going? So I explain the whole process to them...what the Depo actually does... why you menstruate etc. so that they can understand how the Depo works etc.

So I try to tell them that TOP is just not a easy thing. Some of them think that. There's a lot that get off very easy. They come in and in just a few hours they abort. Then they spread the word in the community... 'No, go for termination because nothing happens!' The other day I actually asked the patient's permission that I could make an example of her. She was tranfused with 6 units of blood. She was bleeding because everything didn't come out....and once there's something still in your uterus you will bleed until the doctor removes everything. So with that patient I'm sure there was some mistake were they didn't remove everything. She bled a lot... so she was transfused with 3 units of blood but still they didn't remove the products she had. That blood went in and just came out again so all in all she had six units of blood that she got. She had a high temperature. So if things like that happen to you your uterus can rupture, you can go into shock and die, you can become infertile...you won't be able to have any children, and then one day when she really want's a baby then she won't be able to conceive with all that damage to the uterus. So I actually asked permission from the patient if I could just talk about her to the others and she said yes. So I'm making an example of her.

It's just my husband here that knows and my friends. Some of my friends do ask me how I cope with this, as I'm a regular church-goer. Then I just tell them that I don't have a problem because it's not me that's doing the terminations....it's not me that's pregnant. I'm just looking after the patient...she's the one that made that decision... I'm not the one that's actually pregnant and asking for termination of pregnancy. I don't agree with it. I don't have a problem with doing the termination of pregnancy when they deliver. But if they have to ask 'How do you feel about this law, I would say 'No', because if they can allow something like this, I mean termination of pregnancy, they can just as well bring in the death penalty for all the criminals outside. So for me it's not a problem to do it.

But I do have emotional problems. Like when the patient delivers and the baby comes out still alive and now you must cut that cord. That's the time when I really feel bad. I mean when the baby is still alive and I cut that cord, then when I separate the placenta from that baby, the baby stops. Then I feel... I don't know why I feel that way.... but when the baby comes out dead then I don't feel anything. But when the baby is alive then I feel guilty and I feel quite emotional...it's very upsetting.... very much. You feel you're taking somebody's life. But it's very rare that the baby is alive, that's why it's not affecting me that much.... I have time to forget about it. It's now and again that the baby will still be alive..... maybe once in six months or so that you get a baby that will come out still breathing. So there's time to recover. I'm sure if it had to happen on a regular basis, I won't be able to cope with it.

2.4. If your relationships have changed since you started TOP work, please describe these changes.

Mmmm....No. They were just concerned about how I was handling it.

2.5. Would you say that TOP work has any other effect on your family life? Please elaborate.

No not at all.

3. Relationship with friends

3.1. Describe your friends reactions (ie. their opinions, feelings and attitudes toward you) when you started general nursing.

They were just concerned. Because they did not think of me as a nurse because I am soft-hearted... I was like that. But you know, when you go through life, you change. You become mature. They say

'How do you take this blood and things?' But I say no, in the beginning when you start it's ...you run and hide in toilet etc. because you're scared... you do those funny things but as time goes you get used to it.. Then you can tell the others 'Don't do that, I also did that! But it's wrong!' You tell them about your own experiences to help them not to do the same things. My friends were just worried about me coping because I was very soft and very timid. But I've made it! I think I've reached that professional maturity.

3.2. When you started general nursing was your relationship with your friends affected in anyway? If yes, please elaborate.

Maybe the working hours and things, yes! Maybe socially, it did! Because when I know I must work the next day (7 to 7), they know by now they mustn't ask me to go out because I won't go out. And they know that if I work that weekend, they mustn't even come to visit because they know I'm not going to be sociable. I am like that especially when I have to work a 12 hour shift... I don't go out...like tonight, I'm just going to go home, wash, dish up or whatever, and just go to bed. Because I know it's heavy work that I'm doing! If I get a second chance I won't choose nursing. Not that I don't love my work...I love my work but we are working under very abnormal circumstances.... it's very bad....we're short staffed.... the staff also.... there's a lot of things that stress you! People...because of the shortage, sometimes you do things quickly, you don't do it the proper way. I think that as the years went by people forgot how to do things the proper way because of always taking the short way. But fortunately, I'm not like that. Even though we are a few, I always try to do a thing the way it's supposed to be done. And I think that sometimes it can stress you if you see people doing things... not the proper way. Especially if you know what can happen. It really stresses you at times. Therefore if I could get a second chance I won't choose nursing again.... I won't advise anyone to do nursing.

