NURSES EXPERIENCES OF ABORTION:

AN EXPLORATORY STUDY OF NURSES EXPERIENCES IN ASSISTING WITH TERMINATION OF PREGNANCY IN SOUTH AFRICA AND ZAMBIA.

BY

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DECLARATION

The author hereby declares that this thesis, unless specifically indicated to the contrary in the text, is her own original work and that it has not been submitted for a degree at any other university.

Signed:.....

Date:.....

DEDICATION.

This thesis is dedicated to my four lovely children Lusungu, Wezi, Rumbani and Grace and my wonderful husband Masauso for their love and care and for supporting me while at school.

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ABSTRACT

The legislation of abortion in many countries, allowing women the right to decide to terminate pregnancy, has introduced an unfamiliar situation to the medical professionals, especially nurses and doctors who are the implementers of the legislation.

This qualitative study was designed to gain insight into the experiences of nurses who assist in termination of pregnancy (TOP) and explore recommendations based on these experiences. A thematic analysis was utilised based on in-depth interviews using a general guide approach with eight nurses working in TOP units and gynaecology wards where abortion takes place from Cape Town in South Africa and Lusaka Zambia.

It emerged that though willing to assist in TOP, all the nurses did not completely support abortion except for special reasons, mainly medical. The nurses are negatively affected by abortion procedure especially the site of the fetus and fetal parts. Some of them get very distressed by the procedure and it will affect the rest of their day. All the nurses were more sympathetic towards the woman who has had spontaneous abortion or miscarriage than a woman who has demanded abortion for social reasons. The nurses confessed that their care was biassed.

However lack of counselling and emotional support emerged to be one of the main reasons why nurses attitudes were either judgmental or conservative. None of the

nurses in the study (except one) has ever received any form of counselling or support. They confirmed that there is no readily available counsellor or nurse specialist to assist them through their experiences. Their lack of confidence in dealing with the aborting woman is displayed in their negative or conservative attitudes towards the client, so they just perform their duty but have nothing to do with the patient. Recommendations for improvements and establishment of support groups for nurses in order for them to improve client care is based upon these findings. TOP nurses need to be encouraged by their supervisors and allowed to verbalise their feelings and emotions in order for them to cope with the abortion stress. Thus the findings of the study accentuate the need for counselling interventions designed to assist the nurses express their feelings and emotions about their abortion experiences.

KEY WORDS: Abortion, Psycho-social, Stress, Experience, Attitudes, Nurses, Legislation, Conscience, Counselling, Support.

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CHAPTER ONE

1-0 INTRODUCTION

Abortion has been the most debated issue in the history of medicine in the recent past. Despite the legality of abortion in many countries, questions of its ethical and legal acceptability continue to be widely debated. It is an issue, which has not been easily accepted among health personnel especially, doctors and nurses. Both previous and recent studies have suggested that many nurses and doctors have rejected to participate in termination of pregnancy (TOP) (Poggenpoel, Myburgh and Gmeiner, 1998 and Walker, 1993).

1-1_ BACK GROUND TO THE STUDY

Termination of pregnancy (TOP), otherwise commonly referred to as 'abortion' may be defined as the intentional ending of pregnancy, through the evacuation of the uterus, before the fetus has a reasonable chance of survival (Marshal, Gould and Roberts, 1994). Although universally practiced, no other elective procedure has created such controversy and public debate as has abortion (David, 1992). Hardly a week passes without a national newspaper story about abortion in most countries, and it arouses passions like few other subjects (Moore, 1997). But while, for much of the public, the debate might be academic and divorced from their everyday lives, for nurses, midwives and other health personnel it is the real issue. Abortion is one of the issues in the area of health care that create such conflict between the personal moral demands and the legal professional demands for nurses and other health workers (Haffajee, 1997).

Before the abortion laws were passed, nurses were on the front line often caring for women suffering the horrific effects of back street abortions (Moore, 1997). In South Africa the former legislation, the Abortion and Sterilization Act of 1975, excluded the majority of women from seeking legal abortion. It forced many women to seek 'back street' or illegal abortions. It was estimated that some 200,000 to 300,000 illegal abortions took place in South Africa each year (Suffla, 1996).

Many countries have either legalized or liberalized the abortion laws due to high number of maternal deaths attributable to abortion. For example in Zambia the percentage of gynecological admissions attributable to abortion complications were up to 77% in one hospital (Zambia Health Information Digest, 1997). In a monograph study done in Malawi, Uganda and Zambia, an annual logbook estimate the number of cases of abortion complications at the major teaching hospitals in each of the three countries in 1997 to be approximately 2300 in Malawi, 700 in Uganda and 3200 in Zambia. Many countries are either legalizing or liberalizing abortion to enhance the health and quality of life for the women. If the woman is of the opinion that her pregnancy is an obstacle to her health and quality of life, she may request abortion. The new law in South Africa, the Choice of Termination of Pregnancy Act, 1996 (Act no. 92 of 1996), creates a context where back street abortions can be prevented. It allows a woman to terminate her pregnancy without the consent of her partner. Even a minor can terminate her pregnancy without the consent of her parents or guardian. These changes have brought different feelings in different nurses, midwives and other health workers. While politicians may pass abortion

legislation, the attitudes of health professionals are a key part of the effective implementation of such legislation (Haffajee, 1997).

In Britain many nurses were relieved when the Abortion Act was passed, and women who would otherwise have gone to back street abortionists began to be treated in hygienic conditions in hospitals. Other nurses were dismayed as the number of legal abortions soared from 54,000 in 1969 to a peak of more than 180,000 in 1990 (Moore, 1997).

Health professionals control access to abortion by their willingness to carry out the woman's decision to have an abortion (David, 1992). But to many nurses and doctors the issue of participating in abortion goes against their will. It remains a difficult and emotionally fraught procedure not only to them but to their client also (Prabakaran, 1998). The issues and questions associated with abortion are often a source of anxiety and uncertainty. Investigating the complexities of such issues becomes an exploration of more general aspects of their consciousness as human beings, their moral values and their priority as care givers. Researches into meanings, which nurses attach to abortion, are less often pursued (Walker, 1995).

For many nurses one of the main issues surrounding abortions is the 'conscience clause', guaranteeing their right not to have to take part in a termination if they have moral objections (Moore, 1997). Moore reports that recently the royal College of Nursing (RCN) and the Royal College of Midwifery (RCM) have produced guidelines whose emphasis is on nurses and midwives thinking ahead about the difficulties their moral stance might present.

The RCM guidance suggests that midwives should inform their immediate manager of their objections as soon as possible before any difficult situation can arise. The principle focus of this study is to explore the experiences of nurses who are directly involved in assisting with the termination of pregnancy (TOP) procedure in Zambia and South Africa. They will describe their experiences of therapeutic abortion, and their accounts of the factors that influence their willingness to participate in abortion and in client counseling. Consequently the investigation also aims to find out to what extent they are affected and through participants' discourses identify relevant, specific support necessary for TOP nurses.

The main aim into the abortion investigation is the exploration of the TOP nurses' interpretation of abortion reality. The focus is to obtain data that would facilitate understanding of the effect of abortions on nurses. The findings will form the basis of the description of support strategies to support nurses facing the negative effects of abortion, as these effects may affect the subsequent care nurses will give to their clients. Prabhakaran (1998:3), said that, "the few nurses who are willing to perform the termination of pregnancy don't have their own support systems, after performing 15 abortions a day these nurses need their own counseling. Their jobs are very emotionally taxing".

High levels of distress and anxiety have been found amongst women undergoing TOP for whatever reason it is performed (Marshal et al, 1994). In view of this, the potential roles of the nurse to both maintain physical comfort and provide non-judgmental and supportive care is evident (Marshal et al, 1994). Marshal and others observed that research has suggested that women undergoing TOP do not always receive the supportive and non-judgmental care that they would like. Research which has been done in the United Kingdom and other western

countries, both directly and after implementation of legal TOP and up to 20 years after, have indicated that nurses find involvement with TOP extremely stressful (Marshal et al, 1994).

1-2 PROBLEM STATEMENT

Extensive research both internationally and nationally have been done on nurses' experiences (and perceptions) of abortion, but research focusing on nurses' direct involvement with TOP procedure has not been ascertained. There is no specific support structure provided for TOP nurses, where they can receive support after suffering emotional stress due to the procedure.

1-3 OBJECTIVES

1. To explore and describe the experiences of TOP nurses regarding therapeutic abortion.
2. To assess the willingness of TOP nurses in participating in abortion and in client counseling.
3. To identify relevant, specific support strategies necessary for TOP nurses.

1-4 RATIONALE AND SIGNIFICANCE OF THE STUDY

Many studies have shown that nurses have been indifferent towards women who undergo termination of pregnancy (Walker 1993, McCulloch 1997). Studies have also shown that nurses have complained that lack of counseling skills and support on their part has contributed to their negative attitudes towards women who seek TOP. It is important to recognize that the responses of nurses and other health workers may affect women's responses to the procedure as well as their post-abortion adjustment. While guidelines have been provided for pre and post-abortion counseling of women, there are no guidelines or any literature to provide counseling for nurses who are negatively affected by assisting in TOP

Most studies have focused on the perception of nurses in general regarding abortion and few studies have brought out the actual experiences of nurses who assist in abortion. This study will enlighten the nursing administrators and policy makers on the actual experiences TOP nurses go through, and will contribute towards assisting them to work out various support strategies necessary for TOP nurses especially from the two hospitals where the study will be done. It will also contribute to the need for scholarship for further investigations on the experiences of TOP nurses on a wide perspective in order to develop uniform support strategies for both countries.

1-5 OPERATIONAL DEFINITIONS.

-Termination of pregnancy--- (used synonymous with abortion in this study)---the separation and expulsion by medical or surgical means of the contents of the uterus of a pregnant woman.

-Perception---an interpretation or impression based on one's understanding of something.

-Experience---an event regarded as affecting one; the fact or process of being so affected.

-Conscience---a moral sense of right and wrong especially as felt by a person and affecting behavior.

-TOP nurses---nurses who assist with termination of pregnancy.

1-6 ABBREVIATIONS

TOP--Termination of Pregnancy.

PHCNs--Primary Health Care Nurses.

FP--Family Planning.

MVA--Manual Vacuum Aspiration.

PAC--Post Abortion Care

2-0 CHAPTER TWO: LITERATURE REVIEW

Literature review will be based on the nature of the problem noted in chapter one. It will describe the relevant and important literature for the topic.

The historical background including the political and legal aspects of abortion at an international level will be discussed. Moral and ethical dilemmas of abortion will be followed by the abortion debate. In order for the readers to understand the importance of the nurses' role in TOP, the experiences of women who have undergone TOP will be presented. This will be followed by the nurses' experiences of abortion in general. As there are very few studies done on the actual experiences of TOP nurses of abortion, these will be combined with the general experiences of nurses. These will be discussed in themes identified from the literature. The emotional work of caring will be preceded by aspects of nursing ethics. The procedure of termination of pregnancy (TOP) will be outlined before the conclusion.

2-1 INTRODUCTION

Abortion was an issue which was very silent and secretive to most people especially women. Despite their religious beliefs and legal sanctions around abortion, women throughout recorded history have been terminating unwanted pregnancies. High maternal and morbidity rates have been recorded in most countries due to abortion. In 1996 the Zambia Demographic and Health Survey (ZDHS) estimated the maternal mortality ratio to be 649 per 100,000 live births (Kaseba, Phiri, Camlin, Sanghvi Smith, Chibuye and Folson 1998). Abortion complications in Zambia account for about one third of all maternal deaths.

In South Africa it is reported that at least 425 deaths a year were caused as a result of illegal abortion complications according to the research done by the Medical Research Council (Albertyn, 1998). The same report estimated that at least 45,000 women in South Africa received treatment at hospitals for complications caused by illegal abortions. World Health Organization (WHO) estimates that over 585,000 maternal deaths that occur worldwide each year, 99% are in the developing world. Maternal mortality ratios are highest in Africa, with figures of up to and over 1,000 per 100,000 live births especially in rural areas (Ahmed, 1996).

Most governments have been spending a lot of money treating complications in women due to abortions performed illegally, in an unhygienic conditions (Baboo, Ahmed, Siziya and Bulaya, 1994). A number of nations have either legalized or liberalized abortion, in order for women to have these procedures done in the most hygienic environment. But most nurses and doctors have refused to be involved in the TOP due to moral or religious values (Poggenpoel, Myburgh, and Gmeiner, 1998).

2-2 HISTORICAL BACKGROUND OF ABORTION

According to historical records, abortion has been practiced since the beginning of the organized society. In the writings of the Chinese, Hebrews, Egyptians, Greeks and Romans, mention of the practice of abortion has been found (Forrest, 1994). Laws governing abortion varied through history and were a reflection of the contemporary attitude towards abortion at the time. The spread of Christianity brought about the moral objections with regard to induced abortions as they were considered an offence towards God, as abortions terminated lives (Forrest, 1994).

The movement for legalized abortion in Great Britain had its roots in the feminist movement after the First World War. Before that abortion was only carried out before "quickening" at six weeks of gestation. Abortion became a criminal offence after 1803 (Forrest, 1994). The history of the development of the law on abortion goes back to Anglo-Saxon times. As early as 1846 the Criminal Law Commissioners realized the need to legalize certain abortions (Gadner, 1972). The Infant Life (Preservation) Act of 1929 in Great Britain allowed abortion in the provision that "no act shall be punishable when done in good faith with the intention of saving the life of the mother". In 1967 in Britain the Abortion Act was introduced which was similar to the former South African Abortion and Sterilization Act of 1975, but it encompassed a clause that "account may be taken of the pregnant woman's actual or foreseeable environment, thus providing broader grounds for abortion and allowing for different interpretations (Forrest, 1994). In the United States of America the legislation the British Common Law originally guided concerning abortion. Forrest (1994) noted that in the 19th century a campaign led by the physicians was successful in outlawing abortion and by 1900 abortion was illegal in every state. Feminist activists and organizations developed the 'pro-choice' movement in the US in the early 1960s. The 'Roe versus Wade' ruling in the US Supreme Court brought about the legalization of abortion on request in 1973 (Bell, 1989).

