What are the barriers to the implementation of the Choice on Termination of Pregnancy Act 92, 1996 as amended, in Xhariep District in the Free State Province? A view of doctors, nurses, and Hospital Management in three District Hospitals in Xhariep.

(Submitted in partial fulfilment of the requirements of the degree of Master of Public Health)

NAME : N.E. KGASANE

Student Number : 206524880

Programme : Masters in Public Health

CONTACT DETAILS:-

Department : Free State Department of Health

Tel : 051 477 2194 (Work)

Cel : 072 1580 256 or 079 5244 309

E –mail :KgasaneNE@fshealth.gov.za OR nkaukgasane@gmail.com

Student 's signature:……

SUPERVISOR:

Name : Dr. M. Sebitloane.

Department : Obstetrics and Gynaecology.

Tel : (031) 260 4432.

Cel : 082 562 8681.

E – Mail: sebitloanem@ukzn.ac.za

Signature :…….

HEAD OF DEPARTMENT approval : (if not supervisor)

Name : Prof. J TSOKA – GWEGWENI.

Department: Public Health Medicine.

Signature :…….

Purpose of protocol:- **Master of Public Health (MPH).**

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Background

The Choice on Termination of Pregnancy Act (CTOPA) No 92 of 1996 replaced the Abortion and Sterilization Act of 1975. It promotes reproductive rights and the choice on termination of pregnancy. It aims to reduce deaths resulting from illegal abortions.

It designates District Hospitals and Community Health Centres to render Termination of Pregnancy (TOP). In the Free State there are 24 District Hospitals and ten Community Health Centres. Currently nine render TOP. None are in Xhariep District.

Aim of the study

The study investigated barriers to the implementation of the CTOPA in Xhariep District among doctors, nurses and managers in District Hospitals.

Methodology

It was descriptive in nature, and was divided into the quantitative and qualitative parts. The quantitative part targeted doctors and nurses, while thelatter targeted management. The response rate was 95%.

Findings

The findings are summarised below:-

- Ninety five per cent of the respondents were nurses.
- Infrastructural and human resource deficiencies are a barrier to the implementation of the act.
- There are insufficient budgets to procure equipment, consumables and pharmaceuticals to render the service.

- Training on reproductive health and TOP is not sufficient, except for family planning.
- There is stigma towards TOP from the community, and peers. Its origin is religion and culture.
- There is no psychosocial and management support for those willing to participate in TOP.
- Respondents are willing to refer patients for TOP, and believe that women are entitled to choose whether to terminate unwanted pregnancies or not.
- There are no incentives to for those willing to implement the Act, nor provincial support to the Districts.

Recommendations

- Train staff on reproductive health and TOP.
- Hold management accountable by including TOP and the reproductive health package in their performance agreements.
- Negotiate incentives for those willing to implement TOP, and recogniseTOP as a speciality in line with the Occupation Specific Dispensation.
- Provide infrastructure and equipment for the implementation of TOP.
- Develop a recruitment and retention strategy for professionals. The policy on community service for health professionals is a case in point.
- Resource the District Health System as a vehicle for Primary Health Care Services.

CHAPTER 1 INTRODUCTION

The Choice on Termination of Pregnancy Act No. 92 of 1996 (CTOPA) was introduced in South Africa, in response to the multitudes of women who were dying as a result of back street abortions. According to Jewkes (2005) worldwide, unsafe abortion is recognised as a leading cause of maternal death, causing 13% of pregnancy-related mortality. Prior to legislation in the form of the Act of 1996, access to legal abortion, in South Africa, as in many countries was highly restrictive. Only 800–1000 procedures were legally performed each year. This was as a result of the restrictive Abortion and Sterilisation Act of 1975 which allowed for abortion when a pregnancy could seriously threaten a woman ‘s life or her physical and mental health; could cause severe handicap to the child; or was the result of rape.
In their work on abortion reform in South Africa, Guttmacheret al (1998) state that, financially secure upper and middle class white women could fly to England to terminate an unwanted pregnancy if they could not procure adequate services privately in South Africa. Those without means resorted to risky back street abortions. Guttmacher et al (1998) further state that back street abortions lead to substantial increases in admissions to gynaecologic wards due to women presenting with incomplete and septic abortions. Consequently, maternal morbidity and mortality resulting from septic abortions also increased.

Lang (2005) adds that globally millions of women and men do not have access to reliable family planning methods. As a result twenty million unsafe abortions are performed each year resulting in 70 000 deaths. This excludes the estimated 5 million disability adjusted life years lost as a result of unsafe abortion (Grimes et al, 2006).

According to the 2002 – 2004 Report of the National Committee on Confidential Enquiry into Maternal Deaths (NCCEMD) at Level 1 Hospitals, the proportion of deaths due to abortions increased from 20.6% to 31.7% for the triennia 1996-1998 and 2002-2004 respectively. Owing to this one of the recommendations of the NCCEMD is to reduce the number of deaths resulting from unsafe abortions. The successful implementation of this piece of legislation is therefore critical to the reduction of morbidity and mortality as a result of unsafe abortions.

Despite the fact that the Act was passed by Parliament in 1996 access to the service in the country, and in many parts of the Free State province remains a challenge. This is particularly the case in Xhariep District where there is not one facility that renders the service. This, despite the fact that the Act provides for the designation of District Hospitals to render the service. The Choice on Termination of Pregnancy Amendment Act, No. 1 of 2008 Section 3 (3) broadens the scope of facilities that may perform a termination of pregnancy in terms of the Act to any health facility that has a 24 hour maternity service and complies with prescribed requirements. This essentially expands the scope to include Community Health Centres. Xhariep District has three District Hospitals and one Community Health Centre and none of these render the service.

This study intended to identify barriers to the implementation of the CTOPA in Xhariep District.

CHAPTER 2 LITERATURE REVIEW

INTRODUCTION

The preamble of the CTOPA reads as follows:- “Recognizing the values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the advancement of human rights and freedoms which underlie a democratic South Africa;

Recognizing that the Constitution protects the right of persons to make decisions concerning reproduction and to security in and control over their bodies;

Recognizing that both women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and that women have the right of access to appropriate health care services to ensure safe pregnancy and childbirth;

Recognizing that the decision to have children is fundamental to women’s physical, psychological and social health, and that universal access to reproductive health care services includes family planning and contraception, termination of pregnancy, as well as sexuality education and counselling programme and services;

Recognizing that the State has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm;

Believing that termination of pregnancy is not a form of contraception or population control.

This Act therefore repeals the restrictive provisions of the Abortion and Sterilization Act, 1975 (Act No. 2 of 1975), and promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of Pregnancy according to her individual beliefs”.

The CTOPA also prescribes the circumstances and conditions under which pregnancy may be terminated as follows:-

- Upon request of a woman during the first 12 weeks of the gestation period of her pregnancy; and
- From the 13th up to and including the 20th week of the gestation periodif a medical practitioner, after consultation with the pregnant woman, is of the opinion that :-

(i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or

(ii) there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality; or

(iii) the pregnancy resulted from rape or incest; or

(iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or

(v) afterthe 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;
- Result in a severe malformation of the foetus; or
- Pose a risk of injury to the foetus.

The National Strategic Plan for the implementation of the Choice of Termination of Pregnancy Act 92, 1996, as amended (2001) identifies ten key strategies to successful implementation of the CTOPA, these are:-

- Provision ofan enabling, supportive, safe environment and infrastructure, equitable access and appropriate delivery of good quality TOP services;
- Decentralise TOP service provision;
- Provide adequate resources to meet the nationwide demand for TOP services provision;
- Defend the CTOPA through strategic partnerships by ensuring meticulous practice;

- Create favourable societal context for the CTOPA and its implementation;
- Support health care providers in providing quality termination of pregnancy services;
- Provide client friendly, quality termination of pregnancy services;
- Mainstream termination of pregnancy training now and in the future in such a way that all health care providers in all existing clinical training programs receive training on termination of pregnancy;
- Forge visible leadership on termination of pregnancy throughout the country; and
- Provide an enabling environment and access for minors to termination of pregnancy and related reproductive health services.

The CTOPA was amended by The Choice on Termination of Pregnancy Amendment Act of 2004 with the aim of increasing access to TOP by:-

- Allowing a Member of the Executive Council (MEC) to designate facilities that could provide TOP services.
- Exempting a facility providing 24 hour maternity services from having to obtain approval for TOP services under certain conditions (i.e.) a pregnancy under twelve weeks).
- Providing for the recording of information and the submission of statistics.
- Allowing a trained registered nurse and not only a midwife to perform TOP.

Due to the above it can be concluded that the CTOPA and its amendment intended to remove any restrictions or barriers to legal abortion services in the country. In spite of the fact that this framework was put in place in 2003, followed by the Amendment Act in 2004 there are areas in the country where access to termination of pregnancy is still a challenge, and Xhariep District is one of these.

THE EPIDEMIOLOGY AND COST OF ILLEGAL ABORTION

Rees et al (1997) found that a total of 425 maternal deaths that occurred in South African public hospitals per annum were associated with incomplete abortion. The aim of the CTOPA was also to ensure that the mortality and morbidity which was attributed to illegal backstreet abortions was reduced if not exterminated. Jewkes et al (2002) studied the impact of legislative change on the morbidity as a result of unsafe abortion in public hospitals in the country before and after the implementation of the CTOPA. The first study was done in 1994, and all hospitals in the country with over 499 beds were part of the sample. In 1994, 803 data capture sheets were returned while 761 were returned in 2000. They found that the legislation decreased morbidity, although the magnitude was not substantial. There was also a decline in the number of patients who received transfusions and antibiotics in 2000 as compared to 1994.

The results indicated that the implementation of the Choice on Termination of Pregnancy Act had potential to reduce morbidity and mortality associated to unsafe backstreet abortions. Another study conducted by Mbele et al (2006), studied the impact of the implementation of CTOPA on the morbidity and mortality in Pretoria. They measured the case fatality rate (CFR); the mortality index (MI) and maternal mortality ratio (MMR) due to abortions. The study compared the above measures in cases treated in hospitals between 1997 – 1998 and 2003 – 2005. Table 1 is an illustration of the findings.

Table 1:CFR;MI; and MMR for 1997- 1998 and 2003- 2005 compared

Year	CFR	MI	MMR
1997 – 1998	***2.4/1000 abortions***	***21.7%***	***63.6/100 000 births***
2003 – 2005	***0.25/1000 abortions***	***2%***	***5.54/100 000 births***

Boseley (2009) states that “about 70,000 women die every year as a result of unsafe abortions in countries with restrictive laws on ending pregnancy, according to the report almost all unsafe abortions were in less developed countries”.

Crane and Horde (2006) reveals that “abortion is a very common experience in every culture and society, with an estimated 46 million taking place each year. An estimated 19 million women experience unsafe abortions annually. The World Health Organisation (WHO) researchers calculate that on average; nearly one unsafe abortion will take place for every woman in the developing world”.

Based on theabove studies it could be concluded that unsafe abortion is a problem worldwide. It manifests in the form of increased morbidity and mortality, which threatens the achievement of the Millennium Development Goals (MDGs) in Developing Countries. There is therefore a need to find strategies to deal with this challenge. Research has proved that the introduction of the CTOPA was associated with a reduction in women presenting with incomplete abortion. The prevalence of critically ill women due to complications of abortion has not changed, but the CFR, MI, and MMR have declined substantially. While there might have been confounders influencing the above variables besides CTOPA, it is evident that it played a role.

The above results also prove that morbidity and mortality due to incomplete abortion was significant prior to the implementation of the CTOPA, and has been reduced following the implementation of the Act. This reduction in morbidity and mortality also translated into savings in terms of the treatment and hospitalisation of women with such morbidity.

Kay et al (1997) analysed the cost of incomplete abortion to the public health sector in South Africa, and found that an estimated of R18.7 million was spent to treat women in public hospitals for incomplete abortion. An amount of R9.74 million was spent treating women with unsafe incomplete abortion.

This supports the finding that unsafe incomplete abortion is a health problem in South Africa and it stretches the limited resources available, let alone its effects on morbidity and mortality.

It is therefore important that the CTOPA needs implemented country wide urgently in order for the country to benefit from the reduction in maternal mortality, and morbidity as well as the economic benefits. What follows next is a summary of the incidence of abortion worldwide.

THE INCIDENCE OF ABORTION WORLD WIDE

The Programme of action of the 1994 International Conference on Population and Development urged governments and other relevant organizations to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. In order to implement this recommendation, policy makers need information on the availability and quality of family planning services, the extent of harm to women`s health caused by unsafe abortion, and the incidence of abortion.

Stanley et al (1999) state that approximately 46 million abortions were performed worldwide in 1995. Of these, about 26 million were legal and 20 million illegal. This implies that approximately 44% of abortions worldwide are performed illegally. The abortion rate worldwide was about 35 per 1,000 women aged 15 – 44. Of all pregnancies 26% were terminated by abortion.

Stanley et al (1999) further state that Asia has the largest number of abortions (17 million legal and 10 million illegal), followed by Europe, with eight million, Africa five million, and Latin America with four million, Northern America 1.5 million and Oceania 0.1 million. Asia accounts for 59% of the world's abortions, and Northern America only 3%.