It's very hard work and you don't get appreciated. Our salaries are low. I think if you get motivated more...or a "Thank you" now and again. Sometimes you do things you don't have to...you go out of your way.... but you don't get that "Thank you"...just a "Thank you" to motivate you to go on. So that's what depressed you at times... that you feel you want to resign. Sometimes I just wish I had a rich husband.... that I could just stay at home or do something else.

3.3. What were the reactions (ie. opinions, feelings and attitudes towards you) of your friends when you started doing TOP work?

3.4. If your relationships with your friends have changed since you started TOP work, please describe these changes.

It's just that as I've been telling you. I will always talk to youngsters, including my friends, about contraception..... about safe sex

3.5. Would you say that TOP work has any other effect on your friendships? Please elaborate.

4. Relationship with colleagues

4.1. Describe the reactions (ie. opinions, feelings and attitudes) of your colleagues towards you when you started general nursing. ***(Colleagues refers to social workers, doctors and other nurses at the hospital.)***

Hmmm... I mean you can't actually say you know. You won't actually hear things about you. I'm not one that will talk a lot with nurses. Even at tea.... sometimes I will sit alone...it won't bother me! If somebody comes to sit here then I'll talk to that person. I actually don't know how they see me. But most of them say Sister**** is a nice Sister, She's a nice person to work with. But some of them may not like me because if somebody did not do something right I will call that person, just to show the person the right way to do something.

4.2. When you started general nursing was your relationship with your colleagues affected in any way. Please elaborate.

No.

4.3. What were the reactions (ie. opinions, feelings, and attitudes) of your colleagues toward you when you started TOP work?

When I came here, Gynae wasn't here, and TOPs weren't here. They were on that side. This was a very nice, easy ward, and I think the fact that I came with all these changes, they didn't like it and automatically I expected that they would take it out on me. They were very, very funny.

When TOPs started here, 2nd trimester....the Ward moved to this side in January. They asked me to come here in February. In the beginning people didn't want to work in this ward because of TOPs. It's only now that people are accepting a bit. Because I know how to deal with the TOPs and how to do it, they asked me to come here.

When I started TOP work my colleagues didn't like it at all. I think they also didn't like me...they were funny. I used to cry a lot sometimes during lunch times. I was depressed. My doctor even put me on an anti-depressant. People's attitudes were really, really bad. I don't know if it was because of the work, or if it was toward me personally. Because I had to tell them 'No, you're not supposed to do this like this!' Perhaps that made them cross...I don't know! But in the first place I was called to show them how to do these things, you see. So they had a very negative attitude towards me.

But now things are better!

4.4. If your relationship with your colleagues have changed since you started TOP work, please describe these changes.

No, except you get some of them that won't admit TOP patients. Maybe TOP clinic will phone and then they will ask for beds and they will say "No we only will admit 3 TOPs" but meantime there's 6 beds. Then I will go personally to the Clinic and ask them to send the patients. Because on the other hand I don't want them to delay the patients to 18 weeks...because that's a big baby coming now. I understand why they don't see it the way I see it because I've got the experience....I know. They've never delivered any TOPs, 18 and 19 weeks. So sometimes I try to explain to them the reason why!. They mustn't think I'm for this TOPs....it's better to admit them 13-14 weeks because then it's a small thing that comes out....it's not the formed baby. The nurses that are doing night duty now, they can now see what I'm talking about because most of the TOPs deliver during the night. So they experience the same things now that I've always been telling them. So they understand now. It's only a few now blocking this...they didn't do night duty yet so they didn't experience it. But I'm sure they will experience it. So when I try to explain to them they mustn't think I'm ... because they always say when I'm on duty then the ward is full of TOPs. But I've got my reasons. I push rather for 13-14 weeks because then I know...it's not even a formed thing. It's easier to deal with. (The reader is referred to pictures and actual sizes of the foetus at 12 weeks and 18 weeks at the end of Chapter 4).

4.5. Would you say that TOP work have caused any other effect on your interactions with your colleagues? Please elaborate.