In South Africa prior to the introduction of the repealed Abortion and Sterilization Act of 1975, there was no properly defined law on abortion. The repealed Act, which brought the new Act in force as from 1st February 1997, was said to be 'restrictive and inaccessible'. The new law, the Choice on Termination of Pregnancy Act, of 1996

'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' (Choice on Termination of Pregnancy Act 1996, (Act no. 92 of 1996)). The 1975 Act was said to favor mostly the white women. In 1990 only 868 legal abortions were performed in South Africa and nearly 69% were white women (Suffla, 1996). The new Act stipulates that all women irrespective of age, location and social-economic status can choose to terminate a pregnancy within the first 12 weeks of gestation and thereafter under particular circumstances (Barometer, 1998). The former Act caused most women to resort to 'back street' abortions by unqualified abortionists. It was estimated that in 'every two minutes' in South Africa there was an illegal abortion taking place (Walker, 1993).

Since the new law was enacted the number of legal abortions performed has increased. Rantsekeng, (1997:17) in the National Directorate for Maternal, Child and Women's Health reported that 46,759 abortions had been performed in South Africa from February 1997 to September 1998 at all designated hospitals, while Marie Stopes, an NGO which provides comprehensive family planning services, conducted 20,000 safe abortions in the first two years of the enactment of the Act. Albertyn, (1998:11) observed that the profile for women seeking abortions suggest that they are doing so for social-economic reasons and at an early stage of their pregnancy.

Zambia has had one of the most liberal laws on abortion in Sub- Sahara Africa. The Termination of Pregnancy Act of 1972 *'permits abortion if continuation of pregnancy involves the risk to the life or injury to the physical or mental health of the mother, or if*

there's substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be severely handicapped. A legal abortion can also be obtained if continuation of pregnancy involves a risk of injury to the physical or mental health of any of her existing children. Section 3 (2) of the Act further stipulates that the woman's actual or foreseeable environment or age may be taken into account in determining whether the pregnancy poses any risk to her life or her mental or physical health, or poses a risk of injury to the mental or physical health of any of her existing children' (United Nations 1995: 187). Two registered medical doctors are required to express their opinion on whether it is within the law to end the pregnancy or not (Baboo et al, 1994).

2-3 POLITICAL AND LEGAL ASPECTS OF ABORTION: AN INTERNATIONAL PERSPECTIVE

In 1993 Reproductive Health Matters devoted its second issue to the subject of abortion and called for the Cairo and Beijing conferences in 1994 and 1995 to endorse women's right to abortion, as part of the stated commitment of governments to women's health and women's empowerment. In Cairo the world's governments did acknowledge that unsafe abortion was a major public health problem affecting women in many countries. In Beijing the conference agreed that something needed to be done (Berer, 1997). The international and legal status of induced abortion ranges from complete prohibition to elective abortion at the woman's request (Forrest, 1994). Forrest reports that 10% of the world's populations live in countries where abortion is prohibited without exception, 18% in countries where it is allowed only to save the life of the mother. These include most of Africa, Asia and some countries in Latin

America; five countries in Europe include Ireland, Spain, Portugal, Malta and Belgium. The latest report about Ireland is that, it is now legal to give women information about abortion clinics abroad. In Portugal parliament just missed passing a bill permitting abortion on request up to 12 weeks of pregnancy by only one vote (Berer, 1997).

In Mozambique a courageous health minister made the provision of abortion to be part of the services offered in three major hospitals in the country.

Presently induced abortion is one of the gravest problems associated with women's reproductive health in Nigeria. As a result of restrictive abortion policy most abortions are carried out clandestinely by poorly trained individuals, resulting in high rates of abortion-related morbidity and mortality (Okonofua, Odimegwu, Ajabor, Daru, and Johnson 1999). In Nigeria hospital estimates indicate that induced and unsafe abortions may be responsible for approximately 40% of maternal deaths (Okonofua et al, 1999). Induced abortion has also been cited as the cause of post-abortion complications such as chronic pelvic inflammatory disease, ectopic pregnancy and secondary infertility among Nigerian women. Abortion law is restrictive in Nigeria; it is governed by the criminal code in Southern Nigeria and the penal code in Northern Nigeria. Abortion is permitted only in order to save the life of the woman under both codes (Okonofua et al, 1999).

In Kenya access to abortion is severely restricted and is legally permitted only when it is necessary to save the life of the woman. Hospital based studies in Nairobi have shown that unsafe induced abortion accounts for as much as 35% of maternal

mortality and at least 50% of hospital's gynecological admissions (Solo, Billings, Aloo-Obunga, Ominde and Makumi 1999).

Changes in legal, ethical, medical and political views on abortion have forced onto the public agenda of most countries such questions as the right of women to choose to terminate a pregnancy, the legal and moral protections to be granted the fetus, government policies with regard to population planning, and the role that the medical profession should play with regard to the maintenance of life (Frankowski and Cole, 1987). The use of abortion as family planning in countries where birthrate threaten to reduce living standards, is an issue with important social and political implications, but these include Africa, India and South America (Frankowski and Cole, 1987).

Fashioning public policy with regard to abortion will require assessing how much secular human reasoning can conclude regarding the morality of abortion and what limits exist upon the state's authority to forbid abortion (Bondeson, Engelhardt, Spiker and Winship, 1984). Frankowski and Cole (1987) noted that questions with regard to abortion and protection of the human fetus are controversial, and thus there are political ramifications to the process of decision-making.

In other countries policy development is long and complicated involving legislatures, administrative bureaucracies, political parties, interest groups and courts. In most countries the legislatures have been the focal point for enactment of the abortion policies. But the passage of new statute sets in motion legal actions in the courts challenging interpretations of the law and the operational procedures designed to

implement it (Frankowski and Cole, 1987). They further note that the description exercised by health and human services bureaucrats further defines the thrust of the policies, which in turn often lead to new legislation.

2-4 MORAL AND ETHICAL DILEMMAS

Commitment to certain values guide us in the decision-making process and motivates us to act on those decisions from an ethical perspective. Valuing is part of being human. It is the essence of nursing and is fundamental to making ethical decisions (Shelly and Miller, 1991). The morality of abortion causes an ethical dilemma to society and raises many controversial issues. One of the major problems of abortion has to do with the perception, if not the reality of discriminatory treatment of women who choose to abort (Shannon, 1983). The other issue has to do with religion, how one translates one's religious beliefs or values in relation to abortion. Shannon (1983) noted that there are a few, if any, good alternatives to abortion. Choosing adoption for the woman requires that the woman still carries the pregnancy to term and deal with the reality of separation from the new born, 'a painful experience even if the woman is highly motivated'. There also may be a lack of good or even adequate social, physical and economic support systems to make such a process easier to accomplish and to ensure the health of the mother and the new born. So she may not have either the physical or social support to do so. Others who decide to keep their pregnancies and have their baby especially the teenagers, may lack the ability and appropriateness of caring for their child. These are in relation to 'adequate financial and psychological resources to provide an appropriate setting for the rearing of the child' (Shannon, 1983:10). Therefore those that decide to keep or send the child for adoption face the

problems of how to do it, especially in the light of unavailability of social programs to provide a context, which would facilitate these kinds of decisions. The issue of discrimination has to do with the fact that those who will be affected by lack of obtaining any support services are the poor women.

Abortion raises many fundamental questions such as issues concerning the rights of the fetus, the meaning, quality and definition of human life, the rights of the individual versus those of society and sexual norms and values. Abortion is a multifaceted and complex issue, which arouses a multiplicity of meaning both as a social issue and in individual women's lives (Forrest, 1994). Forrest further observes that the complexity of the abortion question arises from a disagreement as to whether or not the fetus is a human life to be considered in the decision to have a termination of pregnancy, and therefore whether personal or moral considerations should apply.

Tooley (1983) noted that 'other philosophers think an appeal to moral feelings is worthless, and that the way to approach moral questions is by appealing to some general ethical theory that has been established independently of any reference to moral feelings'. His own reasoning is that a person's ethical intuitions seem to depend very heavily upon what ethical principles were accepted by his parents, or by the society in which he was raised'. Views on the morality of abortion, according to Tooley are of three main types: the conservative or anti-abortionist view is that abortion is wrong at any time from conception onwards; the liberal position which says abortion is never wrong or at least not seriously so; and then the moderate

position in which abortion is allowed in certain situations, especially in cases of rape or incest.

Forrest (1994) raises the question "Where does life begin and when does it end?" The pro-choice views the fetus in the early stage of pregnancy as nothing more than a 'blob of tissue' and the pro-life speaks of those who terminate their pregnancies as 'murderers'. Hammond (1999:8) in his argument against abortion said "of what worth is human dignity if babies are denied the right to life". He called abortion as "murder of a helpless and innocent human being". Smith (1998:6) observed that the legal and intellectual issues are open to interpretation, but on moral grounds terminating life is seen by many to be indefensible. He said, 'it is neither given nor created by politicians, so morally, do they have the right to decide on its viability?'

In South Africa the pro-life nurses said that ' preserving and protecting life was what nurses stood for and not 'taking the life of another human being' (Thom, 1998:5). The moral and ethical issues around abortion are important to study in that it is predicted that the ethical viewpoint and religious beliefs of the participant will affect their experience and perception of TOP.

In Zambia many individual physicians are reluctant to perform TOPs for religious or moral reasons. Some health care administrators interviewed by Kaseba et al, (1998) stated that they were aware that abortion was legal but as a matter of policy, they do not allow legal TOP services to be conducted in their hospitals. Most people in Zambia including health care providers either do not know about the Act or are

misinformed about its guidelines. Consequently access to safe legal abortion in Zambia is currently severely limited. Abortion complications are a major cause of maternal mortality in both urban and rural Zambia. In 1993 the ministry of health records indicated that nation wide, over 16,000 hospital admissions were emergency cases caused by illegal abortions (Kaseba et al, 1998).

2-5 THE ABORTION DEBATE

The fact that abortion poses such a dilemma for most people emphasizes the complexity of beliefs about abortion and how such beliefs affect and influence attitudes towards abortions (Haffajee, 1997). According to WHO, each year more than 70,000 women die of complications of unsafe abortions, 99% of them in developing countries (WHO, 1994). Most of these women are poor and in countries where abortion is either illegal or severely restricted by law. Women and health (1999) reports that the majority of these deaths are preventable with current existing but not universally available drugs, technology and procedures. Some experts feel that the availability of legal abortions actually reduces pregnancy maternal morbidity. Since 1973 when abortion was legalized in America maternal mortality rates have decreased (Rosenfeld, 1997). In the United Kingdom since the legalization of abortion, no deaths were recorded from abortion, where as there were 75 to 80 in the three years prior to legalization (Rosenfeld, 1997).

In Latin America it is estimated that unsafe abortions are responsible for 24% of maternal deaths according to Rodriguez and Strickler, (1999). They further observe that other than the increasing number of maternal deaths, unsafe abortion strains

public health resources such as hospital beds, blood supply and antibiotics. Beyond the financial costs, the individual tragedy of maternal death caries with it a variety of severe repercussions on families and society in general.

Clandestine abortion raises issues of social and economic injustice. Restrictive abortion laws encourage the use of clandestine services, promoting the health threatening practices of opportunistic, untrained or incompetent clandestine practitioners (Rodriguez and Strickler, 1999). Such practitioners are not subject to regulations, peer review, or evaluation, and by definition, they disregard legal restrictions, and they often charge exorbitant fees. The women with few resources are normally the ones who utilize such practitioners, especially the young, single adolescents who are hiding their pregnancies from their families. This means that the disadvantaged women run the greater risk of complications, 'while more privileged women have greater access to relatively safe, hygienic abortions' (Rodriguez and Strcikler, 1999). In Latin America the fight to legalize abortion in many countries is still going on. Several Latin American countries have active reproductive rights organizations, which advocate for legalization of abortion. They noted that only Uruguay and Cuba permit abortion for reasons other than maternal health, fetal defects or rape / incest.

Koster (1995) in her study of "Unplanned Pregnancy: Causes and effects" done in Zambia's Western Province, reports on the disproportionate number of school girls who die of complications of unsafe abortions and recommends an intensive awareness campaign and also access to affordable abortion services in hospitals. The health and future fertility of many women can be damaged with chronic pelvic

pain, incontinence, infertility, or obstetric complications as serious physical complications of unsafe abortion procedures. The social consequences for the woman and her family can be serious, and her mental health can be affected by ambiguity, sorrow and despair (Maforah, 1994). The disturbing feature of this trend Maforah says is that women obtaining induced abortions are usually young and in their early reproductive careers, making the safety and subsequent well being of these women an important health concern.

The abortion issue is a difficult and heavily value-laden one from all perspectives: social, religious and legal. It is a subject, which used to be so secretive and private, but now is being debated in public in most countries. Religious groups and pro-life activists are opposed to liberalization of abortion. 'In South Africa anti-abortion groups representing some doctors and nurses (Doctors for Life, Nurses for Life) have repeated their intention to refuse to take part in any abortions or refer pregnant women to abortion clinics (Thom, 1998:5). Some nurses were said to be insisting on imposing their beliefs on their clients seeking to terminate pregnancies. In Bloemfontein a nurse was said to be 'praying for women seeking abortion before sending them to an adoption agency' (Thom, 1998:5).

The abortion Act in South Africa was challenged in court by three Christian groupings, the Christian Lawyers Association of Southern Africa, Christians for Truth in South Africa and United Christian Action in 1998. They based their argument on the fact that' the life of the human being starts at conception'. Abortion terminates the life of a human being (Prabhakaran, 1998:15). 'This challenge to South Africa's abortion

legislation was brought against the Minister of Health, the Gauteng Premier and the member of the executive council responsible for health in Gauteng. The Commission for Gender Equality and the Reproductive Rights Alliance, representing more than 30 pro-choice organisations joined the case as defendants. The counter argument relied in part on section 12 of the Constitution, which guarantees everyone the right to make decisions concerning reproduction. In an important decision reaffirming freedom of reproductive choice, the Pretoria High Court dismissed the application (South African Health Review, 1998:19).

The pro-choice viewpoint is developed from the Marxist and Feminist perspective of reproductive freedom, that women have the right to choose and make their own decisions about childbearing, contraception and abortion. While the pro-life viewpoint is derived from fundamental Judeo-Christian philosophy, which indicates that the fetus is a 'human person' from conception with a soul and has a right to life, therefore abortion is considered to be murder (Forrest 1994). Gardner (1972) a Christian gynecologist faced with the reality of abortion in conflict with his Christian values, provides the framework to understand abortion, but believes that necessary precautions can help prevent the need for abortion. He believes abortion should not be necessary with preventive measures such as increased awareness of contraception and better support networks for the pregnant woman.

