

SOUTH AFRICAN NURSES' ACCOUNTS FOR CHOOSING TO BE TERMINATION OF PREGNANCY PROVIDERS

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Abbreviations

TOP: Termination of Pregnancy

ABSTRACT

The South African abortion law was liberalised with the introduction of the Choice on Termination of Pregnancy Act (CTOP) (1996). This Act allows nurses and medical doctors a choice as to whether they want to be involved in the provision of termination of pregnancies (TOP). Many state nurses have chosen not to be trained. This qualitative study focused on a small grouping of nurses who did volunteer for this training. Twenty-two nurses were interviewed individually and participated in a focus group that explored how they accounted for choosing to be trained as TOP providers. Their reasons for this choice were framed broadly within a public health discourse, rights' discourse and a sociocultural discourse. A profile of the characteristics of nurses who choose to be trained was compiled. Policy recommendations for the selection and training of TOP providers are suggested with a view to strengthening the implementation of the TOP Act and widening access to TOP services.

OPSOMMING

Met die bekendstelling van die "Wet op die Keuse van die Terminasie van Swangerskap" (1996), is die Suid-Afrikaanse wet op aborsie geliberaliseer. Dié wet maak dit vir verpleegkundiges en mediese dokters moontlik om 'n keuse uit te oefen ten opsigte van betrokkenheid by die voorsiening van swangerskapsterminasiedienste. Baie staatsverpleegkundiges verkies om nie opgelei te word in dié verband nie. Hierdie kwalitatiewe studie fokus op 'n klein groepie verpleegkundiges wat hulleself vir hierdie opleiding aangemeld het. Individuele onderhoude is met twee-en-twintig verpleegkundiges gevoer en hulle het aan 'n fokusgroep deelgeneem om ondersoek in te stel oor wat hierdie verpleegkundiges gemotiveer het as voorsieners van swangerskapsterminasie dienste opgelei te word. Die redes wat aangevoer is vir hierdie keuse val binne die raamwerk van 'n publieke gesondheidsdiskoers, diskoers van regte asook 'n sosio-kulturele diskoers. 'n Profiel van die eienskappe van dié verpleegkundiges is saamgestel. Beleidsvoorstelle vir die indiensneming, seleksie en opleiding van voorsieners van swangerskapsterminasiedienste is aangebied met die doel om die implementering van die "Wet op die Keuse van Terminasie van Swangerskap" te versterk en die toegang tot swangerskapsterminasiedienste uit te brei.

INTRODUCTION AND BACKGROUND

In February 1997 the Choice on Termination of Pregnancy Act (CTOP) (1996) was introduced in South Africa, thereby replacing those sections of the previous Abortion and Sterilisation Act (1975) pertaining to legal abortions. The new Act was passed to reduce and ultimately eradicate the burden of morbidity and mortality resulting from unsafe abortion, and to enable women to exercise their sexual and reproductive (and hence human) rights. One of the most significant advances in the definition and understanding of human rights has been the recognition of health (and sexual and reproductive) rights as human rights (Hord & Xaba, 2001:16).

The Choice on Termination of Pregnancy Act (CTOP) of 1996 substantially liberalised the abortion law, permitting the termination of a pregnancy by a registered midwife trained in abortion care up to 12 weeks after conception. This service is offered on the basis of the woman's choice. Under the previous Act, abortion was only available to women for very specific reasons or in special circumstances, for example, in cases of rape or incest; where there was a substantial risk that the continued pregnancy would pose a threat to the health of the mother or child; or where the child would be severely mentally or physically disabled. The previous Act did not accommodate the many women who found themselves with an unwanted pregnancy. Under the new Act, the above-mentioned restrictions on TOP apply only to pregnancies from the 13th to the 20th week of pregnancy. Under these circumstances only a medical doctor may perform a TOP. After the 20th week of pregnancy, abortion is permitted in only very limited circumstances.