5. Relationship with community

5.1. Describe the reactions (ie. opinions, feelings and attitudes) of members of the wider community towards you when you started general nursing. ***(Members of the wider community***

refer to neighbours, members of the same church congregation, and others living in your community).

My neighbours also thought 'Is *** going to make it?'They were also concerned because of my personality. In nursing you deal with a lot of people...and when people used to come and visit at my house, I used to go to my room and sit there. I was very reserved. But I'm not like that anymore. I've changed a lot.

5.2. When you started general nursing was your relationship with these people affected in any way? If yes, please elaborate.

Yes, it changed a lot. I became less reserved because I wasn't one that would talk a lot. I would never go to any place without my parents. I was in matric and I still didn't want to go to the doctor on my own. I had to come to East London. I didn't know anyone. I had to stay in the nurses' home. I cried a lot. Some of the old nurses still tease me about it. But nursing has done a lot to me.... good things. I've achieved a lot of things. I become frustrated very quickly...I don't know why. Even with this course now....I said I'm not going to study again because it's so tough. Because of the hours I work too. It's the first time I'm studying like this, with this you must study in your own time. But with this, if I manage this, maybe I can get my degree.

5.3. What were the reactions of these members of the community when you started TOP work?

I don't think they even know. I don't know a lot of people. I see my neighbours sometimes but I don't go into their houses. I keep to myself...I'm at home and if I'm not at home, I'm at work. Otherwise, I don't go around and visit people. So they actually don't know, what I do, where I work.

5.4. If your relationship with these members of the community have changed in anyway since you started TOP work, please describe these changes.

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5.5. Would you say that TOP work has affected your community life in any other way?

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6. Relationship with Self

If TOP work has brought about any changes in your relationship with self (ie. Your communication with, opinion, feelings and attitude towards yourself), please describe these

changes.

Sometimes I deal with a lot of conflict within myself. I ask myself 'Why am I doing this? Am I doing the right thing?' I like Gynae a lot...hysterectomies...I like that part.... but unfortunately TOPs are also part of gynae, that's why I have to bear with it.

So there's a lot of conflicting emotions. Everyday, it's coming up in my mind! 'Is this the right thing? This termination of pregnancy?' Or even to ask the TOP clinic, 'How many patients do you have? Send them!' Always when I go there and ask, there's always a voice in my head.... the conscience is pricking...all the time....it's guilt. Like if I look at Sister *****, I'm thinking about her... if I look at her, how she was years back , she was a person who was like a spokesperson for TOPs but then when I saw her the last few weeks, I saw a different person...she's totally against the TOPs. Now I ask myself, am I also going to end up like this, because I know her, the 2nd trimester TOPs ...sometimes she used to come there... she really used to talk up for them...saying TOP is a patient's right and all that. I also don't think she personally agrees with the Act but I couldn't see that. But if I see her now, I actually worry about her because it seems to me that it really affected her....It's affected her a lot. It worries me...OK, it's just my observation of her...I'm not a professional psychologist or anything, but it's just my observation of how she was then and how she is now. So I'm a little worried "Is the same thing going to happen to me?"

7. Relationship with God

If TOP work has brought about any changes in your relationship with God (ie. Your communication with, opinion, feelings and attitude towards God), please describe these changes.

Hmmmm.... I pray...as I pray I always mention this... the TOP you know. Sometimes I feel..... I've got a choice....I'm not forced to work here. I can say I don't want to work with TOPs. But now I like Gynae...This is the thing now, it's part of Gynae. Sometimes, I feel if I tell the people I don't want to work here... and that I have such a lot of conflicting thoughts about the TOPs... I think maybe they will get fed up with me because in the beginning I said 'No, I'm OK...I'm used to TOPs' and now all of a sudden I feel this way!... I rather just keep quiet about it.

8.General

Would you say that TOP work has affected your life in any other way? Please elaborate.

No...it's just the thoughts that come up...thoughts of 'Am I doing the right thing?' I have a choice not to do it. If I have to answer for this someday then..... Another thing is, I know I'm a nurse I'm supposed to do it but with the TOPs, it's another story...you can say you don't want to work with TOPs.

9. Recommendations

I think they must get counsellors here for the staff...even if people feel they don't have a problem... but the minute you think about it...the minute the thoughts come up then that means that there is something. And maybe just one day something's going to trigger all those thoughts in your head and maybe this will be the primary cause of that. So I think, maybe it must be a compulsory thing... they mustn't say 'If you need counselling you must go'... there must be counselling sessions for the staff working here. Not just the nurses, but even the doctors also.