In Africa the overall abortion rate is about 33 per 1000. Virtually all abortions are illegal except in Tunisia and South Africa, where since 1997 first trimester abortions are not restricted.

In the same studyStanley et al (1999) found that approximately 26 million legal and 20 million illegal abortions were performed worldwide in 1995, resulting in a worldwide abortion rate of 35 per 1,000 women aged between 15 to 44 years. It was also found that abortion rates are not lower overall in countries with restrictive legislation, and thatwhere legislation is restrictive these are performed under unsafe conditions.

Grimes et al (2006) found that almost all unsafe abortions (97%) are in developing countries. Worldwide, an estimated 68 000 women die as a result of complications from unsafe induced abortions every year – about eight per hour. This prevalence translates into an estimated case-fatality rate of 367 deaths per 100 000 unsafe abortions, which is hundreds of times higher than that for safe, legal abortion in developed nations.

The high rate of abortion worldwide reflects the frequent occurrence of unplanned pregnancy in many developed and developing countries. This is due to a far from universal contraceptive use. This calls for access to legal and safe termination of pregnancy.

CHARACTERISTICS OF WOMEN SEEKING TERMINATION OF PREGNANCY

It will be recalled that in the past despite the restrictions of the previous Act, those women with means could access abortion from private clinics or facilities or even overseas. The majority of the poor and illiterate were therefore the ones who were affected by the restrictive legislation. Once the new Act was passed it was important to find out who sought termination of pregnancy services mostly particularly in government hospitals.

Bowes and Macleod (2006) studied the characteristics of women seeking termination of pregnancy at an urban based government hospital in the Eastern Cape. Lang et al (2005) also undertook a study to determine the profile of women seeking termination of pregnancy in the Free State. The two studies agreed in many instances that the following were the characteristics of those seeking abortion:-

(i) between the ages 20 to 30 years,
(ii) Black South Africans, mainly single,
(iii) Living in extended families,
(iv) Earning a low income (economic),
(v) The majority were pregnant for the first time,
(vi) Many cited the need for abortion as the pregnancy was a disruption of their education.

These studies were important as they would inform policy with regard to the need for the designation of facilities to render the service. The above results indicate that a District like Xhariep will need functional designated facilities to implement the CTOPA, to provide for the above population.

POSSIBLE BARRIERS TO THE IMPLEMENTATION OF THE CTOPA

There are a number of possible barriers to the implementation of the CTOPA.These will be discussed in this section. The barriers will be divided into those related to patients and those related to the health system.

Patient related barriers to TOP

- **Ignorance about the Act on the part of patients**

One of the most important patient related barriers to access to TOP is knowledge about the Act and its provisions. Fortunately this has been researched in a number of studies. One of these is a study by Morroni et al (2006). They investigated the level of knowledge of Abortion legislation among women in the Western Cape eight years after the Act was passed. They found that 78% of women knew about the legislation. The irony was however that of those who knew about the legislation 48% did not know that there were time restrictions involved.

Roberts (2007) in a study conducted in KwaZulu-Natalalso found that the knowledge of women about abortion legislation was significantly high. In urban KwaZulu-Natal 99% of women interviewed were aware of their rights to abortion, while 77% of rural women were also aware of the Act. The study however found that, 40% of the women did not have sufficient knowledge with regard to the time restrictions and circumstances under which they can have TOP performed.

These studies suggest that women, both rural and urban areas are aware of their right to abortion. There was however a varied knowledge of the time restrictions and circumstances under which abortion can be done. Unfortunately despite this knowledge abortion services still remain inaccessible to many women especially in rural areas in the country. It is therefore up to the health care system to make sure that there is equitable access to affordable, cost effective, safe and user friendly TOP services.

- **Unequal power relations**

The patriarchal nature of society has ensured that power relations in families and relationships are biased towards men. According to the study by Ngwena (2005:27) titled “Accessing termination of pregnancy by minors in the Free State: Identifying barriers and possible interventions”, adolescent girls have been socialised by familial arrangements, and cultural and religious beliefs to place their own needs and wishes below those of their male counterparts. This takes away the women`s control over theirreproductive lives which are dictated by a male-dominated society. This coupled with ignorance robs women of their constitutional right to access reproductive health services, including the right to access TOP where required.

- **Distance from facilities, transport and related poverty**

In South Africa following the implementation of the CTOPA, TOP services are provided at no cost to women in the Public Sector. Access to the service is however hampered by the long distances from facilities that many women in rural areas have to travel. In Xhariep District in the Free State women have to travel in excess of 100km to access the service in neighbouring Districts. A study conducted in the Free State showed that 24% of women had to travel a journey of four hours to reach a facility (Engelbrecht*et al.* 2000). This is a barrier considering the high poverty levels in rural South Africa.

Another study conducted by Akinbohun (2005:61) in Lejweleputswa District in the Free State, concluded that “there are more clients in the late presenters group living at places more than 50km from TOP centre compared to the early presenters group. This shows that the distance to TOP centre could be a factor on why some clients delay in coming forward in time for TOP”.

This study aims to answer the above questions and to determine if the above conditions exist for the implementation of the CTOPA in the context of the Free State Province, and specifically Xhariep District.

The following are the health system related barriers to TOP:-

Health System related barriers to TOP

Despite the fact that South Africa is considered to be having a progressive constitution which guarantees in Chapter 2 Bill of Rights (2) (a) the rights to make decisions concerning reproduction, as well as the CTOPA, there are still Health Systems Barriers to access to TOP. A few of these are discussed briefly below.

- **Accessibility of TOP facilities**

There are challenges with regard to the number of facilities rendering TOP services in the province, and the country at large. According to Roberts (2007) although District Hospitals and Community Health Centres are designated to provide the service according to the CTOPA, this is unfortunately not the case. This results women having to travel long distances in the face of poverty and lack of resources to access the service.

- **Staff shortages, lack of skills and attitudes**

Engelbrech (2005) found that among the barriers to access TOP in the Free State is lack of staff, staff that are unwilling to do TOP, and lack of training. Despite the fact that the CTOPA was passed and implemented in 1996 in the country, a lot of professionals are still unwilling to participate in its implementation. The aim of this study is to determine barriers to the implementation of the Act among doctors and professional nurses in Xhariep District.

- **Infrastructure and equipment**

One of the Health Systems barriers to TOP often cited is lack of infrastructure and equipment. These include among others theatres, and appropriate equipment and beds. According to the study conducted by Akinbohun (2005:73) in Lejweleputswa District in the Free State “the problems in the Kopano TOP centre include shortage of trained nursing staff, inadequacy of space and inability to render 24 hour service as a hospital bed in not always guaranteed”. The aim and objectives of the study follow.

AIMS AND OBJECTIVES OF STUDY

The aim of the study is to determine the barriers to the implementation of the Choice on Termination of Pregnancy Act (CTOPA) among doctors and nurses in Xhariep District in the Free State Province.

The specific objectives are:-

- To establish whether the designated hospitals in the District meet the infrastructural requirements for the service according to the CTOPA;
- To establish whether the designated hospitals have the necessary resources to implement the CTOPA;
- To investigate the extent to which the management of the designated hospitals support the program;
- To determine the CTOPA training offered to those doctors and nurses who are prepared to offer the service;
- To determine the role of peer pressure and stigma as barriers to the implementation of CTOPA in Xhariep District;
- To determine the knowledge, attitudes, beliefs, and practices of Nurses and Doctors in Xhariep towards CTOPA; and
- To investigate if there is any form of social and/or psychological support for those doctors and nurses participating or willing to participate in the implementation of the CTOPA.

Chapter 3 examines the Research Methodology and includes among others the target population, the sample and its size and data collection techniques.

CHAPTER 3:RESEARCH METHODOLOGY

INTRODUCTION

As indicated above the aim of the study is to determine the barriers to the implementation of the Choice on Termination of Pregnancy Act (CTOPA) among doctors and nurses in Xhariep District in the Free State Province. It is expected that the findings of the study will inform policy on the implementation of the Act in the province, and improve access to the service.

STUDY SETTING

The study was carried out in the Xhariep District in the Free State Province. This is one of the most rural, sparsely populated, and the poorest district in the province. It has a population of 132 070. This makes just about five per cent of the total population of the province. Eighty five per cent of the population in the District is uninsured. It is assumed that the uninsured population will not be able to afford private termination of pregnancy services if they needed it.

Xhariep has three District Hospitals namely Diamant in Jagersfontein, Stoffel Coetzee in Smithfield and Embekweni in Zastron. The District also has one Community Health Centre. There are sixteen clinics and eleven mobile clinics in the District serving a total of sixteen rural towns. None of these health facilities offer termination of pregnancy services, hence the need for a study of this nature.

STUDY DESIGN

A descriptive study (Survey) was conducted in the District. The study was divided into the Qualitative and Quantitative parts. These are discussed below.

THE QUALITATIVE PART OF THE STUDY

The Qualitative part of the study involved in depth interviews with the management of the three hospitals in the District. Each of the managers was interviewed face to face by the researcher. Neither group nor telephonic interviews were conducted. Interviews lasted an average of 20 to 30 minutes. All interviews were recorded, with the permission of the managers, and were transcribed into text.

A number of points that needed to be covered in the interviews were identified, to direct the discussion in order to obtain the required information. Respondents were however allowed to talk and cover the areas in their own terms and from the perspectives of their hospitals.

No particular sequence was followed in asking these questions and the interviews were not structured to allow for spontaneity. All interviews were conducted in the respective hospitals.

Sampling and Target Population for the Qualitative part of the Study

The target population for the interviews was the management of the Hospitals. This included the Hospital Chief Executive Officer (CEO), the Chief Medical Officers (CMO), and Nursing Managers. However only the following members of management were interviewed:-

- The CEO of Diamant Hospital. The CEO of Embekweni and Stoffel Coetzee Hospitals was not available during the data collection period and was therefore not interviewed. Please note that Embekweni and Stoffel Coetzee are clustered and are managed by one CEO.
- Nursing Managers for all three hospitals.
- The District CMO was not available and was therefore also not interviewed.

Data Analysis Method for the Qualitative part of the Study

All interviews were transcribed into text. Data Analysis involving a process of identifying themes was undertaken through in depth line by line scrutiny of the text. The following techniques were used:-

- ***Word repetitions***, for example all the interviewed managers repeatedly referred to the fact that they ***support*** the implementation of the Act, that they ***respected the rights*** of women in the District to choose to terminate their pregnancies, a frustrating ***shortages of nurses and doctors***, ***budgets that are not sufficient***, and ***support from the province.*** The researcher did not utilise any computer software due to the fact that a very small sample was interviewed.
- ***Key words in context (KWIC),*** were also identified and assisted the researcher to identify themes. These included words such as ***infrastructural deficiencies***, and failure to ***attract and retain professionals*** as a major disadvantage of the District.
- ***Comparing and contrasting,*** this process involved conducting a careful line by line analysis of the text, and identifying the ways in which texts are similar or different from each other. This process proved to be very helpful in identifying themes.

The themes were then analysed and conclusions were drawn.

THE QUANTITATIVE PART OF THE STUDY

The Quantitative part of the study involved a survey, where data was collected through the administration of an anonymous questionnaire (Addendum 1) to 59 respondents, by the researcher.
The respondents included doctors and professional nurses in the three District Hospitals. The Community Health Centre was not included in the sample as the Hospitals were thought of as better resourced to render the service.

The study did not investigate the barriers as they are experienced by patients, but only focused on the service providers. Perhaps it may be necessary to undertake a study onthe experiences of patients seeking TOP services in the District separately later.

TARGET POPULATION

The target population for the quantitative part of the study was all doctors and professional nurses in the three District Hospitals.The Community Health Centre was not sampled, because the Act provides for TOP to be provided in facilities with minimum medical standards, including access to referral doctors should the need arise. This is not the case in the Community Health Centre in Xhariep District.

DATA ANALYSIS

Following data collection a data analysis process was undertaken for both the quantitative and qualitative parts of the study. The data analysis methods are described below.

QUANTITATIVE DATA ANALYSIS

Data were analyzed using descriptive statistics such as frequencies and percentages, and are presented in Tables and graphs. All the responses measured on a 5-point Likert Scale were regrouped to have three levels as follows. Strongly agree and agree responses were combined to form an 'Agree' response, strongly disagree and disagree were combined to form a 'Disagree' response and the uncertain response remained as it is. The data were then described using frequencies and percentages.

The distribution of the responses was compared across the hospitals using a chi-squared test or a Fisher's exact test. The same tests were performed to assess any associations between each of the measured variables and attitudes of the participants towards TOP, as well as the association between the variables and perceived attitudes of peers towards TOP. Logistic regression analysis was used to determine the factors that influence negative attitude towards TOP using all the other variables as predictor variables.

INFORMATION DESSEMINATION STRATEGY

It is envisaged that the results of the Research will be made available at the library of the University of KwaZulu-Natal. A presentation of the results will be made to the management of the Free State Department of Health, as well as the management and staff of Xhariep District with the view that they will implement the recommendations. The report will also be made available on the website of the Free State Department of Health.

ETHICS APPROVAL

Ethics approval was obtained from the Biomedical Ethics Committee of the University of KwaZulu-Natal. Approval for the study was also requested and granted by the Head of the Department of Health in the Free State Province, including the District Manager and the respective Chief Executive Officers of the three District Hospitals.