2-6 THE EXPERIENCES OF WOMEN WHO HAVE UNDERGONE TOP

Most women after abortion experience a sense of loss, guilt, shame and self-blame. Others suffer depression due to unresolved grief. High levels of distress and anxiety

have been found amongst women undergoing TOP for whatever reason it is performed (Marshall, Gould and Roberts, 1994). In view of this the potential roles of the nurse to both maintain physical comfort and provide nonjudgmental and supportive care is evident. However research has suggested that women undergoing TOP do not always receive the supportive and nonjudgmental care they would like (Marshall et al, 1994). From the literature and information gathered by Marshall and others, it does appear that the women who have had TOP because of various medical reasons or spontaneous abortion are the ones who suffer more emotional trauma than those who demanded abortion for social reasons. Reed (1992) in her research on nurses giving emotional care to women experiencing miscarriages found that, 'women experiencing miscarriages perceived nurses and physicians to be cold and indifferent to their situations' (Reed, 1992). Reed (1992) suggests that nurses' indifference may be based on the medical perception of a miscarriage as a simple, non-threatening physical condition. Therefore the nurses may infer that the non-serious physical situation has little emotional impact.

A woman, who underwent TOP several years ago in South Africa, spoke of her trauma following the procedure. After seven years her life still had not returned to normal. She was not counseled prior to abortion about the psychological repercussions she might go through after the TOP. She narrated having to go through a lot of pain and bleeding and ended up with a ruptured uterus. "Let nobody tell you it's easy. You don't bargain on what happens afterwards", she said in a shaky voice (Cassim, 1998:5). She had to go through another operation for a ruptured uterus.

The United States News and World Report (1998) reports on several women interviewed on the effects of abortion on themselves. Seventeen years old Brenda got pregnant and was torn between considering her future and the pregnancy. 'The school referred her to a therapist who showed her pictures of fetal development in an effort to convince her that the amalgam of cells clinging to her uterus was not yet a human life'. She decided she would have her baby and give up for adoption, but after delivery, it was difficult to give up the baby. She brought him up through difficulty and he is now 16 years old. However, she terminated her second pregnancy.

Nicole decided to abort to prepare for her wedding, as having the baby would put 'too much strain on them as a young couple'. She received Methotrexate to end the growth of the fetal tissue. After a week she inserted a Misoprostol suppository intended to induce contractions, which started that evening. She experienced so much pain and aborted. A week after abortion she continued to bleed. She developed depression and her boyfriend walked out on her. She began hemorrhaging again and at the hospital she was scolded by a doctor. She tried to commit suicide by slitting her wrist. Someone directed her to the pregnancy crisis center where she met other women who felt 'devastated about their abortions'. She painted a watercolor that reminds her of the ultrasound of her fetus and hung it in her apartment. Around her neck is a gold charm in the shape of a baby, set with an August birthstone, the month her child would have been born. "I don't want another woman to have to feel this", she said explaining her decision to discuss her abortion. "Its time for women as a group to stand up and say this hurts me" (Ackerman, 1998:28).

Brook had her abortion after talking to a counselor, the procedure used, was manual vacuum aspiration (MVA), which she described as having given her 'uncomfortable feeling'. At school news about her abortion was leaked and she says everybody including her teachers made her feel uncomfortable. She was forced to sit in a presentation by an anti-abortionist by the school officials. She describes the situation as having been 'so horrible'. She developed secondary hemorrhage. Her mother a nurse was afraid of taking her to the hospital for fear that her colleagues will know about the abortion. Brook dreaded school and said "I was made to feel so selfish. I had to keep telling myself that I wasn't, that this was perfectly legal and it was my right, my choice" (Ackerman, 1998:29). After graduating from high school, she started an academic internship at a nonprofit organization that helps finance abortions for women who can't afford them. She says she has never regretted her decision.

Cassandra, 15 years old, had an abortion, which she says she can't regret about despite anti-abortionists plea for her to have the baby and send it for adoption. She says "I have never felt bad, because I had no other choice"

According to research done by Forrest (1994) she reports that since about 1970, research done and reports written indicate that therapeutic abortion seldom induces severe negative emotional reactions and that for most women the termination of unwanted pregnancy is perceived as therapeutic in itself.

Suffla (1996) mentioned the importance of exploring the effects of treatment by health care staff participating in TOP on women's post-abortion responses. She

recommended that the findings may be integrated into interventions aimed at minimizing the risk of deleterious post-abortion consequences and may also form support interventions for staff who may be disturbed by their participation in abortion. This is particularly important since the liberalization of abortion has meant increased participation in abortion procedures for health care providers.

McCulloch (1996) also observed that the treatment by staff especially nurses during the abortion experience may influence women's adjustment to the abortion. Nurses play a very big role in the treatment process of any patient. Their influence can either affect a patient in a positive or negative way. Research into the service provider's perception and experiences of abortion and potential law reform is imperative. He further noted that it is beneficial to assess service providers' moral stance on abortion as it is potentially detrimental to service providers' well being through providing abortions against their belief system.

Haffajee (1997) in a study he conducted among medical students on abortion attitudes, found out that abortion attitudes can also be positively correlated with an individual's willingness to perform or assist in abortions, despite the woman's circumstances. This also emphasizes the urgency of including a conscientious objection clause in any abortion related legislation. McCulloch (1996) concluded his study with a view that service providers who perform or assist in abortions may be less supporting and accepting of women who undergo abortions, and this may be reflected in their service provision, hence the importance of this study. The nurses have a closest contact with patients, their families and members of the community. As

a result they confront key social problems such as abortion on a daily basis. Therefore their views and understandings have been and will continue to be enormously influential in shaping the ways in which abortion as a social problem is managed (Walker, 1993).

2-7 NURSES EXPERIENCES AND PERCEPTION OF ABORTION

The abortion dilemma has been great amongst nurses and doctors who are the implementers of the abortion legislation. Opposing views on abortion constitute a moral dilemma; a dilemma that often finds the nurses in the middle. On the other hand is her own personal belief, on the other, may be a conflicting belief of her patient. The other argument is that physicians and nurses would lose their protective attitude toward life if they were involved in abortion procedures (Bell, 1989). Previous studies on nurses' experiences and perception of abortion will be referred to extensively as these are particularly relevant to this study. These will be discussed under five themes identified from the literature. These are:

1. Factors associated with nurses' experiences towards TOP.
2. Nurses perception of abortion.
3. Nurses dilemma surrounding abortion.
4. Abortion awareness.
5. Recommendations regarding support for TOP nurses.

2-7-1 THEMES

Most nurses interviewed in the previous studies perceive abortion to be 'murder'. They fail to associate themselves with it after having pledged that they will 'refrain from anything that might endanger life or health' in that Nightingale pledge. The portion of the Hippocratic oath on which the doctors use to argue about participating in abortion is more specific. It stated, "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art" (Shelly and Miller, 1991).

1. **Factors associated with nurses' experiences towards TOP**
2. Price (1983) in her research on psychosocial adjustment of pregnant adolescents who seek legal abortion noted that nurses appear to react with the most discomfort. Several investigations have reported clinical psychiatric symptomatology such as obsessional thinking about abortion, depression, anger, lowered self-esteem, hostility and identity conflicts. Furthermore acute identity crises have been demonstrated by most nurses who are discomforted and distressed by the contradiction that they perceive between their training to preserve life and their role in abortion work which aids the ending of life (Price, 1989). Abortion work represents a negative of their personal and professional principles.

In the studies done in the United Kingdom, United States of America and here in Africa, most nurses find involvement with TOP extremely stressful. The source of this stress has been attributed to contradictions arising between nurses' professional

ethics to care for these women and their own personal values (Marshall et al, 1994). Webb in Marshall et al (1994) observed that gynecology nurses often had stereotypical and condemnatory attitudes towards TOP and TOP patients. A North American study has indicated that those nurses working on gynecology wards had more negative attitudes towards TOP than their general ward counterparts (Marshall et al, 1994). This study was considered by the researcher to be a direct consequence of the gynecology nurses' involvement with TOP. The North American and British studies concluded that 'intimate and continual involvement in the TOP procedure itself was related to significantly more negative attitudes (Marshall et al, 1994). They also observed that nurses tend to over identify with the aborted fetus.

According to Marshall et al, (1994) religious belief has emerged from research for being associated with negative attitudes towards TOP both with the general populations and amongst health professionals particularly amongst Roman Catholics.

Walker (1995:44) in her study amongst African Primary Health Care Nurses practicing in Soweto clinics noted that the overwhelming majority of PHCNs expressed a strong opposition to abortion, which took the form of anger, hostility and judgmental responses towards women. She said their anger and hostility lay in 'unpacking and exploring their identities as African women, mothers and nurses'. Walker expected these nurses to play an active role on behalf of women in the community. Some of the sentiments expressed by nurses were:

" My work is to help the woman who wants to have a child, not the woman who wants to have an abortion".

"Women who are having abortion are killers. You are a killer. You are killing the child".

Nurses opposed to abortion were of the view that it was 'unacceptable and unjustifiable'. They accused the women of being irresponsible, careless, unthinking and even promiscuous. They blame the women for not using contraception (Walker, 1995). Among the 27 nurses interviewed by Walker only one supported abortion. Walker had anticipated that religion would be a key factor influencing the responses of nurses towards abortion, but discovered that of the 19 respondents who rejected abortion only two cited religious beliefs as the central reason for their opposition to TOP. What was most interesting in her study is that just over half the Catholic nurses were opposed to abortion, despite their church's stand against abortion.

In England many nurses were relieved when the abortion Act was passed, and women who would otherwise have gone to back-street abortionists began to be treated in hygienic conditions in hospitals (Moore, 1997). Many old retired nurses still remember when gynecology wards regularly admitted women with bleeding and infection from a 'botched' abortion. One nurse remembers seeing a seventeen year old girl die of the effect of illegal abortion. She recalls women who had horrendous injuries such as perforated uterus and renal failure often set in.

"I'm from an Irish back ground nothing disturbed my views until I saw the consequences of illegal abortion. I totally changed my ideas. I get angry inside with

people with anti-abortion ideas, who have not seen the consequences", she said (Moore, 1997:22).

The women in a study done by Maforah, Wood and Jewkes (1997) on the experiences of women who chose to have legal abortions found that, hospital staff treated them like 'animals in a cage' and that the staff were 'unsupportive and judgmental'.

One woman said,....."the nurses are very abrasive.....I was treated like a leper you know..... a complete utter leper.....there was no support, you know. The awful part in all of this is that..... you are made to feel like such a criminal.....".
One respondent honestly acknowledged that she could not provide holistic nursing to such a woman because she felt very negative about the woman's choice to have an abortion

"..... I can't give her holistic care like I would give a normal patient, I just don't want to be involved in TOP and I feel I am neglecting the patient, she is not given the total care" (Maforah et al, 1997).

For nurses one of the main issues surrounding abortions is the 'conscience clause', guaranteeing their right not to have to take part in a termination if they have moral objections. In the UK the 1967 Abortion Act (section 4(1)) permits midwives to object to participation in treatment to which they have a conscientious objection (Ferguson, 1997). It further states that 'It is the individual midwife's responsibility to prove that

she has such an objection to being involved, and as there is no statutory definition of a conscience objection, this can cause some difficulty'. In Scotland it is acceptable for midwives to make a statement on oath to the effect that they have a conscientious objection (Ferguson, 1997). However in cases of emergencies the midwife is expected to weigh what would be practical bearing in mind the UKCC's "code of professional conduct", which states that a midwife must:

Recognize and respect the uniqueness and dignity of each patient and client and respond to their need for care, irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health care problems or any other factor (clause 7). Section 4 (2) of the Abortion Act does stress that, in an emergency situation, where it is necessary to save life or prevent permanent injury to the physical or mental health of the woman, it is the midwife's duty to participate in treatment regardless of conscientious objection (Ferguson, 1997).

2. Nurses perception of abortion.

Research done by Poggenpoel, Myburgh and Gmeiner (1998) on nurses who experience discomfort with abortion in South Africa, they noted that a large number of nurses refuse to be involved in abortions. Most nurses felt angry and unhappy because they were not 'consulted about their opinions regarding the legislation of abortion' (: 4). A large group of nurses felt that if forced to nurse such patients, they would leave the profession. The nurse respondents verbalized that they actually chose nursing because they wanted to preserve life. Many doctors in South Africa have refused to perform abortion because it goes against their profession and the

Hippocratic oath (Poggenpoel et al, 1998). The following were some of the sentiments from some of the nurses interviewed:

"Personally I will not allow myself to be forced into this situation, I will not do it, okay, and I will tell the matron..... I find myself walking out and do something else..."
How am I going to handle myself if I must see something like that? I am going to leave nursing then".

Poggenpoel et al (1998) state that moral values and belief systems should not be imposed on patients. No nurse should be forced to perform or be part of an abortion. According to South African constitution everyone has the right to freedom of conscience, religion, thought, belief and opinion. Democratic Nursing Organization of South Africa (DENOSA) also believes that a nurse has a responsibility to make her/his views known in good time if he or she does not wish to participate in TOP. However a nurse has a professional and ethical obligation according to Nursing Act (Act no 10 of 1997), and its related regulations, to nurse the patient before, during and after the procedure despite conscientious objections to TOP (Choice of Pregnancy Act, no 92 of 1996, Constitution of the Republic of South Africa no 108 of 1996).

The majority of nurses in Poggenpoel et al (1998) study viewed the aborting woman as a 'murderer'. It was noted that nurses who care for women after abortion refuse to look them in the eye, speak to her or touch her. They only monitor the basic vital signs. The nurses stated clearly that they are 'hostile towards such women'.

A nurse at Kings College in London is highly active in the National Abortion Campaign. She finds that there's no contradiction between her job and her strongly held belief that abortion is a fundamental right. "I don't know that my beliefs do affect my work as a midwife. Midwives are involved in late terminations of pregnancy- it is always going to be an aspect of the work and it always has been. Being a midwife is not just about the birthing, it is about family planning and sexual health, and abortion for me is part of the whole picture", she says. She confesses that other nurses really have 'bad preconceptions' about women undergoing TOP. She says she does not mind how other people look at her because it is good to 'challenge ideas' (Moore, 1997).

Moore (1997) reports of a pro-abortionist from Abortion Law Reform Association (ALRA) commenting on doctors and nurses who object to abortion that "they have not seen the awful consequences of back-street or self-induced abortions as older generations have. It is a bit worrying. Abortion is so much a part of everyday life nowadays that we assume doctors and nurses don't need to have anyone explain to them what the benefits are".