The new CTOP Act has therefore broadened the scope of practice of the professional nurse to include termination of pregnancies up to 12 weeks if the nurse is a registered midwife trained in abortion care. Because nurses form the backbone of the country's health system, the successful implementation of the CTOP Act is critically dependent on increasing the availability of trained TOP midwives to ensure the provision of services at designated facilities (Varkey & Fonn, 2000:6). These authors further emphasise the decentralisation of these services to primary health care level.

Health authorities throughout the country have had difficulty in implementing the new Act because health care providers, and nurses in particular, have been reluctant to be trained as TOP providers. After the implementation of the Act, various organisations such as the Planned Parenthood Association of South Africa, the Reproductive Health Research Unit and the Reproductive Rights Alliance conducted values clarification workshops aimed at educating health care workers about the provisions of the new Act, and encouraging them to approach termination of pregnancy in a non-judgemental way. These workshops were attended by over 4000 health care providers (Andrews, 2001:4). However, by 2000 only 90 midwives countrywide had completed the theoretical training. Of these 90 midwives, 45 went on to complete the clinical training and only 31 became actively involved in the provision of abortion services (Varkey & Fonn, 2000:6). The result was that by the end of 2001, less than 50% of designated facilities were providing a TOP service, due mainly to the lack of trained providers (Andrews, 2001:4).

This is hardly surprising if one considers the broader societal and professional context. Andrews (1999:191-210) asserts that nurses' resistance to change and their conservatism can be largely attributed to the education and socialisation process in nursing, as well as the gendered nature of the profession itself. A number of studies have highlighted the "conservative" views held by most nurses. For example, in a study conducted in 1996 in KwaZulu-Natal, only six percent of nurses interviewed believed that women should be able to obtain an abortion on request (Harrison, Montgomery, Lurie & Wilkinson, 1996:424). Walker (1996:43) also reports that, of a sample of 27 nurses at Chris Hani Baragwanath Hospital in Soweto, 70% were against termination as it contradicted their notions of motherhood, womanhood and nursing.

Nurses are not unique in their resistance to the legalisation of abortion. Tancred (1997:34) reports that 25% of medical doctors at Chris Hani Baragwanath Hospital refuse to perform abortions. According to an opinion survey conducted amongst medical doctors at institutions where terminations of pregnancy are conducted, 25% of the participants reported that they would not terminate a pregnancy, and neither would they refer the woman to another doctor. Fourteen percent of the respondents were even opposed to render-

ing a service to an abortion patient in the case of a medical emergency.

This situation is not unique to South Africa. In the United States, where until recently only medical doctors were allowed to terminate a pregnancy, there is a serious shortage of abortion providers (McKee & Adams, 1994:300). At a symposium held to determine why physicians are unwilling to participate in terminations, it was concluded that "social stigma, professional isolation, peer pressure, inadequate economic and other incentives, anti-abortion harassment, violence, and the perception of abortion as an unrewarding field of medicine all adversely affect physicians' willingness to participate" (McKee & Adams, 1994:301). The symposium suggested that midwives and other midlevel health personnel be trained to conduct terminations, despite there being "no known studies of nurse-midwives' attitudes towards the performance of abortion" (McKee & Adams, 1994:300).

As far as the authors could determine, there are no studies that look specifically at why nurses choose to be trained in conducting terminations. Varkey and Fonn (2000:2) reviewed 86 research studies relating to the Termination of Pregnancy Act in South Africa. Not one of these studies focussed specifically on what motivates a nurse to be trained as a TOP provider. The published research by Gmeiner, Van Wyk, Poggenpoel and Myburgh (2000), which explored support for nurses directly involved with termination of pregnancy, was the only research that we felt directly complemented the research presently being discussed. Although their aim was not to explore why women chose to be TOP providers, these authors state "many of these nurses intellectualised and rationalised their experiences regarding their involvement in termination of pregnancy" (Gmeiner *et al.* 2000:76). This statement further points to the need for a study focussing specifically on why nurses choose to be TOP providers.