CHAPTER 4RESEARCH RESULTS/FINDINGS

INTRODUCTION

The findings of the study on the barriers to the implementation of CTOPA among doctors and nurses in Xhariep District are presented in this chapter. These are divided into the quantitative and qualitative aspects of the study. The quantitative part of the study is divided into the background information, followed by infrastructural requirements, human resources issues, training on CTOPA, availability of social and psychological support regarding TOP and finally knowledge, attitudes, beliefs and practices (KABP). The qualitative aspect of the study wasanalysed through the transcription of the in depth interviews followed by the identification of themes that emerged from which findings have been made.

FINDINGS QUANTITATIVE PART OF THE STUDY

Background information/Demographics

A total of 59 participants out of the expected 65 completed the questionnaire which the researcher presented to the participants. The others were not available for different reasons. An explanation of the purpose of the study was given and informed consent obtained. Forty (67.8%) of the participants were from Diamant, eleven (18.6%) from Stoffel Coetzee and eight (13.6%) from Embekweni Hospitals (Figure 1).

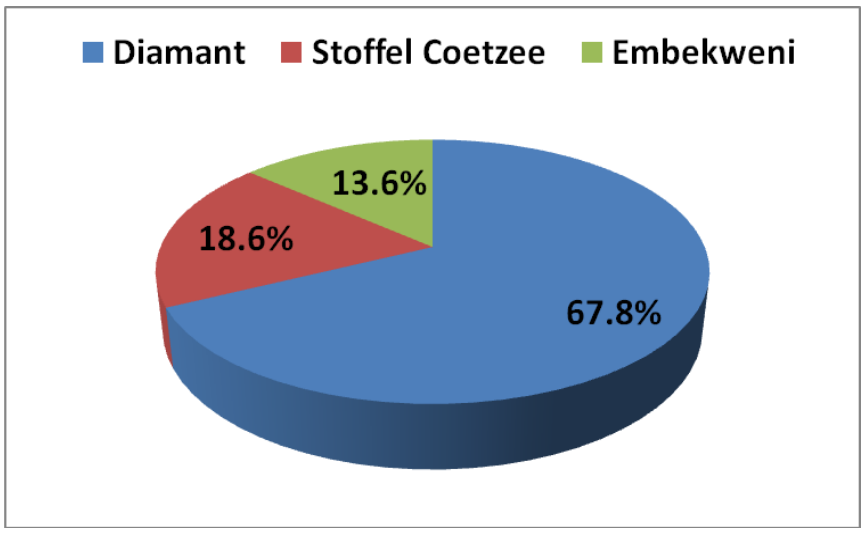

Figure 1: The distribution of study participants across the hospitals

Table 2 presents the distribution of age, gender, racial classification, religious denomination and years in profession for the study participants. Forty one percent of the participants were aged between 30 to 39 years with only seven percent aged between 20 and 29 years. Of the 59 participants, 51 (86.4%) were females and only eight were males.

Table 2: Demographic characteristics of participants

Variable	Count	Percent (n=59) (%)
Age group (years)		
20 to 29	**4**	**6.78**
30 to 39	**24**	**40.68**
40 to 49	**22**	**37.29**
50 or more	**9**	**15.25**
Gender		
Female	**51**	**86.4**
Male	**8**	**13.6**
Race		
Black	**39**	**66.1**
White	**18**	**30.5**
Colored	**2**	**3.4**
Religion group		
Catholic	**12**	**20.34**
Protestant	**19**	**32.20**
Other	**28**	**47.46**
Years in the profession		
Below 5 years	**9**	**15.25**
5 to 10 years	**19**	**32.20**
Above 10 years	**31**	**52.5**

Figure 2 is an illustration of the distribution of professional nurses to doctors in the District. Almost 95% of respondents were nurses, and only five per centwere doctors. The shortage of doctors in the District is a major challenge as is the case elsewhere in the country.

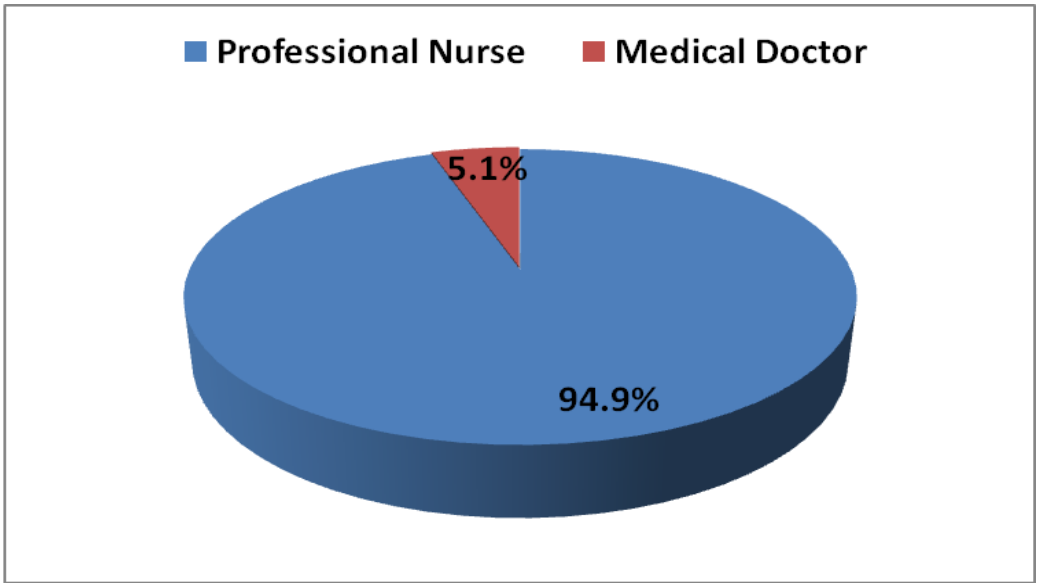

Figure 2: The distribution of the professional categories of the participants

The next section deals with the infrastructural requirements of the three hospitals as perceived by the respondents.

Infrastructure Requirements

The majority of the respondents (60%) indicated that their hospitals did not meet infrastructural requirements for the implementation of the CTOPA. A significant percentage (30%) was unsure, while 10% thought the hospitals meet the requirement for the implementation of the CTOPA (Table 3).

Table 3: Infrastructural deficiencies of the hospitals as perceived by respondents

	Category	Count	%
Does your hospital meet infrastructural requirements in line with the CTOPA in terms of theatre, equipment and other(n=59)	Yes	6	10.2
	No	35	59.3
	Unsure	18	30.5
What are the short comings of the Hospital? (n=35)	Equipment	16	45.7
	Theatre	5	14.7
	Other	14	40

The shortcomings in terms of TOP infrastructure requirements cited by the study participants are also presented in Table 3 above. About 46% (16) of the 35 participants who indicated that their hospital does not meet the requirements cited lack of equipment as the main problem, 14.3% (5) cited lack of theatre at the hospital, while 40% (14) of the participants cited other short comings. The following section looks at the human resources.

Human Resource

As indicated earlier the responses to questions measured on a 5-point Likert Scale were grouped as follows: Strongly disagree and disagree were combined to form category “Disagree”; strongly agree and agree were combined to form category “Agree”.

Nearly 90% of respondents disagreed with the statement that, the Hospital has enough doctors to render the service. The response to the same question relating to nurses was also very similar (84.7%). Table 4 is an illustrationof responses to these questions.

Table 4: Human Resource aspect of the three hospitals

	Disagree		***Agree***		***Uncertain***	
	N	***%***	***N***	***%***	***N***	***%***
Hospital have enough doctors to render the service	**53**	**89.8**	**2**	**3.4**	**4**	**6.8**
The hospital has enough nurses to render the service	**50**	**84.7**	**2**	**3.4**	**7**	**11.9**
The service is just not a priority of the hospital	**27**	**45.8**	**13**	**22**	**19**	**32.2**
The hospital does not have enough resources to render the service	**25**	**43.1**	**24**	**41.4**	**9**	**15.5**

Forty one per centof the study participants indicated that the hospitals do not have sufficient resources to implement the Act. Almost 46% disagreed with the statement that the service is not a priority of the hospital. Twenty two per cent of the respondents felt that the hospitals did not prioritise the service, while a third were uncertain.

Staff training and Social and Psychological Support

The distribution of the responses on questions investigating staff training and availability of social and psychological support within the hospitals are presented in Table 5. Nearly 70% of the participants were not exposed to training on either, CTOPA, Termination of Pregnancy (TOP) related value clarification, Manual Vacuum Aspiration or Pharmacology of TOP. Almost three quarters of the participants were exposed to training on Contraceptives (Family Planning Methods). Only 19% of 58 participants indicated that management will support them if they were to implement CTOPA. Nearly 17% of the participants indicated that there would be debriefing sessions if they were to implement TOP, whereas half were not sure whether they would have management support or debriefing sessions.

Table 5: Staff training, management support and debriefing with regard to TOP

	No		*Unsure*		*Yes*	
Staff training	***N***	***%***	***N***	***%***	***N***	***%***
Exposed to training on CTOPA	**41**	**69.5**	**15**	**25.4**	**3**	**5.1**
Exposed to training on Termination of Pregnancy (TOP) related value clarification	**41**	**69.5**	**14**	**23.7**	**4**	**6.8**
Exposed to training on Manual Vacuum Aspiration	**40**	**67.8**	**11**	**18.6**	**8**	**13.6**
Exposed to training on Contraceptives (Family Planning Methods)	**11**	**18.6**	**4**	**6.8**	**44**	**74.6**
Exposed to training on Pharmacology of TOP	**43**	**72.9**	**12**	**20.3**	**4**	**6.8**
Management support	***N***	***%***	***N***	***%***	***N***	***%***
There is management support and buy in	**18**	**31.0**	**29**	**50.0**	**11**	**19.0**
Debriefing sessions	**20**	**34.5**	**28**	**48.3**	**10**	**17.2**

Availability of social and psychological support

Social and Psychological support seems to be one of the challenges to the implementation of the CTOPA in Xhariep District. Of the 59 respondents 18 (31%) felt that there was no support from management, 29 (50%) were unsure while only 11 (19%) indicated that there was support from management (Figure 3).

Twenty of the respondents (34.5%) indicated that there were debriefing sessions for those willing to participate in TOP, while 28(48.3%) were unsure and ten (17.2%) indicated that there were debriefing sessions. Eighty per cent of those who admitted to debriefing sessions indicated that these were conducted by psychologists and or social workers.

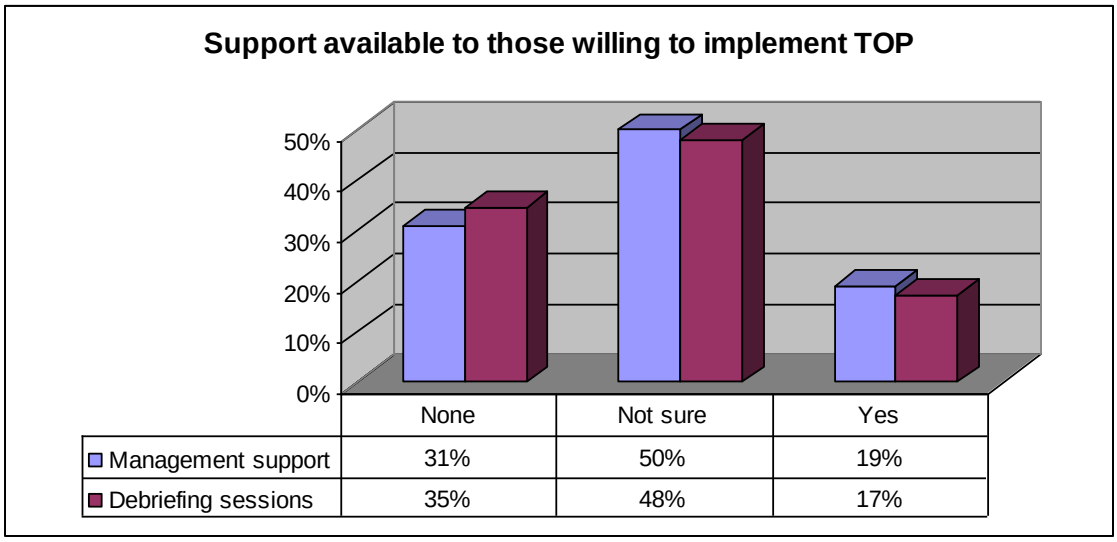

Figure 3: Availability of social and psychological support

Attitude and debriefing

Table 6 illustrates who does debriefing sessions, as well as the attitude of peers and colleagues towards TOP. Ten participants responded to the question. Three of the 10 participants who indicated that they would get debriefing, said the debriefing is carried out by either a psychologist or a social worker. Seventeen per cent of the 59 participants indicated that the attitude of their peers towards TOP is positive, with nearly half of them indicating that the attitude of their peers towards TOP is negative.