3. Nurses dilemma surrounding abortion.

In the US there are violent demonstrations against abortion. Health care staff face a lot of intimidation and threat to life. Since 1993 seven people have been killed and seventeen wounded in attacks on individual obstetricians or abortion clinics (Marissa

and Ventura, 1999). Demonstrators in Britain are said to be 'peaceful' but they are still intimidating to staff and women seeking abortion. 'On call' staffs in Britain have also been telephoned at home and women arriving at the clinic have been handed knitted booties.

Abortion remains an emotional and wrenching issue. Marissa and Ventura (1999) in their recent survey on how nurses still view abortion, found that nurses' views on the subject had changed in the last decade in USA. Since the abortion issue was settled more than 15 years ago in the Roe vs Wade- US Supreme Court the abortion issue has not been settled in America. The nurses' opinions were not solidified nor were the country's (Marissa and Ventura, 1999). They observed that in 1992 the highest court in America ruled that states could impose restrictions on abortion 'as long as they did not "unduly burden" a woman's right to choose.

With the basic right to have an abortion still intact, nurses who personally oppose the procedure may face a professional dilemma- how to uphold their duty to care for patients while remaining true to their personal convictions. Resolving this dilemma is a big problem for nurses; how to uphold their duty to care for patients while remaining true to their personal convictions. In North Carolina a Registered Nurse (RN) worked on an Obstetrics and Gynecology ward where all nurses except she 'refused to take care of the patients who were having abortions'. The latest survey was conducted in July 1998, which revealed that more RNs would refuse to work on a unit where abortions are taking place. Majority preferred to work where abortion would be prohibited (Marissa and Ventura, 1999). Previously the majority of the nurses were willing to work in the unit (52% in 1998), while 40% would not work in the abortion

unit. The latest research showed that only 39% of nurses are willing to work in the unit. 61% of the nurses now say they would not work in the unit. What could be the problem?

More nurses today are opposed to abortion. In the event of numerous available options to prevent pregnancy, most nurses only support abortion in cases of rape, incest or a threat to the mother's life or health. They oppose those women who use abortion as a way of family planning.

A nurse from New York said, *"It is difficult to care for someone who refuse family planning methods, or fail to use them correctly and then have three or more abortions"* (Marissa and Ventura, 1999:45).

The other reason may be fear of being harassed or physically harmed, despite the federal Freedom of access to Clinic Entrances Act of 1994. This law protects any person who attempts to obtain or who provides or assists in providing reproductive health services from injury, intimidation or interference. But violence in America has continued.

Fewer physicians have been trained to perform TOP in America, and only a few of those still do them. The training of nurse midwives to perform TOP may not be the answer to increasing access to this service. Among the nurses who have provided the abortion care and have found it difficult, one had this to say,

"I have deep feelings, which are very hard to hide, about people who throw life away because they were irresponsible or because their life has been inconvenienced".

Another nurse from Iowa admits that her views on abortion influence the care she provides. *"I cannot accept the deliberate* killing *of innocent human beings. It 'comes across' in my nonverbal behavior".*

However, some nurses have put aside their feelings about the procedure and have nursed the patient. One nurse said, *"My personal beliefs about abortion are just personal. I do not wish to assist a doctor with an abortion, but I will defend the woman's right to have one".*

Another nurse expressed this view about TOP, *"I may detest abortion, but I may not detest the person who had the procedure. When I have cared for people with post-abortion complications, I have done so with compassion".*

Yet some provide care because the legal status of abortion leaves them with little choice. One respondent summed up many respondent's views by saying, *"I have to remember to treat the patient not the circumstances".*

In the UK in Hull's Princess Royal Hospital, a nurse-led miscarriage support group was formed in 1991 to support women who go through miscarriage to cope with their grief. The club called 'Forget-Me-Not-Club' in which the nurses aimed to help women 'pick up the pieces' and return to normality. They wanted to acknowledge the grief felt

by women in miscarriage and support them through the experience (Walter and Nelson, 1997:26). The group said, "Our starting point is to acknowledge that the baby- no matter how early in pregnancy- that baby who had died- was a person not simply a bundle of cells. We offer all patients a high level of psychological support by staff experienced in the appropriate counseling skills both in the ward and off the ward in a regular support". At this support group the women are encouraged to spend as much time and share her experiences, and the staff form a bond to help the healing process.

The dilemma of the nurse comes where a woman comes to demand abortion may be for social reasons, and at the same time, in the same ward another woman is grieving and mourning about the loss of her baby. Most nurses find themselves being biased in their counseling towards the later patient. They find marrying the two situations to be extremely difficult and stressful. Probably that explains the reaction of the PHCNs in Walker's study (1993), which she described as harsh, antagonistic and judgmental.

Price (1983) explained the emotional reactions observed in nurses as psycho-dynamically and circumstantially. The three main psychodynamic sources include:

(i) Over identification with the fetus and lack of identification with the aborting woman on a conscious/unconscious level. Nurses remain unfamiliar with the problems of the aborting woman due to her short stay in the ward. On the other hand they are forced to have contact with the fetus, which they must handle and of which they must dispose.

(ii) Reactivation of the fear of loss of control is projected on to the aborting woman. This results in the nurses' anger and fear that abortion will cause a woman to lose control sexually, become promiscuous and undergo repeated abortions.

(iii) Price further said that lack of super ego satisfaction resulting from lack of 'a good reason' for abortion. This reactivates conflicts about abortion work.

Price (1983) explained the circumstantial issues as follows:

(i) Many women obtaining abortion are in highly emotional state and therefore difficult to nurse.

(ii) Aborting women are often a source of tension in a gynecology ward when other women who are being treated for threatened miscarriages or sterility are present. The nurse has to cope with these tensions.

(iii) Many nurses are very young and are ill equipped to cope emotionally with the ethical dilemmas of abortion work.

Nurses have little opportunity to discuss with their colleagues the social and emotional pressures on the patient rendering the pregnancy unwanted. Without adequate understanding of the reasons for the abortion, it is not surprising for the nurse to assume that the reasons are flimsy and largely necessitated by human carelessness.

4. Abortion awareness.

Those who advocate for abortion say it is the individual women who bear the emotional and physical cost of carrying unwanted pregnancies to term, and they alone should have the right to decide whether or not to do so (Brown, 1991). While

those who do not support abortion argue that the family planning services are available at a free cost and mostly nearer to the clients. Therefore women should be able to utilize these services instead of resorting to abortions.

Suffla (1996) in the recommendations of her study acknowledged that research needs to focus on interventions that address issues around contraception, given that findings indicate that contraception failure and non-use may contribute to the use of induced or therapeutic abortion as an alternative to unwanted pregnancy. Most nurses have complained that most women who demand abortion do so on social grounds and that the majority are teenagers. These are mostly ignorant of the consequences of going through TOP, the after effects, the complications and they risk contracting sexually transmitted diseases including HIV/AIDS.

Most clinicians concerned with the problems of teenage pregnancy prefer a primary prevention program - namely, avoiding unplanned pregnancies among teenagers rather than unplanned births (Cates, 1989). They look at factors such as:

(i) Sex education early in grade school to underscore the important decision points involved in making reproductive choices.

(ii) The availability of contraception without parental consent or knowledge.

(iii) Government supported family planning counseling and contraceptive services.

(iv) Parental education programs to enhance their understanding of teenage motivations.

(v) Public education programs to dramatize the realities of teenage sexuality (Cates, 1989).

In the modern day, children as young as twelve years old are calling for 'better sex education to protect them from sexual exploitation - and they want to know how to use condoms' (Waring, 1999:8). At a youth workshop held in Pringle Bay, Cape Town, as part of the National Consultative Conference Against Exploitation of Children, children aged between twelve and sixteen drew up a set of resolutions to prevent sexual exploitation. Some children who attended the workshop had become sexual slaves (prostitutes) at a tender age of twelve. The children advocated that any business promoting child sex should be closed down.

In a study done at the University Teaching Hospital in Zambia by Baboo et al, (1994) on characteristic of women terminating pregnancies, they found that use of contraception was low and hence there was a need for expanded family planning education and making contraceptives available to all concerned including students in order to reduce the abortion rate. They observed that the counseling of the patients currently appears not to be adequate, given that five percent of the clients in their study came back for second TOP and one percent third TOP. They concluded that adequate counseling be given to those seeking TOP but contraception knowledge should also be imparted.

In a study done by Koster-Oyekan (1998:112) in Zambia on illegal abortion, it revealed that more than half the secondary school girls reported sexual contact. Their sexual partners were workers, teachers, businessmen and drivers who could provide money, transport or high marks in school. The girls interviewed in this study revealed that they were ill informed about sexuality. The little they know is from peers and

biology lessons. Schools have no formal 'sexual awareness programs'. Traditionally parents do not discuss sex with their children. Only five percent of the girls had learnt about sex from their mothers. The women interviewed also were not utilizing family planning services.

4.1 Post Abortion Care

The most important part of the care of the woman who has had an abortion is counseling. The woman must have conscientious guidance and suggestions about future contraception needs. Counseling about acute feelings of grief and guilty, and providing the opportunity for further visits is important (Rosenfeld, 1997).

Providers and policy makers in most countries have been active in implementing post abortion care (PAC) services, which mostly focused on introduction of MVA to improve treatment services. Efforts to expand PAC activities and incorporate post-abortion family planning services, ministry of health (MOH) in Kenya is determined to find a way to deliver PAC family planning counseling and methods (Solo et al, 1999). Following the international endorsement of PAC at the International Conference on Population Development (ICPD) in Cairo in 1994, the concept of PAC has gained wide acceptance as one way to improve services provided to women with complications from spontaneous or unsafely induced abortions, and to help reduce maternal morbidity and mortality (Solo et al, 1999).

In Ghana the ministry of health began to implement the Safe Motherhood Programme in March 1995, in an effort to reduce the 'unacceptably high level of maternal mortality

in the country' (Billings, 1997). In addition to providing life saving emergency care, midwives are in a key position to offer post abortion family planning information and methods, and can link women to other appropriate reproductive health services. Providing family planning services at the time of emergency treatment can help prevent repeat abortions.

Inclusive in the above subjects is the HIV/AIDS prevention programs and other sexually transmitted diseases (STDs) in schools and community. The women and students may be successful in procuring abortions, but they stand the risk of contracting HIV/AIDS. In the information provided by Manuel, Molines, Dubuc and Morco (1998:294) on HIV/AIDS talk for adolescents, she observed that pupils aged around fourteen to fifteen years are already sexually active 'which means that information on the risk of HIV infection is not always being provided before there is a possibility of exposure to the virus'.

In Zambia Kaseba et al (1998) recommended that the ministry of health should consider the deploying of nurse/midwives to improve access to PAC services.

5. Recommendations regarding support for TOP nurses.

The Royal College of Nursing (RCN) refused to take sides on the 1967 Act, arguing it was primarily a medical responsibility (Moore, 1997). The Royal College of Nursing and the Royal College of Midwives (RCM) have recently produced guidelines, which emphasize on nurses and midwives to think ahead about the difficulties their moral stance might present. The RCM suggest that midwives must inform their immediate

manager of their objections as soon as possible before any difficult situation can arise. The RCN women's advisor says, " It should not be forgotten that nurses and midwives working with women undergoing TOP might have their own emotional needs". However nurses have options if they object to caring for TOP patients. The Code for Nurses with Interpretive Statements states, "If ethically opposed to interventions in a particular case because of procedures to be used, the nurse is justified in refusing to participate" (Marissa and Ventura, 1999). Nurses are encouraged to express their objections well in advance in terms of their moral, ethical or religious beliefs to protect themselves against retaliatory action.

In concluding their study Poggenpoel and others observed that nurses want to have as little as possible to do with abortions. They noted that nurses feel inadequately prepared to deal with aborting women. They would like to be equipped with counseling skills in order to cope well with the situation and minimize their feeling of inadequacy and guilt. They noted that nurses need support and suggested that support groups for nurses could be implemented in their respective hospitals, where they would ventilate their feelings. They need someone to care for them.

They need to view the woman who has aborted as a human being and accept her without necessarily agreeing with her choice. The nurse must adhere to the principles of unconditional acceptance. Setting up abortion clinics where nurses who are willing to work there could participate even in performing the abortions. The woman should be nursed within her framework of reference not that of the nurse.

Caelers (1998) also recommended in his study of abortion attitudes among doctors, that separate abortion facilities could be set up, staffed by willing employees, as well as mandatory counseling in institutions performing abortion. He also noted that post-abortion counseling in state institutions is nonexistent.

Blain (1993) also recommended the setting up of separate abortion units which will offer the 'ideal opportunity to develop a specialist nursing role that recognizes these women's needs'.

More education on nursing ethics is also needed to help nurses find their way through the moral maze that is not only created by TOP, but also by new advances in infertility treatment and fetal diagnosis. She also observes that nursing and medical profession has had a 'paternalistic image' of 'doctors or nurses know it all' which is being shaken off (Blain, 1993).

In value clarification workshops, which were run in Western Cape for medical personnel 87% of the participants, were nurses. The overall aim of these workshops was to contribute to the effective implementation and management of TOP. Their objectives were:

-To gain understanding of health workers' concerns regarding TOP.

-Develop a framework for assisting health workers relate their values and belief systems to the needs of their clients.

-Test the utility of a training module for different levels of health workers.

-Develop recommendations for the integration of value clarification in pre service and in service training of health workers.

Before the workshop most people had negative and mixed feelings about abortion. But at the end of the workshop 70% of the participants found the workshop had assisted them in clarifying their values to such an extent that they would be able to deal with patients having an abortion far better than they would have before they attended the workshop (Marais, 1997:7). A recommendation was made at the end of the workshop that it was imperative to hold the 'train the trainer' workshops as soon as possible. "Once the trainer has been trained it will be possible to incorporate abortion values clarification into the curriculum of medical and nursing students and offer in-service education to qualified staff".

In many countries there are recommendations to train nurse/midwives, nurse practitioners and physician assistants to perform first trimester abortions under physician supervision (McKee, 1994). In 1992 the American College of Nurse/Midwives rescinded the prohibitive statement on abortion performance by nurse/midwives. One of the findings of the symposium was that 'social stigma, professional isolation, peer pressure, inadequate economic and other incentives, anti-abortion harassment and violence, and the perception of abortion as an unrewarding field of medicine, all adversely affect physicians' willingness to participate in abortion, hence the recommendation to train the nurses.

But the nurses interviewed in South Africa by Poggenpoel et al, (1998) felt that:

-Separate abortion clinics to be set up.

-Staff should work there out of their own free will.

-Aborted fetus to be handled with respect.