This resistance towards their work that TOP midwives face also manifests in their home communities. Given the patriarchal nature of society and the general lack of awareness of women's rights and human rights, many communities do not support women's right to choice (Varkey & Fonn, 2000:12). Nurses are traditionally held in high esteem in communities, but ac-

ording to Walker (1996:45) the hostility towards nurses who choose to provide a TOP service may result in the loss of this status. Because of the way in which termination is viewed, nurses' choice to work in this field has the potential to alienate them from both their communities and their colleagues. The decision to be trained as a TOP provider thus has major consequences for the nurse.

The above discussion suggests that nurses who choose to be trained are unique when compared to the broader population of professional nurses. The following research objectives are thus an outflow of the issues sketched in the previous sections.

RESEARCH OBJECTIVES

The objectives of the study were to:

- investigate how TOP nurses account for their decision to be trained as providers (what motivates nurses to undertake TOP training);
- compile a profile of the characteristics and/or beliefs held by nurses who choose to become TOP providers; and
- make recommendations to health policy makers and training institutions for training strategies of potential TOP providers (since this is not a main aim of the study only very tentative suggestions are made).

An inherent objective of the research was to give this particular group of women a voice regarding a crucial aspect of their personal and professional identity.

Research design

The study was based within a qualitative, feminist, social constructionist paradigm. The aim was to explore, describe and contextualise the experiences of women who provide termination of pregnancy services in South African state hospitals. Qualitative research is interactive and subjective and attempts to both describe and give meaning to life experiences. In keeping with the aims of qualitative research, we wished to understand the social, personal and political context in which the participants operated (Burns & Grove, 1997:27). As feminist researchers we do not believe in value-free research. The data collection process is thus not seen as value free and neutral but

relies on valuing the experiences of participants, and rejects an indifferent, disinterested, alienated attitude towards them. The research process is also concerned with the meanings that participants attach to experiences, and recognises the links and complexity between knowledge and the social context.

METHOD

Participants

The participants consisted of 22 TOP providers at state hospitals who had been working as nurses for ten years or more. Some of the participants were recruited at a workshop for TOP providers while others were recruited directly from state hospitals. In keeping with ethical procedures, all the participants were informed of the research objectives, were assured of confidentiality and anonymity, and gave written consent to be interviewed. They were also told that they were free to withdraw from the study at any stage if they so desired. It was reasoned that certain emotional issues may arise as a result of the interview and that a referral to a professional may be deemed necessary. The nurses were therefore given a list of telephone numbers from the membership list of the Psychological Association of South Africa (PSYSSA) as a resource. The researchers felt that it would be unethical to provide participants with the contact numbers of individual psychologists, as one of the researchers is a psychologist; and from an ethical point of view it might be seen as a conflict of interest. The researchers also undertook to destroy taped interviews once they had been transcribed. The participants were all Black women (that is African and Coloured) who worked in state hospitals in four provinces of South Africa.

Data collection instruments and procedure

The data were gathered by means of a single focus group consisting of six persons and 16 individual interviews. Initially the researchers intended to conduct a number of focus groups as one of the primary advantages of this method provides "the chance to observe participants engaging in interaction that is concentrated on attitudes and experiences which are of interest to the researcher" (Morgan & Spanish, 1984:259). Another advantage of focus groups, as Potgieter (1997:122) points out, is that they "minimise

the researchers' influence on the participants". However, many potential participants who were contacted were not willing to be part of a focus group. They cited issues of confidentiality as the main reason for their unwillingness. While the research was in progress, the researchers were informed that a group of TOP providers who were attending a training workshop would be willing to participate in a focus group. The focus group thus took place at the training workshop. It is noteworthy that the researchers experienced considerable difficulty in recruiting participants. Many TOP providers were not prepared to be part of a research study as they feared further victimisation and could not be convinced otherwise. The sample is thus a convenient one in the sense that recruitment depended on volunteers who responded to the various calls for research participants.