I think the TOPs must also be in one separate ward. I know people say that we'll be discriminating etc. but I think it will be better. Because it's not nice...sometimes there's a TOP lying here and a mother with a baby lying there. I think it just makes things worse for us, the one minute you must work here terminating a pregnancy and then just next door, there's a baby lying there. I feel they must have a separate ward for TOPs. I think then we can put more effort and we will have more time with these TOP patients.... to speak to them about contraception ...about the complications that go with termination of pregnancy. Because now we haven't got time. We admit from Gynae Clinic, we admit from Labour Ward, we admit from the TOP Clinic. I make it a point to speak to them but not everyone will make that time to do that extra bit to speak to that person. I think if we have counselling sessions with the patients, I think that the patients will take this to the communities, and spread the word. But at the moment we don't have time to spend with the TOPs because we're busy with the gynae patients and they go home the next day.

I just wish people could just go for contraception, because TOPs is really unnecessary. OK, you do get rape cases, where that person really can't help it, but this is unnecessary and it's not 2 or 3 ...it's about 6 patients a day.

When we make the nurses' pledge, we say we are there to preserve life and all that, TOP doesn't fit in there at all but we must obey the law of our country.

Note to the reader: The above is not the full transcription of the interview. Many details have been omitted due to the fact that the information had the potential to lead to identification of the respondent. Asterisks have been used in the place of certain information for the same reason.

TABLE 1: SUMMARY OF IDENTIFYING PARTICULARS

NAME	AGE	PERIOD OF TIME GENERAL NURSING	PERIOD OF TIME TOP NURSING	NO. OF CHILDREN	MARITAL STATUS	
					MARRIED	SINGLE
AMBER	Between 30-40 years old	Between 10-15 years	Less than one year	2	x	
BEE	Between 40-50 years old	Between 20-25 years	Less than one year	2	x	
BETTY	Between 40-50 years old	Between 20-25 years	Between 5-6 years	1		x
BLANCHE	Between 40-50 years	Between 20-25 years	Between 1-5 years	1		x
JUDY	Between 40-50 years	Between 15-20 years	Between 5-6 years	3	x	
LINDA	Between 30-40 years	Between 5-10 years	Between 1-5 years	2	x	
LOVELY	Between 20-30 years	Between 1-5 years	Less than one year	1		x
LUCY	Between 40-50 years	Between 5-10 years	Less than one year	3		x
ROSE	Between 30-40 years	Between 10-15 years	Less than one year		x	
THERESA	Between 30-40 years	Between 15-20 years	Between 5-6 years	2	x	

TABLE 2: RELATIONSHIPS WITH FAMILY MEMBERS

NAME	REACTIONS WHEN STARTED GENERAL NURSING (GN)	DID RELATIONSHIP CHANGE WHEN U STARTED GN?	REACTIONS WHEN STARTED TOP WORK	DID RELATIONSHIP CHANGE WHEN YOU STARTED TOP WORK? ANY OTHER EFFECT ON FAMILY LIFE?
AMBER	Positive	No	Positive	No, family was supportive as they had personally experienced a teenage pregnancy.
BEE	Concern, due to nature of the work	No	Family does not know she is doing TOP work	Affected family life as Bee was stressed when she went home daily. No other changes in family life.
BETTY	Positive	No	Neutral. Only her child very negative	Relationships did not change. Better working hours at TOP Clinic impacted family life positively.
BLANCHE	Positive	No	Some were negative and some neutral.	No.
JUDY	Positive	No	Family does not know she is doing TOP work. Only husband knows	Husband is neutral. Better working hours at Clinic impacts family life positively
LINDA	Concern, due to nature of the work	No	Extended family does not know she is doing TOP work	Husband is supportive. Family does not know she is doing TOP work
LOVELY	Positive	No	Family does not know she is doing TOP work. Only husband knows	N/A as family does not know she is doing TOP work.
LUCY	Positive	No	Only children know she is doing TOP work.	No change in relationship. Reactions of children negative
ROSE	Negative. They wanted her to go to University	No	Supportive	No changes in relationships.
THERESA	Positive	No	Family of origin doesn't know she's doing TOP work. Husband is aware.	Husband is neutral. Other family members are concerned about how she copes. No changes to relationships