-Intensive education to women coming for abortion about the negative effects of abortions.

2-7-2 ASPECTS OF NURSING ETHICS

One of the most important features of a profession is that it has a professional code of ethics based on personal morality, which is the foundation of trust for the patient and the community. Individual moral integrity is regarded as the key to a safe standard of practice (Searle and Pera, 1997). A nurse/midwife who abuses the ethical trust placed in her by her profession, employer, patient and fellow professionals, betrays a professional trust and brings the profession into disrepute. The modern nurse is confronted with greater number and variety of ethical problems than ever before due to the complexity of modern medicine and health care technology. Searle and Pera (1997) observe that society worldwide has accepted that nursing is crucial to its well-being and nurse/midwives expected to be worthy of this trust. Ethical codes for professions set the parameters of the responsibilities the nurse owes her patient. They further note that the 'nurse/midwives who have not made their professional code their way of life, who observe the do's and don'ts because they must, and not because they believe in them, are often the ones who advocate the solution to an ethical dilemma at the cost of the vulnerable individual- the unborn child, the aged, the incurably ill etc. They do not see professional ethics as principles which give

meaning to the lives of both the practitioner and the recipient of her care' (Searle and Pera, 1997:151).

Searle and Pera (1997) in their correspondence with nurse leaders from 67 countries came up with 14 elements, which are held in common by many nurses around the world. They are as follows:

1. *The fundamental responsibility of the nurse/midwife is to conserve life, promote health and alleviate suffering. The majority of the correspondents regarded this as a duty that the nurse has to safe guard the vulnerable against abortion and euthanasia and should direct all her efforts towards preservation of life.*

2. *The nurse/midwife must provide nursing care in accordance with human need and with respect for the dignity of man without consideration of race, creed, nationality and social or political and economic standing.*

3. *The nurse/midwife does not use her knowledge to the detriment of society. She should not participate in illegal acts.* In her care she is expected to play the role of an advocate.

4. *The nurse/midwife keeps in confidence all confidential information about her patients.*

5. *The nurse/midwife must be a law-abiding citizen. She is expected to observe the law of the land and enjoy the trust of the public.*

6. *The nurse/midwife has a duty to uphold the efforts of her profession. She must be a member of her professional association for professional strength and development.*

7. *The nurse/midwife must continue to develop her professional competence and assist others to do the same.*

8. The nurse/midwife helps to establish and maintain professional standards in nursing.

9. The nurse/midwife must be concerned with all legislation affecting the health care of the human being.

10. The nurse/ midwife does not advertise.

11. The nurse/midwife has a duty to teach those she works with and to prevent unskilled or unauthorized persons from performing tasks that may harm the patients.

12. The nurse/midwife collaborates harmoniously with other members of the health team to ensure patients' safety.

13. The nurse/midwife does not participate in unethical practices.

14. The nurse/midwife is accountable.

The nurse/midwife may experience difficulty in insisting on her right to ethical practice especially the young nurses who may not know how to withstand the pressures of their circumstances. According to Searle and Pera, a nurse/midwife needs to be well versed on ethical issues, as she has to take a stand on a variety of issues. Like it was observed in Zambia by Kaseba et al (1998) that most health care providers either do not know about the Act or are misinformed about its guidelines. Most modern nurses do not appreciate the value of keeping abreast with the new trends in nursing.

'There are no clear-cut answers to the ethical problems that exist today. Deeply religious doctors, lawyers, nurses and other committed professionals and ministers of religion the world over are discussing the current ethical issues without finding solutions. In the long run they all come back to the issue of that life that has the right

to be protected by concerned persons. The personal conscience of the practitioner, which is the watchdog over the vulnerability of those who cannot defend or speak for themselves' (Searle and Pera, 1997:156).

Ethics are not static. They change as society changes. If we fail to recognize the intrinsic value of every human life and the responsibility we owe to that life, our ethical code cannot be very effective (Searle and Pera, 1997). They concluded that the nurse/midwife must read widely, consult her conscience, and decide whether she will cooperate with the doctor in sensitive issues like therapeutic abortion, euthanasia etc. She has the right to refuse.

2-7-3 THE EMOTIONAL WORK OF CARING

The concept of caring has been associated with nursing since the time of Florence Nightingale. The phenomenon of caring has received specific attention in the literature and researchers (McQueen, 1997). There is an increasing appreciation of emotional aspects of caring. Caring has basically three components according to McQueen, (1997):

-Physical work;

-Emotional work;

-Organization.

McQueen emphasizes the importance of the nurse-patient relationship in the delivery of the individualized patient care. She contends that the nurse is required to get to know the patient as a person. In this respect the organization of work to effect

continuity of care is important to develop the familiarity required for effective emotional work.

Organization as part of care work sets the context within which care is carried out and allows a balance to be achieved between physical and emotional labor. McQueen (1997:233) 'suggests that in institutional settings the organizational framework requires to be sufficiently flexible, allowing modification of routines, if nurses are to provide total patient care and respond to patients' individual needs within this environment'. She also emphasizes the significance of nurses' close professional relationships with patients, making care effortless and satisfying. In this study nurses indicated that a reciprocal relationship, with both 'cognitive and emotional identification' with patients, provided the closest bond and it was in these circumstances that they believed they provided their 'best' nursing care. This level of bonding however requires emotional distancing, because the nurse had to identify with the patient while isolating his or her own feelings, avoiding over-involvement. While emotional involvement and understanding are acknowledged as contributing to both professional satisfaction and good quality patient care, writers note the importance of balance between identification and over-involvement (McQueen, 1997).

Morse, Burttorff, Anderson, O'brian and Solberg in McQueen (1997) identified four mutual relationships in nurse-patient relationship, three are said to be satisfactory and one unsatisfactory. They acknowledge that the development of deeper nurse-patient relationship with increasingly emotional involvement, benefit for continuity of care, time and commitment. In the unsatisfactory over-involvement relationship, the nurses'

feelings for the patient as a person are too dominant. Nurses' expressions of emotions, which engender in other feelings of care, vary according to different circumstances, which they face in the course of their work. They attempt to suppress inner negative feelings while the expression of empathetic feelings is now being valued in caring relationships.

In the past nurses were encouraged to conceal their emotions in professional relationships with the patients and this offered a degree of emotional protection, enabling them to function in a detached manner. The task- oriented which dominated nursing in the past offered some protection against emotional involvement. However the advocacy of primary nursing and other developments in nursing which are patient-centered necessitate nurses having a close relationship with their patients. There has been also a raised awareness of the value in sharing in patients' emotional burdens and demonstrating true feelings of sympathy and compassion (McQueen, 1997). McQueen (1997:234) notes that 'these changes in the ethos of nursing and the organization of care invite nurses to become more emotionally involved with patients as people, may have resulted in breaking down of the protective barrier of former times'. Nurses are now more vulnerable to emotional hurt, emotional stress and exhaustion.

McQueen in her research on caring for patients having TOP, nurses said they tried to meet the needs of the patients going through TOP. 'Although nurses said that they tried not to let their views affect the care that they gave to these patients, the degree of empathy some nurses could share with such patients and the depth of engagement

in the relationship may not be so intense as could be possible if they experienced a natural empathy, because attitudes can leak through into behavior and inadvertently influence care (Webb in McQueen, 1997:237).

The nurses in McQueen's study tried to suspend judgment and did not indicate such condemnatory attitude to the women under going TOP. She observed that nurses did show an appreciation of the mental turmoil that can precede TOP and the possible emotional responses that can follow the event. They also acknowledged the lack of formal post-hospital support after discharge, especially in situations where patients experienced this event alone, in silence and with feelings of guilt.

Nurses indicated that they found it easier to identify with the emotional suffering of patients who had miscarriage than TOP. They shared in the disappointment and sadness experienced by such patients. If intense emotional effort is to be encouraged as a venerable asset in patient care, the nurses require some 'protection' against physical and psychological exhaustion built into the organizational structure (McQueen, 1997). The gynecology nurses described their nursing as a type, which required emotional commitment, and hence emotional labor was great.

2-7-4 TERMINATION OF PREGNANCY (TOP)

Termination of pregnancy otherwise commonly referred to as abortion, may be defined as the intentional ending of pregnancy, through the evacuation of the uterus, before the fetus has a reasonable chance of survival (Marshall et al, 1994).

Vacuum aspiration is the most widely used method of abortion in the first trimester. This method can be used up to twelfth week of gestation. Previously it used to be carried out under general anesthesia (GA). The procedure takes about five minutes to complete. The potential complications may be bleeding due to retained products of conception, infection and uterine perforation and psychological effects in some women.

Drug induced terminations which are being commonly used are:

Mifepristone an anti-progesterone compound used in combination with a vaginal prostaglandin. Mifepristone blocks the activity of progesterone (which is essential for maintaining pregnancy), at the intracellular receptor. It is followed by a low dose of prostaglandin analog, which activates great uterine contraction and causes termination of early pregnancy.

CAUTION: In the absence of specific studies, Mifepristone should be used with caution in the following:

-People with asthma or chronic obstructive airway disease.

-Patients with cardiovascular disease or risk factors.

-Patients with renal or hepatic failure.

-Patients with prosthetic heart valves or who have experienced an episode of infective endocarditis.

CONTRAINDICATIONS:

-Pregnancy beyond 63 days of gestation.

-Suspected ectopic pregnancy.

-Evidence of adrenal dysfunction or long-term corticosteroid therapy.

-Hemorrhagic disorders treated with anticoagulant.

-Where duration of pregnancy is not known.

2-7-4-1 MIFEPRISTINE ADMINISTRATION

Mifepristone tablets are taken orally in a single dose in the presence of a nurse or doctor. Observe the patient for two hours. Within 48 hours patient should start bleeding which may be heavy accompanied by cramp-like abdominal pain. Other women have aborted at this stage. Side effects may include: nausea and occasional vomiting, malaise, faintness, headache and skin rashes.

2-7-4-2 PROSTAGLANDINS

After 48 hours the patient is given one vaginal pessary of a prostaglandin preparation. Progress is monitored for six hours i.e. Blood pressure, bleeding, pain and side effects. In most patients abortion will occur during this time.

In South Africa MVA procedure includes: (Gestational age of 12 weeks and less)

On morning of admission to clinic, 600 micro grams of Misoprostol tablets inserted per vagina. MVA is performed 2 to 4 hours after insertion of tablets. If dilatation of cervix fails, the patient will be asked to return the following day. The same procedure will be done all over again. If any problems refer to tertiary hospital. If the pregnancy is 12 weeks and above the patient is raftered to a tertiary hospital for an experienced physician to conduct the TOP.

In Zambia MVA is done either under the 'cooperation' or with anesthesia. The others are given a sedative in form of Diazepam or a cocktail of Pethidine, Diazepam and largactil. The majority of patients come in as incomplete abortion. They have not started using prostaglandin. After the procedure they are given a full dose of antibiotic.

2-8 CONCLUSION

Before abortion was liberalized, studies done on the nurses' experiences of abortion focused on the woman under going TOP for various medical reasons. In these studies the nurse had been playing the role of how best to console this grieving woman. Where a nurse was uncomfortable with the procedure she needed to make her stand known in good time.

But in the advent of legalizing abortion in many countries the role of the nurse continues to expand and so is her dilemma on ethical issues. The numbers of women demanding abortion continue to increase and so is the burden on nurses and doctors.

The ethics of abortion continue to confront nurses, doctors and many other interested parties, because the questions of life and death are involved.

Abortion is no longer a secretive issue in many parts of the world, but it remains a highly controversial issue especially among medical personnel, who are supposed to be the implementers of the legislation. It has been argued in a lot of studies that women's negative experiences of abortion are short lived, but for nurses who have to witness these procedures it remains a nightmare. Most nurses have refused to assist in abortions because they are highly affected by the procedure. They remain with the duty of disposing the fetus, the pieces of flesh and emptying of the suction bottles that have been removed from the woman. Most of them find this work to be very unpleasant.

In America in one large hospital, it is reported that although the hospital as a public institution provided abortion services, residents were not obligated to participate in the abortion procedure itself if they claim to have moral or religious objections. Difficulties arose not only over who would and would not participate in abortion, but also over who would participate in the patient work ups around abortion (Lazarous, 1997).

As a result of the recent changes in abortion laws in many countries including South Africa, there is need for further research not only in the area of assessing what the needs of the aborting woman are but also the needs of the nurses and doctors who provide the service with regards to counseling. Based on the previous research findings and the changes to the abortion legislation and the current debate on

abortion, the present research is conducted to explore and describe the experiences of TOP nurses regarding therapeutic abortion, to assess their willingness in participating in abortion and in client counseling and to identify relevant, specific support strategies necessary for TOP nurses.

3-0 CHAPTER THREE: RESEARCH METHODOLOGY

Due to the sensitivity and emotive effect of abortion, and the exploratory nature of the study, the qualitative research paradigm is considered to be the most responsive to the research questions.

3-1 INTRODUCTION

The general interview guide approach will be used as a qualitative research design. Qualitative research approach is used because it is primarily descriptive in nature and relies on people's words as a primary database. It values participant's perspectives or their world and seeks to discover these perspectives (Marshall and Rossman, 1995).

Polit and Hungler (1987) described qualitative research as holistic that is concerned with humans and their environment in all their complexities. Its often based on the premise that knowledge about humans is not possible without describing human experience as it is lived and as it is designed by the actors themselves.

It is hypothesis generating which can be tested, understood and replicated (Treecy and Treecy, 1986). The hypothesis points the direction which the researcher is to proceed and provides a basis from which to learn if their speculative statement is probable or not. The qualitative approach to research is uniquely suited to uncovering the unexpected and exploring new avenues. The unique strength of the qualitative paradigm for research is the exploratory or descriptive, that assumes the value of context and setting, and that searches for a deeper understanding of the participants' lived experiences of the phenomenon (Marshall and Rossman, 1995).

3-2 STUDY SAMPLE

In-depth interviews will be done from two academic, tertiary hospitals, one in Zambia and one in South Africa. A total of eight nurses will be interviewed, four from each hospital.

Non-probability method using purposive sampling will be used to select the subjects using non-random procedures. Purposive sampling derives from the belief that a researcher's knowledge about the population and its elements can be used to hand pick the cases to be included in the sample (Polit and Hungler, 1987). Purposive sampling will enable the most representative or productive participants to be selected. It increases the likelihood that variability common in any social phenomena will be represented in the data (Maykut and Morehouse, 1994).