The focus group and the individual interviews were recorded and transcribed verbatim. Due to the concern about confidentiality and anonymity, the researchers agreed to discard the planned biographical questionnaire, and participants merely indicated their length of service. After discussion with the participants, the researchers further agreed not to mention the provinces from which the participants hailed, as the latter were concerned that to do so might compromise confidentiality. The data were gathered by means of a semi-structured interview schedule. A list of open-ended questions was drawn up in order to provide starting points for the interview conversation. The questions asked were informed by the literature and the aims of the study. This procedure also allows for additional information or questions to be brought into focus if necessary (Charmaz, 1990:1162). Open-ended questions further encouraged a freedom of flow in the interviews, enabling participants to talk readily about their experiences. The researchers drew up a fairly detailed interview schedule that covered all the key issues identified, although it was used rather as a guideline and was generally referred to when the individual and focus group interviews required focus and direction. Examples of some of these questions are: "Tell me what led you to choosing to be trained as a TOP provider?" and "Why you think it is necessary to be trained as a provider?" The schedule was treated flexibly since rigid adherence to a schedule could be intimidating for participants and it could also fail to keep track with participants' associations and points of view

(Burman, 1994:54). Despite not being adhered to rigidly, the interview schedule was nonetheless helpful in that it allowed for a focussed and facilitated discussion, or what has previously been termed a “directed conversation” (Charmaz, 1990:1167).

As the research assistant was trained in interviewing skills and could understand all the languages spoken by the participants, they were free to use their language of choice. Interestingly, participants chose to speak English as they felt that it would be much easier for them to express their feelings in this language. One person said: “*We mostly speak about our work in English. Why, I have never thought about why*”. One participant mentioned that English was the common language amongst them (in the hospital). Potgieter (1997:126) notes that people may choose to speak a language other than their first language when discussing issues that are “secret” or of a sensitive nature.

The issue of validity is often questioned when doing qualitative research. Researchers have suggested various ways for ensuring validity in qualitative research. Some of the suggestions adhered to in the present research included applying Silverman’s principle of the constant comparative method and comprehensive data treatment (Silverman, 2000:179-180). The constant comparative method means “immersing” oneself repeatedly in different aspects of the data and then inspecting and analysing all parts. Inspecting, analysing and essentially engaging with the data in its totality leads to what is called comprehensive data treatment. Interestingly, the first author (Potgieter) has observed that whenever she has conducted research related to women’s sexuality, the validity of the research was questioned.

In terms of reliability, as feminist researchers who are working within a qualitative paradigm, the researchers do not claim that the work is perfectly replicable. Although it is possible to repeat the work they have conducted, the new piece of work would also be different because the researchers might change, the informants would change and the meanings of the research tool would also change. This study therefore does not aim to be absolutely replicable. Rather, specificity as opposed to replication is adopted as the aim (Parker, 1994:11).

Data analysis

The recorded data were transcribed verbatim. The data were analysed utilising techniques of constructionist grounded theory (Charmaz, 1990:1162). The grounded theory approach is useful when addressing sensitive issues such as abortion. As suggested by Charmaz (1990:1162), the researchers followed leads and interests that they identified in the collected data during the collection, analysis and writing up process.

The researchers undertook line-by-line coding of all the transcripts. From this, a large number of initial codes emerged. Charmaz (1990:1168) points out that line-by-line coding assists researchers to view the familiar through a new lens, whilst still remaining close to the data. The second step entailed identifying continually reappearing codes. The codes that made the most analytic sense were then selected and categorised more appropriately. The codes were then raised to the level of categories. The categories were transferred to a coding guideline according to discourses (themes). The discourses, which dealt with why the participants had chosen to be trained as TOP providers, were organised into a public health discourse, rights discourse and a sociocultural discourse. Quotations that were deemed to provide insight into the theme/discourse were selected. Both researchers checked the quotations to ensure that they accurately reflected the relevant discourse.