TABLE 3: RELATIONSHIPS WITH FRIENDS

NAME	REACTIONS WHEN STARTED GENERAL NURSING (GN)	DID RELATIONSHIP CHANGE WHEN YOU STARTED GN?	REACTIONS WHEN STARTED TOP WORK	DID RELATIONSHIP CHANGE WHEN YOU STARTED TOP WORK?
AMBER	Concern due to the nature of the work	No	Negative	No
BEE	Positive	Yes, she had less time with them	Negative	No
BETTY	Surprise, they did not expect her to do nursing	No	Some were negative. Others were neutral.	Yes, some friends broke off contact with her due to her starting TOP work
BLANCHE	Positive	Yes, she had less time with them	Negative	No
JUDY	Positive	No	Negative	No
LINDA	N/A. She relocated. Did not have friends	N/A	Some were negative. Others neutral	No
LOVELY	Positive	No	Negative	Yes. She lost friends due to the fact that she is doing TOP work
LUCY	Positive	No	Negative	Lucy did not tell her friends that she is doing TOP work due to the negative response she received from one person
ROSE	Neutral	No	They accepted it	No, initially friends did not want to talk about it but they accepted it
THERESA	Concern due to the nature of the work	Yes, she had less time with them	Concern about she was coping	No

TABLE 4: RELATIONSHIPS WITH COLLEAGUES

NAME	REACTIONS WHEN STARTED GENERAL NURSING (GN)	REACTIONS WHEN STARTED TOP WORK	DID RELATIONSHIP CHANGE WHEN YOU STARTED TOP WORK?
AMBER	Some were positive Others were competitive due to her higher qualifications	Negative	With some, yes! They were very negative, unhelpful and unsupportive.
BEE	Did not notice reactions of colleagues	Negative	No
BETTY	Does not remember. It was a long time ago.	Negative	No
BLANCHE	There were no problems	Negative	There was a breakdown in communication and misunderstanding between TOP staff and Clinic staff, mostly regarding admissions.
JUDY	Positive	Negative	Initially colleagues were very negative. Now they have accepted it
LINDA	Negative. Junior nurses were not treated well by seniors	Negative	Conflict arose as a result of admission of TOP patients
LOVELY	Most were competitive due to her higher qualifications.	Negative	Yes, relationships became strained. Colleagues hold her solely responsible for TOP patients and vent their frustrations and anger on her as they disapprove of TOP
LUCY	Negative. Junior nurses were not treated well by seniors.	Negative	No
ROSE	Neutral	Neutral	No
THERESA	Positive	Neutral. Some were negative	Some conflict arose with regard to the admission of TOP patients, proper procedures etc.

TABLE 5: RELATIONSHIPS WITH COMMUNITY

NAME	REACTIONS WHEN STARTED GENERAL NURSING (GN)	DID RELATIONSHIP CHANGE WHEN STARTED GN?	REACTIONS WHEN STARTED TOP WORK	DID RELATIONSHIP CHANGE WHEN YOU STARTED TOP WORK?
AMBER	Positive	Yes. They saw me as one who wants to help others	Negative	No. Some community members see TOP as a need, whilst others are very negative
BEE	They were concerned about how she would cope with nursing	No	Community does not know she is doing TOP work	N/A. They do not know she is doing TOP work.
BETTY	She moved around a lot. Therefore, cannot answer this question	N/A	Some were positive. Others were negative	No
BLANCHE	Positive	No	Most do not know. Those who do, have accepted it	No
JUDY	Neutral	No	Community does not know she does TOP work	No

TABLE 5: RELATIONSHIPS WITH COMMUNITY (continued)

LINDA	Some were jealous	Yes, due to jealousy.	Relocated, therefore community does not know she does TOP work.	N/A
LOVELY	Some were jealous.	Yes, she could not attend social functions. Was misinterpreted as her acting superior.	Community does not know.	N/A
LUCY	Positive	No	Community does not know. Negative reaction from the only person she told.	N/A. They do not know she is doing TOP work.
ROSE	Positive	No	Positive. People in the community come to her for advice etc.	No other effect. They have accepted her but they do not talk about TOP, nor have they taken a stand on it.
THERESA	They were concerned about how she was going to cope.	Yes, as her personality changed. She became less reserved and more independent	Community does not know she is doing TOP work.	N/A