A good informant is one who has the knowledge and experience the researcher requires, has the ability to reflect, is articulate and willing to participate in the study (Morse, 1994). Patton (1990) suggests that the logic and power behind purposeful selection of informants is that the sample should be information rich. In the present study the researcher has chosen nurses who assist in TOP or work in wards where TOP takes place, in order to study their experiences.

The participants will be identified through their nursing managers in both countries. These participants are involved with assisting with TOP or work in Gynecology ward where abortions take place. Appointments with nursing services managers will be made seeking for permission to conduct the study among the nurses assisting with

TOP. Adequate explanation will be given and proposal will be made available if needed.

The hospital in South Africa is a primary teaching hospital in Cape Town. It is also a tertiary hospital where specialized care is provided, and where research and education of all categories of health care workers are prime goals. It provides TOP services and MVA, which are done either in theatre or emergency unit. Patients are admitted in a different ward and counseling of patients is done in out patients department (OPD).

The hospital in Zambia is a referral center and provides tertiary services to Lusaka Province residents. It provides TOP services and MVA, which are done in the emergency admission unit and is managed mainly by interns and nurses in the acute gynecology ward. Patients are admitted directly to the unit through OPD gynecology clinic. Counseling is done in the unit as well as in the family planning clinic (FP).

3-3 PARTICIPANTS.

The researcher aims to collect data from nurses who possess the following characteristics:

-Should be working in TOP units or gynecology wards.

-Be assisting with TOP procedure.

-Be conversant with English.

-Voluntarily willing to participate in the study.

Individual nurses will be interviewed separately. In-depth interview will be used to explore and describe nurses' experiences of therapeutic abortion, and how these affect client care. The in-depth interview should take between 45 minutes to one hour, and will be tape-recorded and designed to allow the participants to talk about their individual experiences. The questions were designed from the theme in the literature review and will be asked under the following headings:

-Experiences,

-Perception,

-Support and

-Recommendations.

See appendix A for the interview guide used.

Maykut and Morehouse (1994) noted that an in-depth interviewer becomes a part of the investigation but removes herself or himself from the situation to rethink the meanings of the experience.

3-4 RELIABILITY AND VALIDITY

The techniques of securing reliability and validity in different types of qualitative research are not the same but are similar in all qualitative research methods. Validity in qualitative research therefore, hinges to a great extent on the skill, competence and rigor of the researcher (Patton, 1990). It has to do with description and explanation. According to Janesick (1994) description of persons, places and events has been the cornerstone of qualitative research. Silverman (1997) described validity in qualitative

research as concerned with the interpretation of observations, whether or not the researcher is calling what is measured by the right name.

Reliability is concerned with the consistency and ability to collect and record information accurately (Brink, 1993). Holloway and Wheeler (1996) say that the tapes, in tape recording contain the exact words of the interview, inclusive of questions. The interviewer can have eye contact and pay attention to what the participants say. Key aspects of reliability involve selection of what is recorded, the technical quality of recordings and the adequacy of transcripts. Tape recordings and transcripts can provide highly detailed and publicly accessible representations of social interaction (Silverman, 1997). The validity and reliability of this research is therefore based on the factors described above.

3-5 STATEMENT OF ETHICAL CONSIDERATION

Abortion being a sensitive issue, the study will raise certain ethical concerns. Consideration will particularly be given to the ethical interests of the participants through the following procedure:

-informed consent: Consent will be obtained from the participants after the purpose of the research has been explained to them.

-Confidentiality and anonymity: Careful explanation of the procedures to be taken to ensure the confidentiality of information and anonymity of the participants, protecting them from identity. Real names will not be used in the study.

- Tape-recording: Permission will be sought from the participants to tape record the interview.

-Protection from emotional harm: The researcher being a trained counselor will offer to counsel anyone who would require it after participating in the procedure.

-Permission: Securing permission from participants to disseminate information acquired by means of interviews.

3-6 DATA COLLECTION PROCEDURES

Interview appointments will be made with each participant after their respective nursing managers identify them. The interviewer will meet each participant separately and explain the nature and the objectives of the research. An audio tape recorder will be used to collect data with the permission of the participants. Non-verbal language and any other observation made will be noted down after each interview.

The interviews will be held in their respective hospitals for easy access and because of staff shortages in the TOP units. This will also be an advantage for the researcher especially in South Africa where she is not familiar with the country. The researcher is advantaged also by being a professional nurse. The language to be used will be English.

3-7 DATA ANALYSIS

Marshall and Roseman (1995) describe data analysis as a process of bringing order, structure and meaning to the mass of collected data. It's a search for general statements about relationships among categories of data. Data will be analyzed thematically. The interview transcripts will be arranged systematically and thoroughly scrutinized. The challenge is to make sense of 'massive amounts of data, reduce the

volume of information, identify significant patterns and construct a frame work for communicating the essence of what the data reveal' (Patton, 1990:372). The analytic procedure will be based on Marshall and Rossman's (1995) non-linear model, which falls into five modes:

I) Organizing data

This involves repeated reading through the data allowing the researcher to become familiar with those data in an intimate way (Marshall and Rossman, 1995). The transcribing process will involve repeated listening to the tapes and transcribing as verbatim. The researcher will do this process. People, events and quotes sift constantly through the researcher's mind. During the reading and listening process the data available will be listed on cards and notebooks. The necessary editing will be done to make field notes retrievable and generally 'clean up' what seems overwhelming and unmanageable (Marshall and Rossman, 1995). The research findings will be combined in the report.

ii) Generating categories, themes and patterns

Transcribed data will be categorized and search for regularities will be done until patterns get formed. Data will be organized into themes until regularities and patterns emerge and could be converted into systematic categories of analysis. Similar themes, which were identified in literature review, will be utilized.

Marshall and Rossman (1995:114) states that 'identifying salient themes, recurring ideas or language and patterns of belief that link people and setting together is the most challenging phase, and one that can integrate the entire endeavor'.

iii) Testing the emergent hypothesis against the data.

As categories and patterns between them become apparent, the researcher begins the process of evaluating the plausibility of these developing hypotheses and testing them through the data (Marshall and Rossman, 1995). In this phase the researcher will evaluate data for its informational adequacy, credibility, usefulness and centrality. Marshall and Rossman, (1989:119) noted that 'a reasonable stance to approach the data is with skepticism and willingness to consider that the participants in the study have ensured a particular of themselves to the researcher. In illuminating the questions being explored and whether or not they are central to the story that is unfolding about the problem being researched, the researcher must determine whether or not data collected is useful'. After the pilot study the researcher rephrased some questions and will explain some in detail during the interview. The participants will be encouraged to ask where they will not understand.

iv) Searching for alternative explanations

As categories and patterns between them emerge in the data, the researcher must engage in the critical act of challenging the very pattern that seems so apparent (Marshall and Rossman, 1989). Alternative explanations always exist; the researcher must search for, identify and describe them and then demonstrate how the explanation offered is the most plausible of all. The explanations will be done in comparison with the previous studies done in chapter two.

V) Writing the report

In report writing the researcher is engaging in the interpretive act, lending shape and form- meaning- to massive amounts of raw data. Writing about qualitative data cannot be separated from the analytic process. It is central to the process (Marshall and Rossman, 1996). It summarizes and reflects on the complexity of the data.

The report will be written according to the identified themes, which will generate from the interview. The participants will confirm the analysis as being trust worthy. Triangulation is the other method or technique used for verifying validation but will not be used in this study.

3-8 LIMITATIONS OF THE STUDY

-TOP nurses are few because most nurses do not accept to assist in TOP. There are plus or minus seven nurses per clinic in a hospital.

-Due to the sensitivity of the problem, some nurses withdrew from the study for fear of victimization.

-The study intended to cover two hospitals in each country but in one hospital in South Africa the authorities could not allow the researcher to collect data, citing few TOP nurses as the reason.

-Time limitation and factors explained above dictated the researcher to only cover one hospital in each country.

-Due to language barrier especially in South Africa, only English was used, this hindered some participants from expressing themselves well in their own language like Afrikaans and Xhosa.

4-0 CHAPTER FOUR: DATA ANALYSIS (REPORT)

4-1 INTRODUCTION

The interviews were conducted within a period of twelve weeks. All participants met the inclusion criteria; they were all involved in assisting with TOP or working in a gynecology ward where abortion takes place. Names used in this report are not real names of the participants as stated in chapter three. The names of the countries where the participants are coming from will be identified with SA for South Africa and Za for Zambia during the discussion.

The South African participants consisted of one Registered Nurse, one Chief Professional Nurse, one Senior Nurse Assistant and one Enrolled Nurse. While the Zambian nurses consisted of two Registered Nurses and two Enrolled Nurses. All participants were female as no male nurses were found working in these units. No further enquiries were made on this issue. The interview question guide was used as well as probe techniques during the interviews. Informal discussions continued after the interviews, which were relevant to the topic, which were recorded along with any non-verbal observations made. The researcher provided counseling for those that needed it after the interviews. Three nurses needed counseling.

Relevant demographic data was documented. Audiotapes were transcribed in verbatim form by the researcher. Transcribed data was incorporated with the other information from observations and relevant discussions to make a complete database. With reliability checks the researcher analyzed all data. Data gathered is based on the personal experiences of the nurses.

Both interviews in Zambia and South Africa were conducted within the hospital premises. The venues were conducive for the interviews. The results have been reported according to the themes identified from the literature review and are presented here below.

4-2 THEMES

The following five major themes will be utilized to analyze the data:

1. Factors associated with nurses' experiences towards TOP.
2. Nurses perception of abortion.
3. Nurses dilemma surrounding abortion.
4. Abortion awareness.
5. Recommendations regarding support for TOP nurses.

4-2-1 Factors associated with nurses' experiences towards TOP.

These factors will be discussed under the following sub-topics:

-Nurses' experiences of abortion procedure.

- Nurses' willingness to assist in TOP.

-Nurses coping strategies.

4-2-1-1 Nurses experiences of abortion procedure

Discussing some of the factors that disturb them, it was evident that the sight of the fetus and fetal parts and its disposal disturbs some nurses. Carol was particularly more disturbed as she had a recent experience of how she did not know what to do

with the fetus. This is about a patient who was awaiting TOP on a theatre trolley but she aborted in the process.

"Now as we were going to transfer her on to the bed in theatre, when she moved across you know.... the little fetus was among the bloody products. I picked him up shame..... and it was still alive! Like for me yesterday I felt bad. Also what do I do with this fetus, which was still alive? Should I throw it in the red bin? You know.....I felt glad when the anesthetist took the fetus..... But given a choice I don't know if I would have thrown it in the incineration bin, but you know I didn't know".

(Carol-SA)

For Carol the experiences were so fresh because of what she had gone through the previous day but tried hard not to condemn the patient despite being angry. She said:

"I was upset you know.... but I mean it's not for me to judge. I mean it's her choice. I don't know what sort of problems she had, but also on the other hand..... I feel very angry with them for coming wanting to have it done".

(Carol-SA)

Carol also narrated an incident when she started work in the gynecology ward of how she failed to dispose a fetus and took it home. She seemed to be in a real dilemma.

"When I started here in gynae. I took one home; I put it in a little bottle with formalin.... I don't know but later I brought it back".

(Carol-SA)

Concerning their experiences or feelings during the abortion procedure, there were different experiences that nurses went through. In Zambia Beatrice is only comfortable to assist abortions up to eight weeks of gestation. Their experiences are described below:

"At first I used to find it very difficult actually. It used to be very difficult for me. But as time went on..... okay in our place we only do TOP up to a certain stage, which is eight weeks. At eight weeks there isn't so much in a pregnancy, what comes out is just blood. But beyond that, that's where you see fetal parts and it really used to affect me. Beyond that I make sure I refuse, because I don't want to see fetal parts, it really affects me".

(Beatrice-Za)

Beatrice explained that it was very difficult for her to assist a pregnancy of more than eight weeks, as it would cause her a lot of sleepless nights and guilt feelings. She decided to be refusing to assist in such circumstances.

"It depends on the type of abortion. Usually the type of patients we have especially schoolgirls come with induced abortions. So usually when I am nursing such patients I feel offended personally, I feel those patients commit crime".

(Brenda-Za)

"I feel very bad usually when I am assisting with abortion, because it's more like murder. After abortion I usually feel very bad".

(Charity-Za)

Brenda and Charity displayed a judgmental attitude when describing their experiences. In a study done by Walker (1993) among PHCNs, most of the nurses were judgmental, harsh and antagonistic in the way they responded to the issue of abortion. In Poggenpoel et al (1997) study, the nurses they interviewed also displayed a strong judgmental attitude towards the women who undergo abortion.

Mwansa did not want to be judgmental though she said that she feels bad after the fetus is out, but thereafter she forgets about it. She denied any major disturbances while assisting in TOP.

Among the South African nurses, Eva and Jill had no problems with the procedure. Jill said she always puts her feelings aside and deal with the patient. Eva denied any disturbances.

"Well ..... sometimes if I will assist, you know, or if its very difficult, or you feel the pain in yourself, or you feel it for that patient..... what that patient gonna feel afterwards, how she's gonna feel afterwards".

(Cynthia-SA)

Cynthia could not describe her own feelings she kept transferring them onto the patient, she was not willing whatsoever to share her experiences. The researcher probed further about her own experiences and she said the following:

"I will never tell a person that I have negative feelings about abortion. Because every person is different.... I must be.....I can say to you that I have negative feelings about abortion, but I will never say that I have negative feelings because someone might be cross with me. I would rather not say anything about that".

(Cynthia-SA)

in their works around abortion nurses had been dealing more with women who had miscarriages and are grief stricken over the loss of the baby. In some countries nurses have formed support groups, which have even looked at how to dispose of the fetus. To such women nurses have tended to be very sympathetic than the ones who request abortion. They share the grief with the mother and support her through the experience (Walker and Nelson, 1997).

But during abortion procedures of women who demand abortion for social reasons, most nurses become angry and hostile towards the women like in the studies by Walker (1993). Nurses feel they are participating in the 'killing' of an innocent baby. These reactions come out so much in the present study from Brenda and Charity. The other nurses felt that it was not right to have an abortion, but tried to put their feelings aside as much as possible. The study confirms that generally nurses feel discomforted by the abortion procedure.

The problem of handling and disposing of the fetus remains difficult for most nurses as seen in the above sentiments. One of the three main psychodynamic sources cited by Price, (1983) is that of over-identification of the nurses with the fetus and lack of identification with the aborting woman. Nurses do not have much contact with the aborting woman but are forced to have contact with the fetus, which they must handle and dispose. This is true for nurses like Carol who went to an extent of taking a fetus home for fear of disposing it. She becomes more attached to the fetus than the client.