RESULTS AND DISCUSSION

The results of the research are reported and discussed below in terms of the discourses that emerged.

Public health discourse

Many participants indicated that they had chosen to be trained as TOP providers as they felt that facilitating access to safe terminations would reduce the number of backstreet abortions. The participants were not only well-informed of the high mortality and morbidity of unsafe abortions, but many of them personally knew or knew of women in their communities who had borne the consequences of an unwanted pregnancy. The following verbatim excerpts shed light on their positions: “...*Then I realised that now it was a need for us*

to render this service because the statistics which was given of the clients who died because of backstreet abortion was quite high". "I have a sister who went through the backstreet way for help ...my sister is infertile as result.... and two of my and her friends died". "I saw very young girls dying due to septicaemia... due to this incomplete abortion.... if only they could had a hospital to go to".

The above sentiments reflect the public health discourse on the importance and necessity of the participants' role as lifesavers. In offering this service, these nurses see themselves as preventing deaths due to terminations in unsafe circumstances. This discourse is supported by national and international research. Prior to the introduction of the CTOP Act, research on unsafe abortion in South Africa indicates that approximately 425 women died each year in public hospitals as a result of the complications of unsafe abortion (Rees, Katzenellenbogen, Shabodien, Jewkes, Fawcus, McIntyre, Lombard, Truter & The National Incomplete Abortion Reference Group, 1997:432-437). The same research reveals that large numbers of women (44 686 women per year) were treated for complications from incomplete abortions. By choosing to be trained as TOP service providers, nurses help to reduce mortality and morbidity from unsafe abortion. The participants thus validate one of the fundamental reasons for reviewing the criminalisation of abortion (that is, a public health rationale with an epidemiological focus).

A dominant theme that emerged from the interviews is that *"no woman can be blamed for a pregnancy"* and that *"contraception fails"*. This is very different from the anti-termination argument, which generally blames women for unplanned pregnancies and argues that they could have prevented the pregnancy.

The participants also argued that South African women have new public health rights and that they (the TOP providers) were providing access to these rights. The post-1994 public health discourse is one of rights and transformation. Theorists such as Gergen (1989:70) have debated the issue of which or whose discourse becomes entrenched in society. According to Gergen (1989:70), all groups are motivated by the desire to have their version of events heard or, to use Gergen's terminology, all groups warrant voice. However, some

discourses seem to warrant more voice than others because groups that hold powerful positions have both the authority and the resources to legitimise their discourses.

In the light of the strong human rights public health discourse that emerged in the data, it could be argued that the National Health Department's justification for new laws has been driven by a rights discourse, which these participants have internalised. Interestingly, nurses who choose not to be trained use the argument *"that it is their right"* – an argument that reflects the same strong rights discourse that has emerged amongst South Africans.

This rights discourse constitutes a separately identifiable discourse, and as such will be discussed in further detail below. This discourse is divided into three categories, namely, human rights; personal and gender rights; and citizen rights and duties.

Human rights discourse

Many of the participants couched their reasons for being trained within a human rights discourse. A strong argument emerged that a woman's right to a termination was a human right. The participants' choice to conduct the procedure was seen as an attempt to assist women in accessing one of their fundamental *"human rights"*.

"I worked in family planning during the old apartheid days. Many women took contraception but sometimes it failed... many of these women had unplanned children which ended up as street children or they had backstreet abortions, or tried to do the abortion themselves.... Many died. ... Then the right to safe termination was made legal. I decided to train as it would contribute to women having a choice, when contraceptives fail... and it would mean that only wanted children are brought into this world.... by training I was helping to provide a better life for women and their children. I was helping her access her right as a human being". "I chose to train because I believe that women should have the right to choice, choice from dying. Nobody told me to think this way... the things I have seen made me think this way".