Table 6: Questions on debriefing sessions and attitude towards TOP

	Count	Percent (%)
Person who does debriefing [n=10]		
Psychologist	**3**	**30.0**
Psychologist and Social Worker	**2**	**20.0**
Social worker	**3**	**30.0**
Other	**2**	**20.0**
What is the attitude of your peers towards TOP [n=59]		
Negative	**28**	**47.46**
Not sure	**21**	**35.59**
Positive	**10**	**16.95**

Stigma its sources and causes

Table 7 presents the distribution of the responses on the questions investigating stigma towards TOP. Nearly 27% of the participants indicated that there is stigma attached to TOP in their hospital, or district and almost half were not sure. Half of the 16 participants who perceived that there is stigma around TOP indicated that the source of stigma is the community and 44% cited the source of stigma as colleagues. Fifty three percent of the participants indicated that stigma is caused by religion, and 29% said it is caused by culture, whereas 18% indicated that it is caused by both culture and religion.

Table 7: Responses to questions investigating stigma related to TOP

	Responses	Count	Percent (%)
In your opinion is there stigma attached to TOP in your hospital/district? [n=59]	**No**	**13**	**22.03**
	Not sure	**30**	**50.85**
	Yes	**16**	**27.12**
What are the Source of stigma? [n=16]	**Colleagues**	**7**	**43.8**
	Management	**1**	**6.2**
	Community	**8**	**50.0**
What is the cause of the stigma? [n=34]	**Culture**	**10**	**29.0**
	Religion	**18**	**52.9**
	Religion and Culture	**6**	**17.6**

What needs to be done to ensure that nurses and doctors in Xhariep participate in TOP

Twenty five per cent of the respondentswere of the opinion that in order that doctors and nurses in the District are willing to implement the Act, the service needs to be recognised as a scarce skill or a speciality. Nearly 18% felt thatstaffneed to be trained and infrastructure be provided. Fifty seven per cent indicated that all these measures will assist the implementation of the Act. Figure 4 is an illustration of these responses.

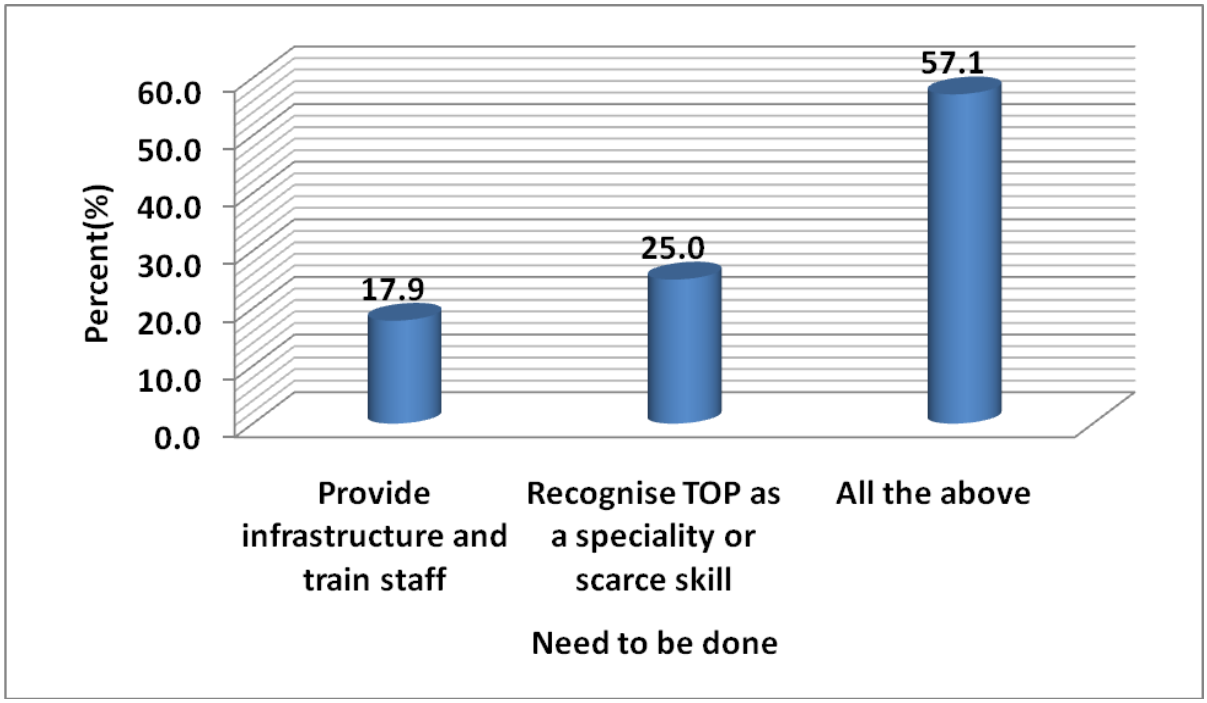

Figure 4: What needs to be done to encourage professional to participate in TOP

Knowledge, attitudes, beliefs, and practices of nurses and doctors towards termination of pregnancy in Xhariep District

The following are the findings on this aspect of the study. These are illustrated in Table 8.

Knowledge

The distribution of knowledge and beliefs of participants towards TOP is shown in Table 8. More than two thirds of the participants thought that their knowledge of TOP was not sufficient. Nearly a third considered TOP unacceptable/ immoral. However more than 80% agreed that family planning services in Xhariep are accessible enough, and also that women in Xhariep are entitled to choose whether to terminate their unwanted pregnancies or not. They also agreed that they will refer a patient seeking TOP to an appropriate service. Almost two thirds of the participants disagreed that they will seek TOP in case of an unplanned pregnancy involving themselves or their family.

Acceptability and morality of TOP

The study found that although 59% of the respondents agreed that their religion is opposed to TOP, forty nine per cent did not consider TOP immoral or unacceptable, while 32% agreed that they do consider TOP immoral and/ or unacceptable, with 19% uncertain.

Respondent‘s practices relating to TOP

Table 8 illustrates that sixty three per cent (37) of the respondents will not seek a TOP in case of unplanned pregnancy involving themselves or their families. However 90% of the respondents indicated that they will refer a patient seeking TOP to an appropriate facility. The CTOPA requires that those who chose not to render the service should refer patients seeking it to an appropriate facility.Two respondents (3%) indicated that they will not refer a patient seeking TOP, and four(6.8%) were not sure if they would.

Respondent‘s view regarding the right of women in Xhariep to chose

Table 8 also illustrates that 81.4% of the respondents are of a view that women in Xhariep are entitled to choose whether to terminate their unwanted pregnancies or not. Almost seven per cent (6.8%) disagreed while 11.9% were unsure. This can be expected considering that the majority indicated that they are willing to refer those women seeking the service.

Access to Family Planning in Xhariep

Eighty six per cent of the respondents indicated that Family Planning in the District is accessible (Table 8). It will be recalled that the majority (75%) of nurses and doctors indicated that they have been exposed to training on Family Planning compared to any other aspects of TOP. It will be interesting to find out what the need for TOP in the District is, or alternatively how many women in the District seek TOP or access it elsewhere, as a sequel to this study.

Table 8: Knowledge, attitudes, beliefs and practices of professionals

	Disagree		*Agree*		*Uncertain*	
	N	***%***	***N***	***%***	***N***	***%***
I have sufficient knowledge about TOP	**41**	**69.5**	**12**	**20.3**	**6**	**10.2**
I consider TOP unacceptable/immoral	**29**	**49.2**	**19**	**32.2**	**11**	**18.6**
Family planning services in Xhariep are accessible enough	**5**	**8.6**	**50**	**86.2**	**3**	**5.2**
Women in Xhariep are entitled to choose whether to terminate unwanted pregnancies or not	**4**	**6.8**	**48**	**81.4**	**7**	**11.9**
My religion is against TOP	**17**	**28.8**	**35**	**59.3**	**7**	**11.9**
I will refer a patient seeking TOP to the appropriate service	**2**	**3.4**	**53**	**89.8**	**4**	**6.8**
I will seek a TOP in case of an unplanned pregnancy involving myself or my family	**37**	**62.7**	**16**	**27.1**	**6**	**10.2**

Combined scores

Combined scores were created to assess the joint effects of related statements. Respondents were regarded as having some knowledge on TOP if they either *strongly agreed* or *agreed*with all three statements namely,*"I have sufficient knowledge about TOP", "Family planning services in Xhariep are accessible enough" and "Women in Xhariep District are entitled to choose whether to terminate their unwanted pregnancies or not"* otherwise respondents were regarded as having no knowledge on TOP.

Respondents were regarded as having negative beliefs towards TOP if they*strongly agreed* or *agreed* with the statements *"I consider TOP unacceptable/immoral" and "My religion is against Termination of Pregnancy"*, otherwise they were regarded as having beliefs that support TOP.

Finally respondents were regarded as having a positive attitude towards TOP if they*strongly agreed* or *agreed*with the statement *"I will refer a patient seeking Termination of pregnancy to the appropriate service"* and *"I will seek a Termination of Pregnancy in case of an unplanned pregnancy involving myself or my family"* otherwise they were regarded as having a negative attitude towards TOP.

The percentages of the respondents regarded as having some knowledge of TOP,negative beliefs towards TOP, and a positive attitude towards TOP are shown in Table 9 below. Just over one quarter of the respondents were regarded as having a positive attitude towards TOP, as well as having some negative belief towards TOP. Only 13.8% of the respondents were regarded as having some knowledge about TOP.

Table 9: Combined scores for knowledge, attitudes and beliefs

Combined Scores	Count	Percent (%)
Knowledge Score [n=58]		
Some knowledge	8	13.8
No knowledge	50	86.2
Belief score [n=59]		
Negative belief towards TOP	17	28.8
Positive belief towards TOP	42	71.2
Attitude Score [n=59		
Positive attitude towards TOP	16	27.1
Negative attitude towards TOP	43	72.9

A comparison of the perceptions of respondents towards TOP and Demographic variables

An association between the different categories of the variable background information, and the attitude of the respondents, as well as the perceived attitude of peers towards TOP is assessed using a chi-square test. The level of significance considered in this study was 10%. This was selected in an effort to accommodate the small sample size.

A comparison of the variable attitudes towards TOP of the different categories of the variable back ground information is presented in Table 10. A higher percentage (56.2%) of the respondents regarded as having a positive attitude towards TOP were aged 40 to 49 years, whereas most of those regarded as having a negative attitude (39.5%) were aged 30 to 39 years. Around twelve percent of the white respondents were regarded as having a positive attitude towards TOP, compared to 37.2% who were regarded as having a negative attitude.

The categories are vice versa among the blacks, with 86% regarded as having a positive attitude, while 58% were regarded as having a negative attitude.

More Protestant respondents were regarded as having a negative attitude towards TOP compared to those who were regarded as having a positive attitude (39% vs. 12%) respectively. The results were vice versa among the Catholics (19% vs. 25%).

All the variables measuring the background information are not statistically significantly associated (all p-values are greater than 10%) with attitude of the respondents except for age groups (p=0.0717).

Table 10 : Association beteen demographic background information and created attitudes of respondents towards TOP

Demographic Information	Combined attitude score of respondents towards TOP		
	Regarded as Positive Attitude [n=16]	Regarded as Negative attitude [n=43]	p-value
Age groups			**0.0717**
20 to 29	0.0	9.3	
30 to 39	43.8	39.5	
40 to 49	56.2	30.2	
50 or more years	0.0	20.9	
Religious group			**0.1403**
Protestant	12.5	39.5	
Catholic	25.0	18.6	
Other	62.5	41.9	
Racial classification of the respondents			**0.1003**
Black	87.5	58.1	
White	12.5	37.2	
Coloured	0.0	4.7	
Gender of the respondents			**0.3171**
Male	6.2	16.3	
Female	93.8	83.7	
Knowledge score		[n=42]	**0.4992**
Knowledge	18.8	11.9	
No knowledge	81.2	88.1	

Demographic information is compared across the classifications of perceived attitudes of peers towards TOP in Table 11. A total of 10 respondents perceived their peers as having positive attitude, 28 participants perceived their peers as having a negative attitude towards TOP, while 21 were not sure. The percentage of the respondents, who perceive their peers as having a negative attitude towards TOP in the 30 to 39 age group, is similar to the percentage of respondents who perceivedtheir peers as having a positive attitude towards TOP for age group40 to 49 years. The same is the case for those perceiving the attitude as positive for the two age groups. Overall 80% of the respondents who perceived peers as having a positive attitude towards TOP were aged between 30 and 49 years.

All 10 respondents who perceived their peers as having a positive attitude towards TOP were females; this includes 86% of those who perceived their peers as having a negative attitude. More white respondents perceived their peers as having a negative attitude towards TOP, compared to those who perceived their peers as having a positive attitude (50% vs. 20 %). These perceptions are vice versa among the blacks (80% vs. 43%).

All the demographic information variables are not statistically significantly associated with perceived attitude of peers except for religion (p=0.00083). A higher percentage (60%) of the respondents who perceived their peers' attitude towards TOP as positive were Catholic. In terms of the variable racial classification 80% of the respondents (p=0.0088) who regarded the attitude of their peers towards TOP as positive were black.