4-2-1-2 Nurses willingness to assist in TOP

Participating in abortion was one of the issues, which was forbidden in the traditional nursing world. But now with the liberalization and legalization of laws, individual nurses have been left to decide whether or not to assist in works around abortion according to their convictions. Below are some of the sentiments that motivate nurses to assist in

TOP.

"..... the way I look at it is this, I am not the one who is doing that TOP, although I am assisting to prepare the set and the room. I might be part of it but the one who made the decision is the client not me".

(Beatrice-Za)

Beatrice seems comfortable with abortion as long as the client has made her decision. For her if there will be anyone to blame it should be the client. Her only part is to prepare for the procedure and assist the doctor.

"Its simply because, I mean, I want to help save the lives of the patients, because they come bleeding profusely. So for us to stop that bleeding MVA will be done, and that's when my part comes in".

(Brenda-Za)

Some patients in Zambia come in with self-induced abortion, so the bleeding begins outside the hospital. Manual vacuum aspiration (MVA) is done to remove the remaining products of conception, which normally cause a lot of bleeding. So Brenda sees her main task as a nurse in the procedure as helping save the life of that mother.

"Whether someone has induced their abortion or not, I feel compelled to help because that's the nature of nursing. The most important thing is you want to save life".

(Charity-Za)

"When I come from home, I come with one mind to come and help the patient".

(Mwansa-Za)

One of the responsibilities of the nurse is to conserve life and promote health. Conservation of life means preserving, looking beyond the circumstances of that patient. A nurse should be responsible for every life entrusted into her hands. For these three Zambian nurses that is their motivating factor, whether or not they support abortion. In South Africa Cynthia will assist in TOP whenever duty calls her to do so regardless of her opinion on abortion.

".....before then I wasn't involved with TOP but I am also religious, I don't believe in abortions, but as a nurse I will assist where ever I can and with the shortage of nurses here, I think I will be able to help".

(Cynthia-SA)

"As part of my job so I do it.... but I get upset..... I feel very angry with them for coming wanting to have it done. I suppose ah.....I don't know..... may be I think it must be very difficult for them also to make that decision. .... I think its part of my job. It has to be done. Cos I mean they come to the hospital for help, otherwise they would not be here".

(Carol-SA)

Carol feels she has to help because the patients come to the hospital for help but she seemed to have conflicting emotions, which she could not put in words. Feelings of anger, guilt, frustration and care cannot be quantified, but they are very important in a person's life. She is going through conflicting moments.

"I am the only one who has been working here for so long, because I love it very much yah especially with gynae. I love gynae but the other side of gynae which I don't like is the abortion side. But I will assist the doctor"

(Jill-SA)

Jill seemed uncomfortable with the abortion but feels for the sake of the patient she can just assist the doctor.

While Eva is the only nurse in the study who went through counseling before working in TOP unit and she feels competent to handle the abortion issue.

"At the beginning I didn't have a choice you know, we didn't even know we gonna start doing abortions here. I think like for myself, I have had counseling and it's helped me a lot".

(Eva-SA)

Values, attitudes, personal qualities and consistent patterns of behavior, which begin to develop early in life, are fostered and helped by the process of socialization to the profession. These values influence our behavior and ultimately shape our character (Shelly and Miller, 1991). A clause in the Nightingale pledge which most nurses recite says 'with loyalty will I endeavor to aid the physician in his work.....' meant that the nurse's responsibility was to follow doctor's orders. Nurses were not even allowed to know the medicines they dispensed (Shell and Miller, 1991). In Zambia during graduation ceremonies, nurses are made to recite the pledge in a solemn manner with lit candles in their hands and pledge to abide by it.

Many nurses today like the ones in the study still carry themselves as assistants to the doctor. They may not question doctor's authority, even when they are right. But is this what the clause in the pledge meant? Shelly and Miller (1991) noted that such mindless obedience is not what the pledge professed. Even Florence Nightingale herself did not hesitate to question the doctors' orders. 'The pledge is expressing a commitment to interdependence and colleagueship' (Shelly and Miller, 1991:47). The nurses are not obliged to assist the doctor if their conscious is not clear.

None of the nurses mentioned that they are willingly participating in the abortion procedure in both countries. They seem to be doing it out of duty rather than self-will. This confirms that very few nurses are willing to assist in the abortion procedure even those who are pro-choice.

4-2-1-3 Coping strategies for nurses

It was evident in the interviews that after an abortion experience almost every nurse needed to deal with her feelings. How each nurse handles their feelings is described below.

"With my colleagues we are quite a happy bunch of people, working together... we share, we talk a lot to each other and we just forget it and just your work goes on".

(Jill-SA)

Eva does not necessarily get upset with the abortion but only when a patient is rude to her. In those moments she says, "Ah..... I just walk away for a moment, take a smoke, or talk to one of my colleagues".

(Eva-SA)

Carol seemed rather confused about her situation. She is not sure how to handle her feelings, she kept referring to what had happened the previous day. She feels

fortunate that she did not have to make a choice of whether to abort or not, because she does not know how she would handle that situation.

".... Like yesterday that moment I was upset, but we were busy, you know, I just forgot. But when I went home, again you know when I pray, I also don't know how to deal with the feelings ya.... I just am grateful that I have a child, I didn't have to make that choice..... but its difficult for them also, I don't know.... how I don't know. May be just working and not thinking about it. But when I go home, the anger towards them is still there".

(Carol-SA)

Carol appeared disturbed during the interview and rather confused. She takes the situation too personal. She gets over-involved in a patient's situation rendering herself vulnerable to low self-esteem and obsessional thinking about abortion.

According to Price (1983), this situation is called an acute identity crisis which is experienced by nurses who are distressed by the contradiction they perceive between their training to preserve life and their role in abortion work which aids the ending of life. This is also known as having a fatalistic attitude.

Beatrice feels secure that as long as she is not doing the procedure herself she is not to blame, but she fears to share anything with anyone because of negative comments.

"Mh.. Mh... I try to reassure myself that it's not me who has done the procedure. It's my job to assist the doctor. All I have done is just to lay out a set, I'm on duty. I make the set ready, I don't do the procedure. At least that tries to brighten me up a bit. Sometimes I fear to share anything with anyone for fear of those comments. You may need somebody to talk to but when you look around, you find there's no one to talk to. You just keep it to yourself".

(Beatrice-Za)

Brenda lets out her feelings on to the patient, which are judgmental.

"Personally I don't hide, I let the patient know my feelings..... I tell them what they have done is wrong, and that they shouldn't repeat it because its crime".

(Brenda-Za)

Charity said that she feels offended when she sees the baby. She described her experience as very bad, but she feels that she should not be judgmental in trying to deal with her feelings.

"I don't throw it to the patient except I try to talk to them...."

(Charity-Za)

Mwansa tries to quickly forget about her feelings and centers her mind on the patient, though she confessed that the sight of the fetus does affect her.

"It does have some effect on me especially when the fetus comes out. It really affects me. At times I always imagine if it were me being poked with a screwdriver or a knife, it will really be painful. Thereafter I do forget about that. Now the person who is there is the patient who has come in my presence. I do forget what has happened...."

(Mwansa-Za)

All the nurses in this study do not receive any form of support to help them cope with their feelings. The South African nurses talk about it among themselves. Other than that no one else gives them support. While their Zambian counterparts tell it to the patient, they feel that the patient must know what they have done which they have called 'bad'. This situation is known to compound or worsen the guilty feeling in the patient. They too do not have any form of support, which they so badly need.

It is evident in this study that most nurses can hardly cope with the abortion situation and they need a form of support from their immediate supervisors and significant others. The care the nurses give to the patients is evidently affected by their coping mechanism. Who has the responsibility to care for the nurses?

4-2-2 NURSES PERCEPTION OF ABORTION.

This theme is discussed under three sub-headings:

-Nurses' attitudes towards abortion.

-Nurses' attitudes towards women who request abortion.

-Religious sentiments- issues that came out in the interview, which relate to nurses' religious beliefs.

4-2-2-1 Nurses attitudes towards abortion

The issue of abortion was found to highlight a serious tension within nurses' socialization. None of the nurses totally supported abortion. They accept it only in certain circumstances. Beatrice and Charity support abortion only for medical reasons.

"It depends on the reason for which it is done. If its medical reason I feel its okay. But the reasons they give these women.....social, economical, etc. I feel TOP is being abused. Because you will find that one woman will come back more than three times with the same reason. But she has free access to family planning, she lives near a clinic but she will keep on coming for repeat abortions. They really abuse it".

(Beatrice-Za)

"Mh..... I feel it's very sad; it's a very sad thing. But there are cases where they can't help it, its medical, there is nothing they can do".

(Charity-Za)

Brenda was very judgmental in her perception of abortion, she totally condemns it. While Mwansa feels the women must take preventive measures to avoid unwanted pregnancies. Their sentiments are quoted below:

"Its bad, one from biblical point of view, its condemned. God doesn't like the people who do that, because they are as good as murderers".

(Brenda-Za)

"I don't like abortions, I don't like them. Because if someone doesn't like the baby, it's better she takes necessary precautions instead of becoming pregnant and abort. Before meeting a man she must take precautions".

(Mwansa-Za)

Like in Walker's (1993) study, many nurses express a strong opposition to abortion in the form of anger, hostility, and judgmental responses towards the women. The woman is always blamed for getting an unwanted pregnancy, because the nurses feel that the woman should exercise her responsibility to control her fertility.

The South African nurses though opposing abortion tried not to be as hostile and judgmental as their Zambian counterparts. But what comes out of both of them is that the woman must take responsibility over her sexual life.

The way a woman reacts to abortion not only depends on her subjective attitude but also on the attitudes of the health service personnel with whom she is in contact (Figa-Talamaca, 1989). Judgmental attitudes can compound the guilt feeling of the woman. Though some nurses will not support abortion, they have decided to put their feelings aside and care for the patient in the best possible way they can. Their sentiments are expressed here below:

"Ah..... I know how difficult it is especially for young schoolgirls. You know in some cases I support abortion. But if its someone older, say above 20 or 30 years, they have a stable job, then I don't see why they still have to go through abortion".

(Eva-SA)

Jill feels that because she was able to handle her own situation of an unwanted pregnancy, so the other women should be able to do the same. They must be capable of solving their own problems without having to go for TOP.

"I feel it's not right. Because I take it from..... I am also a mother, and with my last pregnancy, I was unprepared for it. I go through... although I was married but I wasn't ready for the pregnancy. I also went through that stage, but after that..... for me.... it was just God who showed me the way.... that He gave me little bunch of love for my baby. I went through it afterwards. I was so much in love with this baby. I just feel that there is always an answer to each problem".

(Jill-SA)

Despite not wanting to share her feelings, Cynthia was able to voice her stand on abortion with a quick turn that she would support her patient who comes for abortion.

"I don't support it, but as for my patient, I mean the patient that comes for abortion, is a patient, I will support her".

(Cynthia-SA)

Carol had difficulties to express her feelings and her stand on abortion for fear of being judgmental, though she appeared very deeply affected by abortion.

"Its difficult for me to say. I don't know honestly I don't know. As I said you know..... I don't want to be so judgmental 'cos I think it must be very hard for any person to make that decision. If they came for the second time, I think it will be a bit too much..... I mean..... I'm sure it must be very difficult for them to come to the hospital, knowing that everybody is opposed to it you know.... Err..... I don't say it's not right..... I don't know. May be I would do the same thing, I don't know.... I have never been in that situation".

(Carol-SA)

In Latin America Rodriguez and Strickler (1999) report that clinicians worked under greater stress than the counselors and administrators, since they were the ones that performed the physical act of abortion. Many clinicians are torn between offering

services to the ever growing numbers of women who presented themselves requesting abortions versus 'burn out' by trying to keep up with the demand. Burn out comes about by working in stressful situations such as abortion units, emergency units, cancer units etc, and having no form of support.

4-2-2-2 Nurses attitudes towards women who request abortion

Abortion is only acceptable to the nurses depending on the circumstances in which it is done. Each of them had a reason in which they could accept or support abortion. Their attitudes towards women who request abortion depended on the type of woman and the reason for the abortion. Most of them did not accept abortion for social reasons.

"I also wonder why..... Sometimes when I have time I will speak to my patient, then after evacuation I will always encourage them to have..... to use contraceptives or whatever because I always tell them to use something and I tell them please I don't want to see you again".

(Jill-SA)

The fact that Jill can tell a patient not to come again shows how much she does not support abortion. She seems to have hidden feelings about the women, which she tried very hard to suppress.

"Well sometimes as I see it, its the young girls..... sometimes they don't know what is happening. So I think if that young girl or woman get counseling, or you talk to the patient before hand, maybe you can still talk to them or get them to change their mind, don't do it, rather keep it. It will be difficult to give other options and talk to them you know"

(Cynthia-SA)

Cynthia seems to contradict herself in a lot of situations. Earlier on she said if a patient came for abortion she would support her even if she herself does not agree with it, but now she would try to convince the patient not to abort.

Carol tried to bring out her hidden feeling of being a mother and not understanding why a mother should get rid of their baby.

"No I actually pity them also, cos I'm sure nobody would like to give away a child, cos I'm a mother also, so I really can't understand how they can do that, but I mean I don't know".

(Carol-SA)

Eva is only sympathetic towards schoolgirls compared to the older women. She feels the older women ought to be responsible enough to know how to utilize the family planning services, but she says that her attitude towards them does not change at all.

"Sometimes just for interest's sake you know, I have opened the folder and see..... you are 33 years old and you have a nice job and I know you can support a child. But still I don't have negative feelings towards the patient, no".

(Eva-SA)

Beatrice says she shows the woman the fetal parts after the procedure, so that they will think twice if they get pregnant again and try to abort. While Brenda confesses that her attitude is negative towards the women.

"My thoughts about the women are negative, but I can't help it, since the patient is already in my hands. I just do what I am supposed to do".

(Brenda-Za)

Charity's attitude appeared to be very positive and sympathetic towards both women and the schoolgirls in the area of counseling. In talking to them she even warns about diseases like HIV/AIDS.

"I don't call them names, because we differ in the way we react to situations. People have different reasons for going through abortions. Others do it because they were really scared of their father or they were hard pressed by a difficult situation. So I explain that next time take precautions. The schoolgirls I tell them that if you can't abstain from sex at least use a condom or any other family planning method".

(Charity-Za)

Mwansa says she does not have any negative feelings about the patient. She makes the patient her priority, she forgets whatever she has seen.