It is interesting to note (as the latter quote indicates)

that the participants who justify their decision to be trained from a human rights perspective are pro-choice as a result of practical and personal experiences. This differs from the international situation where many pro-choice activists have chosen this position as a result of being exposed to feminist theory or women's rights movements. This does not seem to be the case with the participants in the current study. Their decisions seem to have been influenced by practice rather than theory. One participant said: *"I have not read books about my choice – although many people have said I am reading the books that are read by women's libbers"*.

Personal and gender rights discourse

The general human rights argument in the participants' responses was at times translated into a personal or women's rights discourse. This again reflects a dominant South African discourse in which recent campaigns have argued that women's rights are human rights. Many of the participants reasoned that they were providing women with choices and opportunities that they personally did not have access to because of the stringent laws in the past. *".... the stress that I had for falling pregnant while studying, it was terrible. If this service was available I would have been given a second chance. I would have made use of it if it was available. So, I have to allow other women to further their studies and meet their goals... Women need to be empowered". "I fell pregnant when I was still studying, that I could not complete. Unfortunately I did not have this right available to me"*.

The participants felt that by assisting in the procedure they were, in a sense, *"helping women achieve their goals as women as a group and obviously as individuals"*.

Although the participants at times made it clear that they were not comfortable with the description of themselves as "feminist", their arguments nonetheless represent a feminist position. Being uncomfortable with the term "feminist" while in fact engaging in acts of "feminism" is not unique to this group of South African women.

Citizens' rights and duties discourse

Many of the participants said that they supported the policies of the post-apartheid South African government and felt that *"because we have all these new rights under the new constitution these rights mean that we have duties as citizens"*.

Generally the participants who argued very strongly from a human rights perspective were the ones who raised the issue of their duties as citizens. The following reflects this sentiment: *"One of the reasons I chose to be trained is that this means I am implementing a policy of the government which I fought for and voted for and now we have duties as citizens to implement the policies"*.

The pro-choice position of the participants can be interpreted in the light of what has recently been labelled as citizenship literature. Higgins (1999:286) argues that "the sense of full citizenship – enjoying the formal status and substantive effects of civil, political and social rights as equal members of the community" is a contributing variable for citizen participation in health reform.

It is argued that the notion and recognition of sexual rights rewrite the rights discourse. It redefines the relationship between public and private life because a woman's sexual rights break through the borders of patriarchal citizenry. A woman's control over her body becomes a fundamental human right. This strong argument of the duties of citizens could be explored in ongoing training to encourage midwives to be trained as TOP providers.

Sociocultural discourse

The participants took time to point out that performing terminations was not against either their culture or religion. *"Actually one of the reasons for being a TOP provider is that my culture has always had TOP providers although they were not called TOP providers"*.

Many participants pointed out that for years, women in African societies have used herbs and other traditional medicine to terminate unwanted pregnancies. The participants were aware of women in their communities who could be approached for these herbs. However, in recent times many of these older women

have died and the knowledge has not been passed to younger generations. This concurs with Bradford's (1991:121) assertion that terminating pregnancies has been "a South African way of life for a large part of the last 150 years". One participant said: "*Culture changes.... Before we used the traditional medicine to help women; now we use the modern way*".

The role of religion was also a topic that warranted much discussion. All the participants identified themselves as practising Christians and argued along the lines that providing access to a safe termination was what God would have wanted them to do. Some of the participants pointed out that religion could be interpreted in many ways. They argued that God would bless them as they were helping women in need. One participant claimed: "*If one takes the role that Jesus played in assisting the needy then I cannot see how my assisting needy women goes against the Bible as some want us to believe*".

Some of the participants also stated that certain ministers in their communities supported their stance. "*My minister says it is okay what I am doing as our God is a just, practical God*".