TABLE 6: RELATIONSHIP WITH SELF, GOD AND OTHER EFFECTS OF TOP WORK

NAME	EFFECTS ON RELATIONSHIP WITH SELF	EFFECTS ON RELATIONSHIP WITH GOD	OTHER EFFECTS OF TOP WORK ON ONE'S LIFE
AMBER	Positive. She is become more empathic. She is pleased and proud she is helping others	No change	No
BEE	No changes	No changes	Yes. TOP affected her when she began but not now. She felt stressed and did not accept it at the beginning
BETTY	It had a drastic effect on her emotions and feelings. Has become emotionally detached and frustrated. Feels she is committing murder daily and breaking the ten commandments	Yes. She doubts the existence of God now. Wonders how God could allow women to use TOP as family planning? How could He give children to women who do not want them?	She is become emotionally detached from patients. Job affects her psychologically. She is become a 'hard' person ie. not sympathetic to patients anymore
BLANCHE	She feels guilty about doing TOP work	Yes. She knows it is not right. She just prays daily for God to forgive her if she is doing the wrong thing. She says she knows that babies have been created by God	She questions why people are not using family planning as it is easier and less painful than TOP. She thinks of her job when she is alone at night and about the babies and feels guilty although she knows she is helping people
JUDY	Feels great that she did TOP work despite negative attitudes from her colleagues and that she saves lives. Feels she is helping her community and is proud of herself for doing TOP	No. Believes that God knows what is happening and understands.	No
LINDA	On a professional level, feels she is giving these women a second chance. But from a religious perspective wonders if what she is doing is right	No, no real changes as she never was a regular church goer	No

TABLE 6: RELATIONSHIP WITH SELF, GOD AND OTHER EFFECTS OF TOP WORK (Continued)

LOVELY	Feels stressed and confused at the times and feels that she must stop TOP work	She does not have any relationship with God.	Sometimes feels very stressed at home. Dreamt one night that a mother had demanded her baby and that she'd been running around trying to resuscitate the baby.
LUCY	Sometimes feels very guilty because of TOP and thinks it is not right. It affects her conscience. She is also lost patience with those who come for repeat TOPs. Sometimes feels frustrated.	Has not really changed as she apologizes quite often to Him for the job she is doing. She speaks to Him about it.	It has brought about an appreciation of and respect for pregnant mothers and people taking contraceptives. She is become 'hard' on patients coming for repeated TOPs She worries about HIV infection due to the fact that they work with blood all the time.
ROSE	It makes her appreciative of her life and the supportive parents she's had and that she never had to go through a TOP	She now has a better relationship with God, after clarifying for herself that He would have stopped TOP if He did not want it to happen.	No
THERESA	Deals with a lot of conflicting emotions on a daily basis about TOPs. She feels guilty and upset. Her conscience worries her, especially when the aborted baby is still alive. She feels concerned about herself and the long term effects of TOP work on her.	She prays to God about TOP. Wonders if she is going to be held accountable for it one day.	Has constant thoughts about whether she is doing the right thing or not.

TABLE 7: RECOMMENDATIONS

NAME	RECOMMENDATIONS
AMBER	Counselling, TOP awareness workshops, In service training
BEE	Counselling, Training, Incentives
BETTY	Compulsory Counselling; Focus on Family planning and Sex education; Specialized, trained staff
BLANCHE	Second trimester patients should abort at home and only be hospitalised for Dilation and Curette, Clinics should do TOPs.
JUDY	Recruitment and training of new TOP staff, In service training on TOP at hospitals, Workshops to raise awareness on TOP.
LINDA	TOP awareness workshops, Focus on Family planning, TOP should be included in the nursing curriculum, Incentives
LOVELY	Counselling, Separate wards for TOP patients, In service training, TOP awareness
LUCY	Choice Act should be amended to restrict women to one TOP per woman per lifetime, and prevent married couples from TOPs. Mothers should encourage daughters to keep their babies and not accompany them to abortion clinics
ROSE	Counselling, Nurses disapproving of TOP should not be allowed to work with TOPs
THERESA	Compulsory counselling; Separate ward for TOP patients, Focus on Family planning

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