Table 11: A comparison of Demographic Information across theclassification of the perceived attitude of peers towards TOP

	Perceived attitude of peers towards TOP			
	Negative [n=28]	Positive [n=10]	Not sure [n=21]	P-value
Age groups				**0.3238**
20 to 29	14.3	0.0	0.0	
30 to 39	39.3	40.0	42.3	
40 to 49	39.3	40.0	33.3	
50 or more	7.1	20.0	23.8	
Religious group				**0.00083**
Protestant	36.4	30.0	14.3	
Catholic	10.7	60.0	14.3	
Other	42.9	10.0	71.4	
Racial classification				**0.0088**
Black	42.9	80.0	90.5	
White	50.0	20.0	9.5	
Colored	7.1	0.0	0.0	
Gender				**0.3463**
Male	14.3	0.0	19.0	
Female	85.7	100.0	81.0	

A comparison of the created knowledge and attitude scores across the perceived attitude of peers towards TOP is shown in Table 12. More respondents (88.9%) who perceived their peers as having a negative attitude towards TOP were regarded as having no knowledge ofTOP. Eleven per cent of those with some knowledge of TOP thought their peers had a negative attitude towards the practice, whereas 30% thought the attitude was a positive one. There is no statistically significant association (both p-values are bigger than 10%) between perceived attitudes of peers and belief or knowledge.

The pattern was the same with those respondents withpositive attitudes towards TOP perceiving their peers as having apositive attitude to the practice at 50%, and those perceiving the attitude of their peers as negative being only 11%.Those respondents with a negative attitude towards TOP perceived the attitude of their peers negative 89% against positive 50%.There is a statistically significant association between the attitude of respondents and their perception of the attitude of their peers towards TOP (p=0.02084).

Table 12: Comparison of knowledge and attitudes across perceived attitudes of peers towards TOP

	Perceived attitude of Peers towards TOP			
	Negative [n=28]	Positive [n=10]	Not sure [n=21]	P-value
Knowledge Score [n=58]				**0.2600**
Some knowledge	**11.1**	**30.0**	**9.5**	
No knowledge	**88.9**	**70.0**	**90.5**	
Attitude of participants				**0.02084**
Positive attitude	**10.7**	**50.0**	**38.1**	
Negative attitude	**89.3**	**50.0**	**62.9**	

Comparison of the responses across the hospitals

A comparison of the responses of the study participants across the hospitals is discussed in this section. The section starts by comparing the infrastructure followed by management support, etc. Table 13 shows the comparison of infrastructural requirements across the hospitals. The majority of the respondents from each hospital indicated that their hospital does not meet the infrastructural requirements in line with the CTOPA. StoffelCotzee was the worst in this regard.

There is a statistically significant association (p=0.0761) between the required infrastructure and the hospital. Lack of theatre and equipment were cited as the main problems resulting in the hospitals not meeting the infrastructural requirements.

Table 13: Comparison of infrastructure across the hospitals

	Diamant [n=40]	Embekweni [n=8]	StoffelCotzee [n=10]	P-value
Does your hospital meet infrastructural requirements for TOP				**0.076**
Yes	**5.0**	**25.0**	**10.0**	
No	**57.5**	**25.0**	**80.0**	
Unsure	**37.5**	**50.0**	**10.0**	
If not what are the short comings				**0.638**
Lack of Equipment	**46.1**	**0.0**	**62.5**	
Lack of Theatre	**34.5**	**100.0**	**25.0**	
Other short comings	**15.4**	**0.0**	**12.5**	

Table 14 presents a comparison of management support across the hospitals. Less than one quarter of the respondents from each of the hospitals indicated that there would be support from management if they were to implement the CTOPA. Embekweni hospital was again the worst in this regard with only 13% anticipating management support. Only 15% of the respondents from Diamant Hospital indicated that they would have debriefing sessions compared to 25% from Embekweni and 20% from StoffelCotzee.

Availability of both management support and debriefing sessions are not statistically significantly associated among the hospitals, with p-values of 0.452 and 0.92 respectively. In all the hospitals debriefing sessions are provided either by a social worker, a psychologist or both.

Table 14: A comparison of management support across hospitals

	Diamant [n=40]	Embekweni [n=8]	StoffelCotzee [n=10]	P-value
Is there any support from management available to you if you were to implement the CTOPA				**0.452**
Yes	**20.0**	**12.5**	**20.0**	
None	**37.5**	**12.5**	**20.0**	
Not sure	**42.5**	**75.0**	**60.0**	
Is there any debriefing sessions available to you if you were to implement the CTOPA				**0.692**
Yes	**15.0**	**25.0**	**20.0**	
None	**37.5**	**12.5**	**40.0**	
Not sure	**47.5**	**62.5**	**40.0**	
Person doing debriefing at the hospital	**[n=9]**	**[n=2]**	**[n=2]**	**0.221**
Psychologist	**33.3**	**0.0**	**50.0**	
Psychologist and Social Worker	**0.0**	**50.0**	**50.0**	
Social worker	**44.4**	**50.0**	**0.0**	
Other	**22.2**	**0.0**	**0.0**	

A comparison of the perceptions of peers and the required changes across the hospitals is presented in Table 15. None of the respondents from Embekweni and StoffelCotzeehospitals perceived the attitude of their peers towards TOP as positive. A quarterofthe respondents from Diamant hospital perceived their peers as having a positive attitude towards TOP. An average of 16% of the respondents from all hospitals thought that infrastructure and training on TOP need to be provided. Recognition of TOP as a specialty or scarce skill was suggested by 18% of the respondents from Diamant and StoffelCotzee Hospitals. Seventy one percent of the respondents from Embekweni suggested recognition of TOP as a specialty or a scarce skill. There is a statistically significant association between the perceptions of the attitude of peers towards TOP in the hospitals (p=0.084), and what needs to be done to ensure that doctors and nurses are willing to participate in TOP in the hospitals (p=0.049).

Table 15: A comparison of perceptions of peers towards TOP and required changes across hospitals

	Diamant [n=40]	Embekweni [n=8]	StoffelCotzee [n=10]	P-value
What is the attitude of your peers towards TOP				**0.084**
Negative	**47.5**	**62.5**	**36.4**	
Positive	**25.0**	**0.0**	**0.0**	
Not sure	**27.5**	**37.5**	**63.6**	
What needs to be done to ensure that nurses and doctors in Xhariep are willing to participate in TOP	**[n=38]**	**[n=7]**	**[n=11]**	**0.049**
Provide infrastructure and train staff	**18.4**	**14.3**	**18.2**	
Recognize TOP as a specialty or scarce skill	**18.4**	**71.4**	**18.2**	
All the above	**63.2**	**14.3**	**63.6**	

Table 16 compares the distribution of the perceptions of respondents on the presence stigma across the hospitals. Nearly one third of the respondents from Diamant, one quarter of the respondents from Embekweni and 9% of the participants from StoffelCotzee Hospitals indicated that there is stigma attached to TOP in their hospitals. The source of the stigma was mainly considered to be the colleagues or the community by the respondents from Diamant. All the respondents from Embekweni Hospital suggested that the source of the stigma was from the community, whereas all respondents from StoffelCotzee believed that the source of the stigma was their colleagues. An average of 65% of the respondents from all the hospitals believed that the stigma attached to TOP is caused by religion. There is no statistically significant association between any of the items investigating stigma in the hospitals.

Table 16: Comparison of stigma across hospitals

	Diamant [n=40]	Embekweni [n=8]	StoffelCotzee [n=11]	P-value
Is there stigma attached to TOP in your hospital/district				**0.521**
Yes	**32.5**	**25.0**	**9.1**	
No	**17.5**	**25.0**	**36.4**	
Not sure	**50.0**	**50.0**	**54.5**	
Source of stigma	**[n=13]**	**[n=2]**	**[n=1]**	**0.348**
Colleagues	**46.2**	**0.0**	**100.0**	
Management	**7.6**	**0.0**	**0.0**	
Community	**46.2**	**100.0**	**0.0**	
What is the cause of the stigma	**[n=26]**	**[n=4]**	**[n=4]**	**0.378**
Culture	**34.6**	**25.0**	**0.0**	
Religion	**46.2**	**50.0**	**100.0**	
Religion and culture	**19.2**	**25.0**	**0.0**	

Items used to investigate the respondent `s knowledge of TOP are compared across the hospitals in Table 17. More than 60% of the respondents from each of the three hospitals agreed that they have sufficient knowledge of TOP. More than 90% of the respondents from Diamant and Embekweni hospitals agreed that family planning services in Xhariep are accessible enough, whereas only 64% of those from StoffelCotzee agreed with the statement. More than 70% of the respondents from each of the three hospitals agreed that women in Xhariep District are entitled to choose whether to terminate unwanted pregnancies or not. There is no statistically significant association between the respondent `s knowledge of TOP and all the items measuring knowledge across the three hospitals.

Table 17:Comparison of items investigating knowledge across hospitals

	Diamant [n=40]	Embakweni [n=8]	StoffelCotzee [n=11]	P-value
I have sufficient knowledge about TOP				**0.266**
Agree	**22.5**	**25.0**	**9.1**	
Disagree	**70.0**	**75.0**	**63.6**	
Uncertain	**7.5**	**0.0**	**27.3**	
Family planning services in Xhariep are accessible enough		**[n=7]**		**0.125**
Agree	**90.0**	**100.0**	**63.6**	
Disagree	**5.0**	**0.0**	**27.3**	
Uncertain	**5.0**	**0.0**	**9.1**	
Women in Xhariep District are entitled to choose whether to terminate unwanted pregnancies or not				**0.711**
Agree	**82.5**	**87.5**	**72.3**	
Disagree	**5.0**	**12.5**	**9.1**	
Uncertain	**12.5**	**0.0**	**18.2**	

Items used to measure beliefs are compared across the hospitals in Table 18. More than 50% of the respondents from each of the three hospitals agreed that their religion is against termination of pregnancy and just over one third of the respondents from Embekweni and StoffelCotzee Hospitals agreed that TOP is unacceptable/ immoral to them. There is no statistically significant association between each of the items investigating belief in the three hospitals.

Table 18: Comparison of items investigating beliefs across the hospitals

	Diamant [n=40]	Embakweni [n=8]	StoffelCotzee [n=10]	P-value
My religion is against Termination of Pregnancy				**0.347**
Agree	**57.5**	**75.0**	**54.5**	
Disagree	**32.5**	**0.0**	**36.4**	
Uncertain	**10.0**	**25.0**	**9.1**	
I consider TOP unacceptable/immoral				**0.980**
Agree	**30.0**	**37.5**	**36.4**	
Disagree	**50.0**	**50.0**	**45.4**	
Uncertain	**20.0**	**12.5**	**18.2**	

Table 19 presents a comparison of items used to measure attitude towards TOP. More than 80% of the respondents from each of the three hospitals agreed that they will refer a patient seeking TOP to the appropriate service, whereas less than 30% of them agreed that they will seek a TOP in case of an unplanned pregnancy involving themselves or their families. None of the items measuring beliefs are statistically significantly associated among the hospitals.

Table 19: Comparison if items investigating attitude towards TOP across hospitals

	Diamant [n=40]	Embekweni [n=8]	StoffelCotzee [n=10]	P-value
I will refer a patient seeking Termination of pregnancy to the appropriate service				**0.529**
Agree	**85.0**	**100.0**	**100.0**	
Disagree	**5.0**	**0.0**	**0.0**	
Uncertain	**10.0**	**0.0**	**0.0**	
I will seek a Termination of Pregnancy in case of an unplanned pregnancy involving myself or my family				**0.383**
Agree	**30.0**	**25.0**	**18.2**	
Disagree	**65.0**	**50.0**	**63.6**	
Uncertain	**5.0**	**25.0**	**18.2**	

A comparison of the items investigating training of the study respondents on TOP is shown in Table 20. More than 60% of the respondents from each of the three hospitals indicated that they had no training in all the items investigating training around TOP, except for family planning methods were more than 60% were trained. None of the items investigating training of respondents are statistically significantly associated among the three hospitals.

Table 20: Comparison of training across hospitals

	Diamant [n=40]	Embekweni [n=8]	StoffelCotzee [n=10]	P-value
I have been exposed to training on CTOPA				**0.715**
Yes	**7.5**	**0.0**	**0.0**	
No	**65.0**	**75.0**	**81.8**	
Unsure	**27.5**	**25.0**	**18.2**	
I have been exposed to training on Termination of Pregnancy (TOP) related value clarification				**0.798**
Yes	**7.5**	**12.5**	**0.0**	
No	**67.5**	**62.5**	**81.8**	
Unsure	**25.0**	**25.0**	**18.2**	
I have been exposed to training on Manual Vacuum Aspiration				**0.438**
Yes	**17.5**	**12.5**	**0.0**	
No	**62.5**	**62.5**	**90.9**	
Unsure	**20.0**	**25.0**	**9.1**	
I have been exposed to training on Contraceptives (Family Planning Methods)				**0.336**
Yes	**75.0**	**87.5**	**63.6**	
No	**15.0**	**12.5**	**36.4**	
Unsure	**10.0**	**0.0**	**0.0**	
I have been exposed to training on Pharmacology of TOP				**0.792**
Yes	**7.5**	**0.0**	**9.1**	
No	**70.0**	**75.0**	**81.8**	
Unsure	**22.5**	**25.0**	**9.1**	

Availability of resources is compared across the hospitals in Table 21. More than 80% of the respondents from each of the three hospitals disagreed with the statement that they have enough doctors and nurses. Just over one third of the respondents from Embekweni, and 23% of those from Diamant hospital agreed that the service is not a priority of the hospital. Less than 45% of the respondents from each of the three hospitals agreed with the statement that "the hospital does not have enough resources to render the service". There is however, no statistically significant association between each of the items measuring availability of resources among hospitals.