Opposition to abortion has often been dominated by religious arguments. It is therefore interesting that the participants in this study challenged the dominant religious teachings without rejecting the religion per se. MacDonnell's (1987:15) notion that power and resistance always operate together is extremely relevant here. As Reboul (*in* Duncan 1993:57) appropriately comments, "An oppressed class has within its means to appropriate the oppressor's discourse or even to 'valorise' its own discourse (so as to oppose the oppressor's discourse)". Certain discourses, it is argued, are generated to challenge the discourses of the dominant grouping. In terms of this study, it may be argued that the church's anti-abortion teachings are dominant, although the dominant religious discourses are both accepted and challenged. Hence some people would adopt an anti-termination stance because of religious convictions and another group would challenge the religious interpretations and reinterpret these without rejecting the religion itself. Again it should be noted that the discourses on which the participants drew positioned them as still being adherents to their culture and religion, thus countering the discourse

which "othered" them as outsiders and "bad" women. It seems clear, therefore, that discourses are ideologically positioned and that they are never neutral (Macdonnell, 1987:33). Discourses can also be labelled as "action oriented" in the sense that they always occur in relation to other discourses (Macdonnell, 1987:33).

PROFILE OF TOP WORKERS

The following table (Table 1) was compiled from the results of the interviews and focus group. The researchers emphasise the point that the profiles of the participants who chose to be trained were drawn from the discourses which accounted for their choice. The profile should therefore be construed as an attempt to highlight some of the issues that could be considered when designing training programmes for potential providers. It should thus not be seen as "final" or even "scientific" in the classical sense but merely as training "tool". It should be clear to the reader that the "profile" could be extended if the discourses are further analysed.

CONCLUDING REMARKS AND RECOMMENDATIONS

The discourses indicate that nurses (participants) who choose to be trained as TOP providers have a clear understanding of mortality and morbidity as a result of backstreet abortions. They argue that the 1975 Act prevented women from accessing their human rights: the Act forced women to resort to unsafe backstreet abortions and thus prevented access to safe health care, which is a basic human right.

It is therefore recommended that all nurses receive ongoing training and information to make them aware of women's plight under the previous Act. Although this has proved useful with nurses who choose to be trained in TOP, the researchers question its value in recruiting potential trainees, as making such workshops compulsory might create resistance in nurses who might see this as an attempt to brainwash them into being trained. Rather, compulsory ongoing training and education should be a requirement for all nurses in order to maintain their registration. This compulsory training might include aspects of reproductive

Table 1: Profile of TOP providers

1.	Knowledgeable about the impact of unsafe abortion on women's mortality and morbidity.
2.	Hold non-judgemental attitudes towards TOP.
3.	Believe it is a woman's right and a public health right to have access to TOP.
4.	Have a flexible and wide interpretation of religion and culture.
5.	Have a good sense of their role as active citizens; simultaneously aware of both their rights and duties or obligations.
6.	Recognise that the personal is political, view a woman's right to control her body as a fundamental human right.
7.	Feel supported by their community leaders and priests and challenge conventional and static interpretations of religion and culture.

health epidemiology, in particular the epidemiology of unsafe abortion. This ongoing training, as well as the curriculum at nursing colleges and universities, should aim to expose nurses to new information that would encourage a liberal attitude toward TOP.

The data also suggest that the participants tended to have been involved in anti-apartheid activities. These participants argued that rights did not extend to equality in terms of race only. Since it is mostly poor black women who require terminations from state hospitals, the participants believed that their actions in fact helped to reduce racial inequity by providing access to services for this group of women. Ongoing training, as well as the contents of nursing curricula of universities and nursing colleges, should emphasise the importance of supporting poor black women in obtaining access to safe health care in a post-apartheid South Africa.

The participants who were trained were also largely non-judgemental. They argued that they did not make value judgements but attempted to provide a safe service, which was the woman's right. This is a very important point. It is possible that if such a value were entrenched in nurses' training, it could possibly increase the willingness to provide health care services

irrespective of the kind of service requested.

Many nurses who are anti-termination and who choose not to be trained argue that abortion is against their religious beliefs (Hord & Xaba, 2001:16). However, the trained group all stated that they practised the Christian faith and that they did not see their work as being "unchristian". They argued that God is just and that God advocates human rights. This rendered their work acceptable from a Christian human rights perspective. Including this line of argument in training courses may expose nurses to a different interpretation of their religion and encourage them to re-evaluate their position. Ministers, academic theologians and other respected religious leaders who support termination could assist in imparting the alternative message.

Accepted community and societal norms are often used as a reason to oppose termination (Harrison, Montgomery, Lurie & Wilkinson, 2000:428). This discourages nurses from undergoing TOP training. In training programmes, trainers could draw on the participants' arguments that controlling fertility and performing terminations through the use of herbs have always been an acceptable part of African culture. In this study, the participants felt that because society has

changed, it is acceptable to use more mainstream medical approaches to further this practice. This argument may encourage attitude change through the mechanism of cognitive dissonance, which is an unpleasant feeling resulting from inconsistency between one's thoughts and/or actions (Baron & Byrne, 1987:119). In teaching a course in feminist health psychology to postgraduate nurses, the first author (Potgieter) found that many of those who were anti-termination at the beginning of the course changed their attitudes when they were exposed to alternative arguments. The work of Helen Bradford (1991:120-143) was particularly useful in making them aware of the history of abortion in African societies.

The trained providers also had the support of community leaders like priests and teachers. The Department of Health could draw on supportive community persons to assist in educating hostile community members. Many persons choose not to be trained because of negative community attitudes and many exit the TOP service after being trained partly as a result of community attitudes. The ongoing training advocated here should therefore be compulsory - not only for nurses, but also for clerks, managers and community members, as both TOP providers and the women seeking such services face resistance from various parties.

It is generally accepted that people's attitudes about certain issues may change as a result of personal experiences such as interacting with others who hold different opinions (Baron & Byrne, 1987:119). Providing a non-threatening environment in which different opinions on the subject may be shared is one way in which hospitals and other health care organisations could address this issue. In terms of the current findings, the Department of Health and individual hospitals could thus provide opportunities for dialogue in which those who hold different opinions on the issue share their viewpoints and experiences in a non-threatening environment.

A further focus of the recommended ongoing training should be the impact of public health programmes and policy on human rights (especially as these apply to women). By engendering the recognition of health (and sexual and reproductive health) as a human right within a public health discourse, it is hoped

that potential providers would be willing to undergo training that would in effect make the implementation of the CTOP Act of 1996 a reality in South African public health services.

Further research is needed to monitor and evaluate the impact of the CTOP Act on morbidity and mortality. This could serve two purposes: to keep TOP nurses motivated and committed to their choice of work, and to arm them with information to help counter resistance by colleagues and communities. Demonstrating a reduction in deaths as well as reduced morbidity will hopefully contribute to changing attitudes towards TOP.

Currently no strategies are in place to significantly increase the pool of trained providers and to make the new termination laws a reality for South African women who are dependent of state health services. This essentially means that women are denied a choice regarding their reproductive health. The insights gained in this research could possibly be piloted in an attempt to address the needs of the carer (TOP providers) as well as those in need of care (women seeking terminations).

One of the shortcomings of this research is that it did not include all provinces and the range of state institutions represented was thus limited. It is suggested that a national study be conducted. The recommendations made here are therefore tentative and exploratory and the authors would argue therefore that certain of these recommendations should be piloted and evaluated in training courses.

This study can thus be seen as the beginning of further studies. The authors believe that there is still a long road to be travelled before the majority of South African women have the power to make decisions regarding issues of reproduction. However, when working in the area of women's health, one must keep in mind that: "it is important to acknowledge when progress is made while at the same time not losing sight of the distance we still have to travel" (Lister, 1997:203). The following statement by Mama (1995:159) captures the authors' sentiment regarding this research: "How does one end the beginning of something... at the very heart of the approach advocated here is a feeling of perpetual change and movement... This is not a story ending

with all capillaries cauterised and stitched with surgical precision, but one, which makes a small opening through which it is hope new ideas and arguments may flow”.

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