Table 21: Comparison of resources across the hospitals

	Diamant [n=40]	Embekweni [n=8]	StoffelCotzee [n=10]	P-value
Hospital have enough doctors to render the service				**0.5294**
Agree	**5.0**	**0.0**	**0.0**	
Disagree	**85.0**	**100.0**	**100.0**	
Uncertain	**10.0**	**0.0**	**0.0**	
The hospital has enough nurses to render the service				**0.5570**
Agree	**5.0**	**0.0**	**0.0**	
Disagree	**80.0**	**87.5**	**100.0**	
Uncertain	**15.0**	**12.5**	**0.00**	
The service is just not a priority of the hospital				**0.5348**
Agree	**22.5**	**37.5**	**9.1**	
Disagree	**42.5**	**50.0**	**54.5**	
Uncertain	**35.0**	**12.5**	**36.4**	
The hospital does not have enough resources to render the service				**0.8702**
Agree	**43.6**	**37.5**	**36.4**	
Disagree	**38.5**	**50.0**	**54.5**	
Uncertain	**17.9**	**12.5**	**9.1**	

Table 22 is a comparison of the created knowledge, attitudes and beliefs scores. More than 60% of the respondents from each of the three hospitals were regarded as having a positive belief towards TOP, and more than 70% were regarded as having no knowledge of TOP, as well as a negative attitude towards TOP. None of these scores are statistically significantly associated among the hospitals.

Table 22: Comparison of the created knowledge, attitudes and beliefs scores across hospitals

	Diamant	Embekweni	StoffelCotzee	P-value
Belief of the participants				**0.6429**
Negative belief towards TOP	**25.0**	**37.5**	**37.4**	
Positive belief towards TOP	**75.0**	**62.5**	**62.5**	
Knowledge Score				**0.2128**
Some knowledge	**15.0**	**28.6**	**0.0**	
No knowledge	**85.0**	**71.6**	**100.0**	
Regarded attitude of participants				**0.7295**
Positive attitude	**30.0**	**25.0**	**18.2**	
Negative attitude	**70.0**	**75.0**	**81.8**	

Factors that influence negative attitude towards TOP

The factors that influenced negative attitude (created scores) towards TOP are investigated using logistic regression analysis. Attitude was selected as the outcome variable for this analysis, because it is considered very important when rendering a health care service, in particular TOP. The information is presented in the form of odds ratios, and their corresponding 95% confidence intervals. The effect of each of the 7 variables on the negative attitude towards TOP is shown in Table 23.

Female respondents were 0.34 times less likely to have a negative attitude towards TOP compared to their male counter parts. Respondents whose religion is Protestant were 4 times more likely to have a negative attitude towards TOP compared to Catholics. This difference is not statistically significant. Black respondents were almost 0.2 times less likely to have a negative attitude towards TOP compared to their white counter parts 95% confidence interval of (0.040;0.983).

Respondents regarded as having no knowledge of TOP were more likely to have a negative attitude towards it, whereas those regarded as having sufficient knowledge of the CTOPA and the procedurewere less likely to have a negative attitude towards it. Respondents from StoffelCotzee Hospital were found to be more likely to have a negative attitude towards TOP comparedto those from Embekweni Hospital. All these differences are not statistically significant.

Table 23: The effect of demographic variables on attitude to TOP

Model	Variable	Negative attitude towards TOP	Odds Ratio	Std err	95% Confidence Interval
1	Gender	Female	0.343	0.381	0.039;3.033
		Ref: Male	1		
2	Religion	Protestant	4.250	4.107	0.639;28.245
		Other	0.900	0.656	0.216,3.751
		Ref: Catholic	1		
3	Length of service	5 -10 yrs.	0.469	0.563	0.045;4.931
		More than 10 yrs.	0.227	0.256	0.025,2.062
		Ref: <5 yrs.	1		
4	Hospital	Diamant	0.778	0.689	0.1369;4.419
		StoffelCotzee	1.500	1.696	0.1636;13.749
		Ref: Embekweni	1		
5	Racial classification	Black	0.198	0.162	0.040;0.983
		Ref: White	1		
6	Created knowledge score	No knowledge	1.708	1.363	0.357;8.164
		Ref: Some knowledge	1		
7	Created belief score	Negative belief	0.267	0.219	0.053;1.333
		Ref: Positive belief	1		

The results on the effect of social and psychological support variables on the attitude towards TOP are presented in Table 24. Respondents who would not have debriefing sessions at their hospitals are almost 5 times more likely to have a negative attitude towards TOP, compared to those who would have debriefing sessions. Respondents who were not sure whether they have management support at their institution were nearly 11 times more likely to have a negative attitude towards TOP [CI 2.165; 55.246], although the confidence interval is wide, this may be due to the small sample size.

Respondents who perceived their peers as having a positive attitude towards TOP are themselves significantly less likely to have a negative attitude towards TOP[CI 0.021;0.673]. Those respondents who indicated that religion is the cause of stigma were 8 times more likely to have a negative attitude towards TOP compared to those who believe that culture is the cause of stigma[CI 1.170;54.722].

The confidence intervals are however very wide and this is attributed to the small sample size.

Table 24: The effects of social and psychological support variables on attitudes toward TOP

Variable	Negative attitude towards TOP	Odds Ratio	Std err	95% Confidence Interval
Debriefing Sessions	**None**	**4.500**	**3.720**	**0.890;22.743**
	Unsure	**6.900**	**5.606**	**1.404;33.919**
	Ref: Yes	**1**		
Perceived attitude of peers	**Positive**	**0.120**	**0.106**	**0.021;0.673**
	Not sure	**0.195**	**0.148**	**0.044;0.862**
	Ref: Negative	**1**		
Management support	**None**	**4.550**	**3.724**	**0.915;22.627**
	Not sure	**10.937**	**9.038**	**2.165;55.246**
	Ref: Yes	**1**		
Causes of stigma	**Religion**	**8.000**	**7.848**	**1.170;54.722**
	Religion & culture	**5.000**	**6.325**	**0.419;59.657**
	Ref: Culture	**1**		
Stigma	**No**	**1.111**	**0.973**	**0.200;6.181**
	Not sure	**0.778**	**0.546**	**0.197;3.076**
	Ref: Yes	**1**		

Table 25 presents the results of logistic regression models used to assess the relationship between each of the variables measuring staff training and attitude towards TOP. None of the variables used to investigate training was statistically significantly related to negative attitude towards TOP. The 95% confidence intervals the odds ratios of all the variables include 1. A strange observation from the variables measuring training of individual staff members with regard to TOP was that some respondents indicated that they are not sure whether they have been trained or not, an issue that one is expected to definitely know**.**

Table 25: The effects of training on attitude towards TOP

Variable	Negative attitude towards TOP	Odds Ratio	Std err	95% Confidence Interval
Training on CTOPA	No	1.208	1.537	0.0999;14.6170
	Unsure	2.000	2.769	0.1326;30.1624
	Ref: Yes	1		
Training on TOP	No	0.806	0.970	0.0760;8.5405
	Unsure	1.222	1.620	0.0909;16.4293
	Ref: Yes	1		
Manual Vacuum Aspiration	No	1.582	1.284	0.3223;7.7626
	Unsure	2.700	2.888	0.3317;21.9770
	Ref: Yes	1		
Family planning Methods	No	0.400	0.279	0.1017;1.5726
	Ref: Yes	1		
Pharmacology TOP	No	0.769	0.924	0.0730;8.1053
	Unsure	1.667	2.317	0.1092;25.4329
	Ref: Yes	1		

The adjusted logistic regression model is shown in Table 26. After adjusting for the other variables in the model, black respondents are still statistically significantly less likely to have a negative attitude towards TOP [CI:0.002;0.594]. Respondents whose length of service is more than ten years were significantly less likely to have a negative attitude towards TOP [0.001; 0.582] after adjusting for all the other variables in the model.

Table 26: Results of the adjusted logistic regression model

Variable	Negative attitude towards TOP	Odds Ratio	Std err	95% Confidence Interval
Belief	**No belief**	**0.675**	**0.808**	**0.065;7.046**
	Ref: Have belief	**1**		
Knowledge	**No knowledge**	**3.330**	**3.720**	**0.373;29.739**
	Ref: Have knowledge	**1**		
Racial classification	**Black**	**0.0370**	**0.052**	**0.002;0.594**
	Ref: White	**1**		
Hospital	**Diamant**	**1.230**	**1.572**	**0.100;15.076**
	StoffelCotzee	**0.847**	**1.489**	**0.027;26.537**
	Ref: Embekweni	**1**		
Length of service	**5 -10 yrs.**	**0.387**	**0.517**	**0.028;5.300**
	More than 10 yrs.	**0.027**	**0.043**	**0.001;0.582**
	Ref: <5 yrs.	**1**		
Religion	**Protestant**	**0.613**	**0.789**	**0.049;7.644**
	Other	**0.488**	**0.500**	**0.066;3.637**
	Ref: Catholic	**1**		
Gender	**Female**	**0.121**	**0.170**	**0.008;1.917**
	Ref: Male	1		

FINDINGS OF THE QUALITATIVE PART OF THE STUDY

Introduction

As already indicated this part of the study involved face to face interviews with the CEO of Diamant Hospital, and the Nursing Managers from the three District Hospitals. These lasted for 20 – 30 minutes on average, were recorded and transcribed into text.

Knowledge, attitudes, values, and believes

Generally the attitude of the management of the three hospitals towards the CTOPA was positive. Almost all managers indicated that they are willing almost desperate to render the services in their hospitals. They were all aware of the absence of the service in their District, and were of the opinion that this was a disservice to those seeking the service. In response to a question one member of management indicated that:***"Honestly I will seek a TOP in case of an unplanned pregnancy involving myself or my school going daughter"***. The rest of the respondents indicated that while they would not seek it themselves, they however***support***those seeking it, and encourages their staff to refer them to facilities rendering the service. These facilities are unfortunately in Motheo, the neighbouring District. One Nursing Manager indicated that: ***"Although my religion is opposed to termination of pregnancy, I believe my profession compels me to render the service, I will therefore support the service in this hospital, given the resources".***

Training

None of the respondents have had any form of training on the Act. They however thought that they have sufficient knowledge of the Act, although deficiencies in the knowledge could be identified during the course of the interviews. For example the knowledge in terms of infrastructure requirements was found to be suspect. They also have not been exposed to any training on value clarification. This is a weakness that needs to be addressed urgently. All respondents indicated that they were willing to support those doctors and Professional Nurses who may be willing to render the service.

This is contrary to the view of the professionals. They indicated that as part of the District Management they have decided to undertake a process of identifying Professional Nurses in all Primary Health Care services in the District who are willing to render the service and allocate them to nearby designated hospitals. The Province will be requested to provide training as soon as the Professional Nurses have been identified.

The respondents also expressed an opinion that women in the District have a right to choice as according to the ***Constitution*** of the country and the CTOPA. They agreed that they as part of the District Management feel that they deny women their legitimate right to the service, but will continue to refer them while attempting to establish the service in the District.

The general impression amongst management was that ***family planning*** services in the District were accessible and are a strong point of the District, this it was emphasised had nothing to do with the failure to implement the CTOPA in the District. None of the respondents was of the view that the service was being used as a family planning method.

Resource availability for the service

The responses to the questions with regard to availability of resources as a barrier to the implementation of the Act did not differ much from those of the quantitative part of the study. The following were identified as barriers:-

Infrastructure, equipment and consumables

- The managers indicated that the equipment for TOP was the major challenge. They did not have a budget to procure these and were hoping to be assisted by the provincial Reproductive Health Unit.
- In some instances the managers also referred to the absence of a Theatre as a barrier. This is seen as a result of ignorance with regard to the Act as the procedure does not necessarily need to be done in an operating theatre.

- They also indicated that they did not have a budget for the consumables that will be required. This gave an impression that the managers see the service as if it was not part of the Comprehensive Primary Health Care Package of services that they are expected to render. It was seen as an unfunded mandate.

Human Resources

Shortages of Professional Nurses and doctors were cited as the main barrier to the implementation of services as prescribed in the package for District Hospitals in the country. The implementation of the CTOPA was worst affected as professionals have a choice as to whether to participate or not. The stigma associated with it made the situation worse. One Nursing Manager expressed her frustration: ***"There is no way you can force a professional nurse to do TOP against their beliefs, they will simply leave and seek employment elsewhere".***

The managers indicated that because Professional Nurses and Doctors are difficult to attract and retain in rural Xhariep it is virtually impossible for them to exert any form of pressure on them to render the service for fear of losing them.

Training of staff

The training of staff was also identified as one of the major shortcomings. Managers indicated that a lot of professionals seem to prefer training on family planning rather than any form of training on the CTOPA. This is in line with the results of the quantitative study which indicated that 75% of the professionals who responded to the questionnaire have had some form of training on Family Planning, but very little had training on the CTOPA. The study could not determine when the training on Family Planning was done.

It is also important to note that although the managers felt that they have sufficient knowledge of the Act, none of them has been exposed to any form of training relating to the CTOPA or value clarification. This training is crucial if the managers are to motivate and enforce implementation of the Act in their Hospitals.

Support to those willing to render the service

All the interviewed managers indicated that they were willing to give all the support to those professionals who are willing to render the services. They however indicated that they will require a lot of support from the province due to shortages of resources that has already been addressed above.

They also indicated that once they have identified those professionals willing to implement the CTOPA, they will arrange for training, and the District Management was willing to move staff around between the Primary Health Care facilities and the District Hospitals to facilitate the implementation of the Act.

The managers were aware of the need for debriefing but considered that the provincial function. They were therefore not planning for it.

Provincial support

The general feeling was that the province was not supportive enough. The expectation was that the province should provide infrastructural support in the form of the necessary renovations, equipment as well as training. Their budgets they felt were not enough to render the service. In addition they would appreciate support in the recruitment of professionals and incentives to assist with their retention. They felt that a lot can be done to motivate those professionals who are willing to implement the Act, if ***"only the province was willing to support District Hospitals with some form of an incentive to render this service".***

Training is the only area where they felt the province provides support on as several invitations for training were received in the past. They could not send enough professionals for training due to the reluctance of professionals to attend, but also due to the shortages of professionals.

CHAPTER 5: DISCUSSION OF THE RESULTS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

INTRODUCTION

The aim of the study is to establish whether the designated hospitals in the district meet the infrastructural, material, and human resource requirements to render TOP services according to the CTOPA. To investigate the extent of the support by management, determine whether doctors and nurses who are willing to implement the Act have access to training, to determine whether peer pressure and stigma are barriers to the implementation of the Act.To determine what the knowledge, attitudes, beliefs, and practices of doctors and nurses towards the CTOPA in the District are, and lastly the study investigated if there is any psychosocial support available for those willing to participate in the implementation of the Act.

The study has both the quantitative and the qualitative aspects. The quantitative part of the study is discussed first.

Response rate

The response rate to the questionnaire was very good. This is attributable to the fact that the researcher distributed the questionnaires to the respondents and allowed them to complete them. The questionnaires were then retrieved immediately. There were some professional nurses who were on night duty at the time of data collection. Questionnaires were left for them to complete and were later collected by the researcher.

The total number of doctors at the time of data collection in the District was four. Three had left over the three months preceding the study. Three of them responded to the questionnaire. The fourth, the Chief Medical Officer was supposed to participate in the qualitative part of the study but was unfortunately on leave at the time of data collection. So were three professional nurses. The response rate was therefore 95%, which is considered to be very good for the quantitative part of the study, but the sample for the qualitative part was very small. This is acknowledged as a limitation of the study.

Discussion of the Quantitative part of the study

All three hospitals in Xhariep were included in the study and 67% of the respondents were from Diamant Hospital. Nearly 95% of the them werenursing personnel, and 86.4% were females. This is consistent with the health sector in South Africa which is female dominated.

In general the hospitals are perceived by the health care providers as not having the required infrastructure. The main infrastructural barrier to the implementation of TOP cited by the respondents was lack of equipment. This is consistent with the findings of a study conducted by Engelbrecht (2005), which states among others problems such as insufficient space, the fact that there are no theatres, and lack of privacy. Another study by Akinbohun done in Lejweleputswa District in 2005 cited the Kopano TOP Centre, the only one serving two Districts in the province as having inadequate space and beds as barriers to the implementation of the CTOPA.

Availability of human resources was also cited as a barrier to the implementation of TOP in the district. This is however a general problem in the Free State province and the rest of the country, wheredoctors and nurses are very difficult to attract and retain, especially in rural areas. The above mentioned study by Engelbrecht performed in the Free State also cites lack of staff, especially those willing to implement the CTOPA.

The study found that nearly 70% of the respondents were not exposed to training on either, CTOPA, related value clarification, Manual Vacuum Aspiration or Pharmacology of TOP. It was also found that more than 80% of the participants were regarded as having no knowledge around TOP. Therefore lack of training of health care providers maybe one of the barriersto the implementation of TOP in the district. The complexities associated with TOP should not be underestimated. It can therefore not be expected that untrained professionals implement the CTOPA. This may be as risky as unsafe backstreet abortion.

Health care providers need to be properly trained in the area where they are expected to provide the service.

The availability of Social and Psychological support to those willing to provide the service seems to be one of the least researched areas. This seems to be one of the challenges to the implementation of the CTOPA in Xhariep District. Nearly one third of the respondents felt that there was no support from management. This is a cause for concern because management support is key to successful implementation of health care services in general let alone TOP.

Negative attitude of peers/colleagues towards TOP was also cited by almost half of the respondents. Furthermore a combined score on attitudes towards TOP indicates that nearly 73% of the respondents were regarded as having a negative attitude towards TOP. This suggests that despite lack of training, attitude of staff towards TOP is also a challenge that needs to be addressed for successful implementation of TOP in this district.

This negative attitude is coupled with stigma attached to TOP. Nearly 27% of the participants are of the opinion that there is stigma attached to TOP in the district, and the source of the stigma is mainly the community or colleagues. More than half of the respondents are of the opinion that religion is the main cause of the stigma.

The attitude of health care providers towards TOP was considered the outcome of interest because implementation of health care services, TOP in particular depends on the attitude of the service provider. Perceived attitudes of peers towards TOP was statistically significantly associated with the age group of the respondents, racial classification, religion as well as the combined score measuring their attitude.

All the responses of the participants were similar across the hospitals except for perceived attitude of peers towards TOP (p=0.084) as well as what needs to be done in the hospital (p=0.049). Embekweni Hospital has the highest negative perception of the peer `s attitude to TOP compared to other hospitals, as well as the highest percentage of the respondents suggesting the need torecognize TOP as a specialty or a scarce skill.

All the demographic variables did not have a significant influence on the negative attitude towards TOP, except for blacks. Black respondents were almost 0.2 times less likely to have a negative attitude towards TOP compared to their white counter parts at 95% confidence interval of (0.040;0.983).

The above arguments are supported by the study conducted in 2006 by Morroni et al, which concluded that, the CTOPA gives women is South Africa the right to choose whether or not to have a safe abortion. As a direct results of this legislation, abortion-related morbidity and mortality have plummeted across the country. However, abortion services still remain inaccessible to many women because of stigma, provider resistance, lack of trained providers and facilities certified by the National or Provincial Departments of Health to provide abortions, especially in rural areas.

The following section discusses the qualitative part of the study.

Discussion of the Qualitative part of the study

Introduction

The sample of the qualitative part of the study was rather small. Only the CEO of Diamant Hospital and the Nursing Managers of the three hospitals were interviewed. Other members of management were not available for a variety of reasons when data was collected.

Knowledge, attitudes and values

The interviewed managers had a positive attitude towards CTOPA, and indicated that they are willing to implement the act in their hospitals. One manager indicated that she would seek the services should the need arise in her family. Those who felt that they would not make use of the services understood their obligation to make the service accessible in their hospitals.

Training

None of the managers had undergone any training on any aspect of TOP. Although managers are not directly involved in the procedure they could benefit from training on value clarification. This would strengthen their resolve to implement the Act. As the quantitative study found some of the respondents were not convinced that they would get support from their managers if they were to implement TOP. One manager indicated that it is also difficult to release professionals for training on the CTOPA, citing staff shortages in the District.

Resource availability

Both parts of the study found that resources are a major challenge. Although it could be argued that the implementation of the CTOPA was an unfunded mandate in 1997, this argument cannot be advanced in 2010, therefore this may be an indication of failure to prioritize the service as indicated by some respondents. It is important therefore to expose all role players to training especially value clarification for managers.

The challenges around human resources are real and require a national strategy to address. It will always be difficult to implement the CTOPA fully where doctors and professional nurses are as scarce as they are in Xhariep. As one nursing managers say, they can hardly persuade professionals to render the service, as doing so may be a good reason for them to leave.

Availability of required infrastructure

The CTOPA does not necessarily require TOP to be performed in a theatre, although the perception among managers and professionals seems to suggest that. Education on the Act and Manual Vacuum Aspiration in this regard will be important. It was however found that equipment may be a challenge. This needs to be addressed if the CTOPA is to be successfully implemented in the District.

Provincial Support

All the managers indicated the need for support from the province, and the indication was that this support must be in the form of equipment, with some respondents also indicating some infrastructure deficiencies. The province needs to assess the needs of the different Districts and device strategies to support them, however if implementation is to be sustainable, managers need to be committed to the service. They therefore need to be held accountable.

CONCLUSION

Generally the study findings suggest that health care workers need proper training and management support for the CTOPA to be successfully implemented in the district. Managers also need to be trained, specifically on value clarification, in order that they support implementation of the act. This will also assist them to realize that implementing the act should be a priority, as it is an important strategy for reducing maternal mortality. The absence of incentives for those implementing the CTOPA is one of the deterrents and a possible barrier. This is a national issue, which needs to be addressed at that level. Provinces have a responsibility to raise the issues at national level in order for it to receive the necessary attention.

RECOMMENDATIONS

INTRODUCTION

One of the major purposes of this study was to identify the barriers to the implementation of the CTOPA in Xhariep District, and to make recommendations to the District and the Provincial Management of the Department of Health on how to remedy the situation. It is expected that this will expedite implementation of the Act in Xhariep and the rest of the province, and improve access to the service.

The reason for the need to implement the CTOPA is to prevent deaths and complications from unsafe abortions. Procedures and techniques for early induced abortion are simple and safe, and when performed by trained health care providers with proper equipment, correct technique and sanitary standards, abortion is one of the safest medical procedures (WHO, 2003:14).

It is an undeniable fact that in South Africa women are still having illegal abortions, and many continue to die as a result.

It is also expected that the findings of this study will inform the provincial strategy on the implementation of CTOPA. The following are the recommendations:-

TRAINING AND MODIFYING ATTITUDES TOWARDS TOP

Attitudes have been found to be a major barrier to the implementation of the CTOPA, both in the community, and among health professionals. Religion and culture have been identified as among the leading causes of the negative attitudes. A lot of effort will without doubt have to be made to deal with these. This must include the following:-

Training

- Training on the CTOPA must not only be limited to Professional Nurses and Doctors who are willing to implement the Act. All Professionals must be targeted for training, and must be persuaded to attend. They must be assured that attending training does not make them party to implementation. This must particularly be the case with training on Value Clarification, conscientious objection and the implementation of the CTOPA. As indicated above this training is powerful and appealing and may influence professionals to commit themselves to implement the Act.
- According to the National Strategic Plan for the implementation of the CTOPA(2001:14) TOP training must be mainstreamed now and in the future in such a way that all health care providers in all existing clinical training Programmes receive training in TOP. This will ensure that they are better prepared to implement the act once qualified.
  Train Management on the Act, Value Clarification and conscientious objection. This must include District Managers, Hospitals CEOs, Chief Medical Officers and Nursing Managers. This will assist them to understand the need to make sure that their Hospitals and Community Health Centres implement the Act. The Provincial Reproductive Health Unit must facilitate all forms of training in partnershipwith Non-Governmental Organisations such as IPAS South Africa.
- Training must be deliberately directed towards addressing the negative attitudes towards TOP.Communities can also be targeted with health education messages that are designed to change their perceptions of TOP. This in an attempt to create a favourable societal context for the CTOPA and its implementation (National Strategic Plan for the implementation of the CTOPA, 2001:14). Value clarification is important in this regard.

Social mobilisation

With regard to Social Mobilization Hord (2001) recommends that women be informed about the CTOPA and relevant procedures. These include:-

- Circumstances under which abortion permitted.
- Which providers are authorized to perform abortion?
- Issues around parental or spousal consent.
- Whether there is a waiting period.
- Whether health care workers are allowed to charge for abortion procedures.
- Involvement of men and other people who can be barriers to women`sability to obtain safe abortion.
- Talk with men about their families and women‘s role in them. Explore what life would be like if their wives died or were incapacitated from unsafe abortion.
- Working with local religious and traditional leaders to discuss women‘s rights, health and how to achieve them. Traditional leaders have to be provided with information on the implications of unsafe abortion and its contribution to maternal mortality. Religious leaders should be made to understand that providing sexuality education on abortion would not promote promiscuity (Okonofua, 2004:73).
- Mobilising youth for advocacy.
- Making sure young women and men know how pregnancy occurs and how to prevent unwanted pregnancy and sexually transmitted infections.
- Calling for the removal of obstacles to access to and use of contraceptives, and making sure that girls know about emergency contraception.
- Involving parents in discussion about adolescent’s sexuality and unwanted pregnancy.

- Preparing for opposition as the results indicate that religion and culture are the barriers to the implementation of the CTOPA. It is therefore important to identify groups or individuals (pro-life/anti-choice) who are likely to oppose your efforts, and try to understand how they think and work. Knowing their beliefs, strategies, resources, and constituencies can help to expose their tactics, anticipate their future activities and neutralise their effectiveness (Hord, 2001:28).

YOUTH FRIENDLY SERVICES

Ngwena et al (2005:125) suggests that Youth Friendly Services are seriously lacking in the Free State and do not comply with the World Health Organizationrecommendations. It is therefore recommended that health services should seek to establish youth friendly reproductive and sexual services that are in line with the recommendations of WHO. Youth services should be made available on Saturdays, and school health services should be re-introduced in order to visit schools and provide health care including family planning to the learners.

HOLD MANAGEMENT ACCOUNTABLE FOR THE IMPLEMENTATION OF THE CTOPA

- District Management including Institutional Management must be held accountable for ensuring that their facilities implement the CTOPA, as they are held accountable for the delivery of all other Primary Health Care Services. The implementation of the CTOPA must therefore be part of the Provincial Strategic Plan, Annual Performance Plan and District Health Plans.
- This will therefore be subjected to Monitoring and Evaluation (M&E) and also form part of the Performance Agreements of all Managers in the District, including the Maternal and Child Health Directorate at provincial level.
- The implementation of the Act is the 9thRecommendation of the NCCEMD (2005 – 2007:33). The recommendation states that the number of deaths from unsafe abortion must be reduced. The NCCEMD Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa also notes that the number of deaths due abortion has increased slightly in the last triennium, while the number of terminations of pregnancy in public institutions has been declining during the triennium, as has the number of public institution performing TOP.

STRENGTHEN FAMILY PLANNING SERVICES

The results of the survey suggeststhat the District does not have sufficient resources for the implementation of the act. Family Planning will obviously reduce the need for the service while also reducing deaths due to unsafe abortion. According to the National Strategic Plan for the implementation of the CTOPA (2001:21) Empowering women to take control of their sexual and reproductive rights require accessible, appropriate contraceptive services. If contraceptive services are optimal the need for TOP will be reduced. Fortunately family planning seems to be the strength of Xhariep as a District. The District needs to build on this strength. The Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa (2005 – 2007:33) recommends that the implementation of improved contraceptive services must be incorporated into the Key Performance Areas of appropriate managers.

It needs to be noted however that strengthening family planning services (contraception) can never be a replacement for TOP. According to the WHO (2003:12) even if contraceptive users were to use methods perfectly all the time, there would still be nearly six million accidental pregnancies annually. Thus, even with high rates of contraceptive use, unwanted pregnancies will occur which women may seek to end by induced abortion.

GIVE INCENTIVES FOR DOCTORS AND PROFESSIONAL NURSES IMPLEMENTING THE CTOPA

As suggested by the respondents, doctors and nurses who are willing to implement the act deserve to be rewarded with some form of an incentive. Occupation Specific dispensation should therefore be considered as the scarce skills allowance has been done away with. The Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa (2005 – 2007:34) recommends that Occupation Specific Dispensation for TOP should be considered and negotiated with the National Department of Health.

PROVIDE APPROPRIATE INFRASTRUCTURE AND RESOURCES

- Support District Hospitals and Community Health Centres in providing the necessary infrastructure, such as the beds, and equipment such as the MVA, and others. Provinces and Districts need to form partnerships to optimize their resource base and form or strengthen partnerships to optimize resource use. Non-Governmental Organizations such as IPAS South Africa can be of a lot of assistance in this regard.
- Support efforts to create additional space to accommodate the service.
- The National Strategic Plan for the implementation of the CTOPA (2001:13) calls for the provision of adequate funding for TOP services.
- Furthermore it calls for the provision of an enabling, supportive, safe environment and infrastructure, equitable access and appropriate delivery of good quality TOP services.

DEVELOP A RECRUITMENT AND RETENTION STRATEGY FOR SCARCE SKILLS

The recruitment and retention of scarce skills is a serious challenge in Xhariep District. The current staffing levels in the District are not conducive for the implementation of the Act even if professionals were willing to implement it. This is in fact a much broader challenge that is not only restricted to Xhariep District, or the Free State province alone. All rural areas in the country are probably experiencing this challenge.

It is therefore crucial that provinces develop strategies to attract and retain scarce skills such as doctors and nurses in the rural areas. The Policy on Community Service by Health Professionals of 1996 is the first crucial step towards attracting nurses and doctors to rural areas. The policy aims at ensuring that in addition to young professionals providing services in needy areas, there is to a certain extent an equitable distribution of newly qualified doctors in underserved communities (Department of Health: A National Human Resources for Health Plan, 2006:13). Districts need to develop creative strategies to ensure that these professionals are willing to stay much longer post community service. These could include, appointing them at much higher levels, offering incentives such as free housing etc.

STRENGTHEN DISTRICT HEALTH SYSTEM

Following South Africa ‘s Democratic Elections in 1994 the National Department of Health adopted the Primary Health Care (PHC) approach and the District Health System (DHS) as an organizational framework of the country ‘s Health Care System. The DHS has since then been plagued by many challenges ranging from human to material resource constraints. The result has been the inability to render a comprehensive and integrated package of health care services.

When the CTOPA was passed by Parliament in 1996, its implementation was also to be negatively affected by the same challenges. It is therefore necessary for provinces to deliberately shift resources from a system that has essentially been curative, hospicentric and unsustainable to comprehensive PHC. Until this is done the implementation of services such as TOP and others will continue to experience resource challenges that will make it impossible to succeed. According to Hord and Xaba (2001) one of the most critical lessons learned from the South African experience is the need to prepare the health system – including individual health professionals – for a change in the law. It is believed that the slow implementation of the CTOPA thus far resulted from inadequate attention to health system issues before the Act became law.

DEFEND THE ACT THROUGH STRATEGIC PARTNERSHIPS AND ENSURING METICULOUS PRACTICE

There is no doubt that the Act is under siege from anti – choice groupings. The negative attitude towards the CTOPA among communities can mainly be attributed to these groups. The National Strategic Plan for the implementation of the CTOPA (2001:24) recommends that the Act should be defended through:-

- The development of effective legal strategies;
- Managing compliance with the stipulations of the Act;
- Maintaining strong relationships with the civil pro – choice movement;
- Promoting pro – choice health care provider initiatives; and
- Promoting reproductive choice as a fundamental human right.

LIMITATIONS OF THE STUDY

The study had a few limitations. These are discussed below:-

Sample size

The size of the sample was rather small in some District Hospitals. The breakdown was as follows:-

- Diamant Hospital 40 respondents
- Stoffel Coetzee 11, and
- Embekweni 8.

Only three of the respondents were doctors. The hospitals lost among themselves three Doctors over the period leading to the survey; one of the doctors was not available. This reduced the total of those that participated to three. All the three doctors two of them Chief Medical Officers therefore participated in the survey and none in the in depth interviews. This is due to the high turnover and the difficulties that the Hospitals experience with the retention of medical officers.

A total of 56 Professional Nurses participated as against the expected 58. Two were on leave during the data collection period. The overall response rate was however high (95%) due to the fact that the researcher presented the questionnaire to the respondents and retrieved them once completed. Embekweni Hospital had a doctor employed on sessions. He was however unavailable at the time data was collected. The sample size in StoffelCotzee (11) and Embekweni (8) has however not necessarily affected the validity of the results in anyway.

The use of the category “other” in the questionnaire

The use of the above mentioned category proved to be incorrect, as a high percentage of respondents ticked this option. This might be an indication of the fact that insufficient options were given to respondents.

CHAPTER 6 CONCLUSION

The study has revealed a significant amount of information and made a number of recommendations that if implemented must change the face of Reproductive Health Services including TOP in the Province. While a lot has been done so far with regard to TOP, the study found that access to the service in Xhariep District in particular and the province at large is still a challenge. This contributes to the high maternal mortality rate in the province. The fact that the WHO has indicated that even if family planning services were accessible, there would still be millions of unwanted and unplanned pregnancies, means that it is an abuse of the rights of women in Xhariep and throughout the province not to have access to TOP. This needs to be corrected.

It was also found that efforts to improve the quality of the TOP services, as well as access to it are not targeted and strategic. To achieve this province needs to develop a provincial strategy that will ensure that efforts are targeted and strategic. For example one of the glaring deficiencies is failure to train all professionals on the Act, Value Clarification and conscientious objection. This training as indicated has potential to change the attitude of the recipients towards the Act. The recommendations of this study are a good starting point towards achieving this objective.

The study also found that despite the fact that managers are not opposed to TOP the District is not prioritising resources for the implementation of the CTOPA. This needs to change. The Human resource aspect of TOP will almost always be a barrier to the implementation of this Act, especially in rural areas. There are also no incentives to motivate and encourage those professionals willing to implement the Act to do so. This issue needs to be attended to as it gives an impression that TOP is not a priority as other Maternal and Child Health Services.

Finally a lot of effort and time needs to be invested in changing the attitude of both staff and the communities towards the Act and TOP. It appears that not much was done when the Act was introduced to ensure that it is accepted. In order to achieve this social mobilization will without doubt need to be improved. Specific focus must be put on cultural and religious issues. It will therefore be useful to targets religious and traditional leaders in the country.

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ADDENDUM 1

SURVEY QUESTIONNARE XHARRIEP DISTRICT 2009

What are the barriers to the implementation of the Choice on Termination of Pregnancy (CTOPA) Act 92, 1996 as amended, in Xhariep District in the Free State Province? A view of doctors, nurses, and Hospital Management in three District Hospitals in Xhariep.

You are requested to take 10 to 20 minutes of your valuable time to complete this questionnaire and to return it to the researcher. Please note that participation in this Survey is voluntary and your responses are anonymous and will be treated confidentially.

1. Personal details

1.1. What is the name of your hospital (Nearest hospital in the District).

Diamant	1	Embekweni	2	Stoffel Coetzee	3

What is your age group

20 to 29 years	1	30 to 39 years	2	40 to 49 years	3	50 and above	4

What is your gender?

Male	1	Female	2

What is your race?

Black	1	White	2	Colored	3	Other	4

What is your religious denomination?

Protestant	1	Catholic	2	Other	3

What is you profession?

Medical Doctor	1	Professional Nurse	2

1.7. How long have you been in the Profession?

Less than 5 yrs	1	5 to 10 yrs	2	More than ten years	3

2. Infrastructure

2.1. Does your hospital meet infrastructural requirements in line with the CTOPA in terms of theatre, equipment and availability of beds.

Yes	1	No	2	Unsure	3

If your response to the question above is No, please indicate what the shortcomings are below:-

Theatre	1	Equipment	2	Beds	3	Other	4

3. Human Resources

How strongly do you AGREE or DISAGREE with the following statements. NB:- 1 = Strongly Agree; 2 = Agree, 3 = Uncertain, 4 = Disagree and 5 = Strongly disagree.

3.1. The Hospital has enough doctors to render the service	1	2	3	3	5
3.2. The hospital has enough nurses to render the service	1	2	3	3	5
3.3. The service is just not a priority of the hospital	1	2	3	3	5
3.4. The hospital does not have enough resources to render the service	1	2	3	3	5

4. Training

Have you or any of your colleagues been exposed to training on any of the following in your knowledge (1 = Yes; 2 = No; 3 Unsure)

4.1. CTOPA	1	2	3
4.2. Termination of Pregnancy (TOP) related value clarification	1	2	3
4.3. Manual Vacuum Aspiration	1	2	3
4.4. Contraceptives (Family Planning Methods)	1	2	3
4.5. Pharmacology of TOP	1	2	3

5. Social and Psychological Support

How much support is available to you if you were to implement the CTOPA (1 = Yes; 2 = None; 3 = Not sure).

5.1. Management support/buy in	1	2	3
5.2. Debriefing sessions	1	2	3

If you responded yes to 5.2. above, indicate who does debriefing?

Psychologist	1	Social Worker	2	Other	3

What is the attitude of your peers towards TOP?

Negative	1	Positive	2	Not sure	3

In your opinion is there stigma attached to TOP in your Hospital/District?

Yes	1	No	2	Not sure	3

If your answer to 5.5 is yes, please tell us the source of the stigma.If your response is no please proceed to 5.8

Colleagues	1	Management	2	Community	3	Other	4

In your opinion what is the cause of the stigma?

Religion	1	Culture	2	Ignorance	3	Other	4

What in your opinion needs to be done to ensure that nurses and doctors in Xhariep are willing to participate in Termination of Pregnancy/

Management support	1	Train staff	2	Recognise TOP as a scarce skill	3	Recognise TOP as a speciality	4	Provision of infrastructure, equipment and other resources	5	All of the above	6

6.Knowledge, attitudes, beliefs, and practices of Nurses and Doctors towards termination of pregnancy in Xhariep District
How strongly do you AGREE or DISAGREE with the following statements. NB:-
1 = Strongly Agree; 2 = Agree, 3 = Uncertain, 4 = Disagree and 5 = Strongly disagree.

6.1. I have sufficient knowledge about TOP	1	2	3	4	5
6.2. I consider TOP unacceptable/immoral	1	2	3	4	5
6.3.Family Planning services in Xhariep are accessible enough	1	2	3	4	5
6.4. Women in Xhariep District are entitled to choose whether to terminated unwanted pregnancies or not	1	2	3	4	5
6.5.My religion is against Termination of Pregnancy	1	2	3	4	5
6.6.I will refer a patient seeking Termination of Pregnancy to the appropriate service	1	2	3	4	5
6.7.I will seek a Termination of Pregnancy in case of an unplanned pregnancy involving myself or my family	1	2	3	4	5

7. Thank you for participating in this study. The results of the study will hopefully be used to inform policy with regard to the implementation of the Choice on Termination of Pregnancy Act 92, 1996 as amended in the District, the province and the country. The Research findings and report will be presented to the management and staff in the District and the three hospitals and will hopefully benefit the policy making process as well as improve the accessibility of the service in the province.