Figa-Talamaca (1989) reports that most studies have shown that maternity ward nurses are often aggressive and unsympathetic towards abortion patients and women are openly insulted when admitted with complications resulting from unsuccessful attempts to induce abortion. Under such circumstances TOP women could easily develop feelings of depression and guilt. Findings of the study have shown that nurses who assist with abortions do not necessarily have more permissive attitudes towards abortion. While they may consider assisting in abortion an undesirable practice in general they judge it necessary in their own personal situation.

Studies done by McCulloch (1996) and Suffla (1996) on women's experiences of abortion, they mention that the women who have been treated with great sympathy have shown good response in dealing with their abortion than women who have received judgmental treatment. Words like murderer, killer and criminal can have such negative effect on a patient. Feeling of incompetence to handle a situation and lack of counseling skills can be very frustrating to the nurse, leading to making the situation to be more stressful for the patient. Nurses definitely need to be equipped in order for them to know how to deal with abortion clients better. Support needs will be discussed in detail in the fifth theme.

4-2-2-3 Religious sentiments

A number of nurses in the study brought out some religious sentiments, which they have attached to their abortion stand.

Beatrice feels that though her Catholic religion condemns abortion, she feels she is only assisting the doctor, it is not her who is doing the abortion. She also feels that because the woman is the one who has made a choice she cannot be part of the abortion. Is the doctor therefore guilty of performing abortion according to Beatrice?

"I am not the one doing the TOP"

(Beatrice-Za)

Brenda says abortion is condemned from the biblical point of view:

"God doesn't like people who do that because they are as good as murderers".

(Brenda-Za)

Religious beliefs have emerged from research as being associated with negative attitudes towards TOP both within the general population and amongst health professionals.

"Before then I wasn't involved in TOP, but I am also religious..... I don't believe in abortions....."

(Cynthia-SA)

"For me it was just God who showed me the way.....He gave me little bunch of love for my baby....."

(Jill-SA)

Probably Cynthia suffers from a guilt conscience each time she assists in abortion but has difficulties to share these feelings with anyone. She also mentioned later that if she could avoid assisting in TOP she could do it. For Jill she feels every woman must know how to sort out her problems and not necessarily have an abortion. They must seek God's help in their decision to abort.

Carol was not even sure if her Christian faith played a part in her decision to assist with abortion. Her not being very religious seemed to compound her confusion. She seems to be having a fatalistic attitude, which is a submissive attitude to events as being inevitable.

"But I mean ... but you know, I don't really give it any thought..... I am.....I am not very religious. But I mean, I believe in God and what has to be done and not be done. But you know its part of my job".

(Carol-SA)

According to Gardner (1972) all decisions of abortion are religious decisions. He says, 'at one end of the spectrum the Roman Catholic can have no part in it because of his religious belief in the sacredness of God's gift of life' (: 89), and at the other end the pro-abortionist view that the dignity of the mother as a person must include her right to decide whether to bear her baby or not.

In a study done by Marshall et al (1994), the nurses who professed some religious affiliation were found to have significantly more negative attitudes towards TOP than those who did not. Walker (1995) also mentioned that Christianity has a particular relevance for nurses. Therefore questions of morality and religion provide reasons and explanations for the nurses' responses to abortion.

McCulloch (1996) observed that different women create different meanings and position themselves differently with regard to religion. Other nurses will integrate their religious and moral beliefs with their abortion decisions and suffer less negative effects after assisting. While nurses like Carol who do not seem to be sure how to integrate their religious and moral beliefs may suffer a lot of negative effects after assisting in abortion.

4-2-3 NURSES DILEMMA SURROUNDING ABORTION.

Nurse working around abortion face a professional as well as a personal dilemma, how to uphold their duty to care for patients while remaining true to their personal convictions. In the United States of America more and more nurses are withdrawing

away from the abortion units and gynecology wards so as not to take part in the works around abortion. The nurses dilemma will be reported under two headings:

-Judgment versus caring,

-Job satisfaction versus obligation

4-2-3-1 Judgment versus caring

Morally abortion is viewed by many people as something not accepted. Many women up to now still keep it to themselves, they do not want anyone to know that they have aborted. Most nurses too go through a similar situation. They feel guilty to be identified as nurses who assist in TOP, because people know them as lifesavers. They would rather it is done privately.

Jill feels guilty to be seen working with women who come for abortion. She does not want to be seen even by other people that she is one of the nurses who assists with TOP. She feels that the public will lose confidence in nurses who are supposed to be saving life, but instead they are taking it away.

"Another problem is that this place does not promote confidentiality and privacy. Patients outside can hear you talking, and now you will go out and they will say 'what kind of a nurse is this' even the patient herself will think 'what kind of a nurse are you? You don't have feelings for me'. Because most patients know what is happening here. They are just wondering what kind of nurses you are. You are here to save life but now just see what they are doing. So they are rather so confused. Can they really trust us?"

(Jill-SA)

The other problem she has is to nurse patients who come with infertility and at the same time nurse the patients who demand abortion in the same room. She feels that she is bound to be biased towards the later women and this makes her feel guilty.

"You normally end the day with mixed emotions, because sometimes you get a patient who is here with infertility, she can't fall pregnant. And after that you have this other patient-seeking TOP. So by the end of the day you end up with mixed emotions between patients...."

(Jill-SA)

In the study by Poggenpoel et al (1998:5), 'nurses verbalized that they experience inner conflict because they work in a hospital where babies are born in one unit and babies are murdered in a unit directly opposite the first one'.

For Brenda and Charity abortion is 'crime' and 'murder' and to them the woman 'must know' that she is as good as a 'murderer'. Walker (1993) called this kind of judgment 'harsh' and 'antagonistic'. Both in the previous and present study nurses have confirmed that they do not know how to nurse a woman who has undergone abortion. Their dilemma makes them feel angry and uncomfortable.

Beatrice feels it is important to give the woman a last chance to think again before the abortion is done. The whole procedure must be explained and the complications that

might arise, this might help them to make a better decision. She says some women have changed their mind in theatre and have decided to keep the pregnancy.

"Although we don't have plenty of time to talk to the clients and explain everything but at least we try to talk to them, especially before the procedure to ensure that they know what they are going into. ..... We give them a chance to think again about the TOP and make the final decision while in theatre".

(Beatrice-Za)

Beatrice explained that this helps her not to feel guilty because she has given the patient a chance to think again. She feels that this is the only way she can contribute to the psychological needs of her patients by helping them make the final decision.

Searle and Pera (1997) noted that nurses have a duty to take care and that they always practice their profession within the constraints of the laws in their country and the ethical code of their profession. Both these aspects require that they shall provide patient care in a manner that will protect the patient's physical and emotional well being.

While trying not to be judgmental Carol maintained that it was difficult for her to say what she felt about abortion. She tried to put herself in the position of the patient.

"Err.....I don't say its not right... I don't know, but I think, if I was in that position, I would be very desperate, I don't know. May be I would do the same thing. I don't know.... I have never been in that situation".

(Carol-SA)

There is an increasing appreciation of emotional aspect of caring in nursing. McQueen (1997) noted that it is important to develop the familiarity for effective emotional work. While nurses have acknowledged that the close professional relationships with patients helps them to give better care McQueen says that this level of bonding requires emotional distancing, because the nurse had to identify with the patient while isolating their own feelings avoiding 'over-involvement'.

But TOP nurses hardly know their patients because patients do not stay long in the ward. So they have no opportunity to find out what problems led to the patient-requesting TOP. This contributes so much to the judgmental attitudes and the lack of sympathy towards TOP patients. Price (1983) suggests that many nurses are very young and are ill equipped to cope emotionally with the ethical dilemmas of abortion work. Most nurses in the study fear to talk to the patients because they do not know whether what they are saying is wrong or right. Those that have chance to talk to the patients give warnings like 'don't come here again'.

Jill, Mwansa, Charity and Carol say they put 'their feelings' aside and try to help the patient, they do not 'throw it to the patient', trying to avoid being judgmental. How will

these nurses be able to give adequate care and at the same time avoid being judgmental?

4-2-3-2 Job satisfaction versus obligation

One question that comes to the researcher's mind while analyzing this data is: Are the nurses assisting in TOP having any job satisfaction or they simply do it under obligation?

None of the nurses in the present study is working in the TOP unit on their own will, they were not consulted whether or not they are comfortable to work in the units.

"At the beginning I didn't have a choice you know, we didn't even know that we gonna start doing abortions here. ..... Oh really you know most of the time, there's a shortage of nurses. If there's no other replacement and there's a shortage in that ward, you just have to go, and you have to do the duty you know". (Eva-SA)

From Eva's sentiments, it does appear that nurses are not given any chance to express their feelings about working in the TOP unit, therefore she is more under obligation than self will.

Though she does not support abortion Jill feels that as nurses they need to be involved in the decision making process especially where the implementation of abortion was concerned. She feels insecure in the place where TOP is done in her

department and says she would feel better if the place was separated from the rest of the department.

Nurses in the study by Poggenpoel et al (1998) said they feel angry and unhappy because they were not consulted about their opinions regarding the legislation of abortion. A large group of nurses in their study refused to participate in abortion. They recommended that separate institutions or centers be opened for TOPs, where only staffs that are willing to assist should work.

Carol, though aware of her right not to take part in the abortion procedure, said she was not consulted before being sent to the unit. Mwansa in exercising her right as a nurse refuses to participate in TOP for patients who demand for it on social grounds.

"In fact they can't blame me, its me to say no, I have a choice"

 (Mwansa-Za)

All the participants in the present study were aware of their right to make their feelings known to their respective managers if they were not comfortable. But it seems an opportunity is not given to them to exercise this right.

Brenda expressed this in her longing to have the senior managers visit their wards and be part of the supporting team.

"It will be encouraging to have some of the senior nurses like matrons and even nursing services managers come to give us support. They should understand the situation in which we work under. They should not be quick to make us write statements when a patient turns round and accuses us".

(Brenda-Za)

Emotional work of caring can be very stressful especially if done under obligation. Nurses need to be assisted to be able to be free to choose areas where they will be most comfortable to render their services. They need to be assisted to have some job satisfaction in their areas. According to Poggenpoel et al (1998) Democratic Nursing Organization of South Africa (DENOSA), believes that nurses have a right to freedom of conscience. The nurse should not be coerced to participate in direct TOP. Nurses too have a responsibility to make their viewpoint known in good time, if they wish not to participate in abortion.

According to the South African Nursing Act (no. 10 of 1997) and its related regulations the nurse has a professional and ethical obligation to nurse the patient before, during and after the procedure despite conscientious objections to TOP. In American Nurses Association the Code for Nurses with Interpretive Statements states: 'If ethically opposed to interventions in a particular case because of the procedures to be used, the nurse is justified in refusing to participate' (Merissa and Ventura, 1997).

4-2-4 ABORTION AWARENESS.

Participants interviewed both in South Africa and Zambia concurred with the need to intensify the teaching on abortion in sexuality education, its consequences and how to

make use of the available family planning services. Nurses have observed that many women are using abortion as a method of family planning for fear of using contraception. Little research done suggests relatively low use of contraception especially among adolescents and wide spread fear of the potential risks or side effects (real and imagined) associated with contraceptive use (Zambia Information Digest, 1997). Abortion awareness will be discussed under education for women and community and education for adolescents.

4-2-4-1 Education for women and community.

Participants have expressed concern over the rising numbers of abortions taking place even with a variety of family planning methods available. In 1998 the University Teaching Hospital treated 5,268 women with incomplete abortions inclusive of the therapeutic abortions.

Jill expressed sentiments similar to Gardner's (1972) in her discussion about her pregnancy which she was not ready for. She said she was confused and almost settled for an abortion but decided to keep her baby. She suggested that a better decision is made before conception.

Cochrane (1998:16) observed that 'for every woman it is painful to have to consider an abortion. She will not take the decision lightly, knowing that the grief for her unborn child will remain a constant companion in her life'.

While Eva takes it for granted that women who come for abortion have made up their minds she feels it is important for them to be sure that this is the right decision.

"You know, I don't know how its done (counseling) at OPD. Because when you come for abortion they send you to OPD for counseling and booking, and I am not sure how the counseling is done that side. But I think its very important to make sure that this is what the patient really wants before doing the actual procedure. Because..... otherwise the patient can live long with those negative feelings".

(Eva-SA)

Some women have been using abortion as a way of family planning which Beatrice has called 'abuse of TOP'. In South Africa the new Termination of Pregnancy Act (1996) states that: 'Termination of pregnancy is not a form of contraception or population control'. Nurses were of the opinion that women should be completely informed about the complications of abortion and different contraceptive methods available which they can use.

"Well I would advise concerning the contraceptive, I think that's the most important thing and then now we do have them in stock. So that's what I would do yah".

(Eva-SA)

In the study by Poggenpoel et al (1998) nurses were of the opinion that women should be completely informed about contraceptives which should be available 'freely and cost free'.

Concerning information on family planning most nurses in the study felt that as nurses they were not doing enough to educate the community. They suggested that intensive education is needed on family planning issues for both women and adolescents.

"We advise the patients but I think its not enough. There's need for people to go round schools and townships and hold meetings and teach about FP- it's not adequately covered".

(Charity-Za)

"I think we are not doing enough on FP or may be the patients themselves don't want to utilize the services of the FP clinics. At times when you ask them that now you see you are pregnant and you don't want the baby, why didn't you take precautions? Others will say no maybe the boy friend or the husband didn't want to use either the condom or has thrown away the pills. So I think that the most important thing is the education on FP with the community using the community nurses".

(Mwansa-Za)

An intern at one hospital in South Africa admitted that the counseling aspect and post abortion contraceptive services are practically non existent (Guest, 1999). Guest also admitted that 'education is undoubtedly the key to reducing the number of unsafe abortions in the future' (: 7). This education the nurses' feel should include the entire community in order for them to understand the implications of abortion and advantages of utilizing family planning services.

"But if I was working in the wards, I would definitely organize support group or talks to give them before they go home or even give the nurses advise to tell them about prevention"

(Cynthia-SA)

Gardner (1972) in his book noted that for many women the knowledge that legal abortion exists implies that they find themselves confronted with a choice, which they cannot cope with. Through this they become anxious, depressed, emotionally labile and in some cases aggressive and desperate. He suggests that it would be helpful for women to give this question a 'long cool look' when not pregnant. The choice of an abortion is not easy or effortless. Gardner (1972:238) continues to say that if the woman 'feels that her situation is such that were she to conceive, she would seek an abortion, now is the time for her to ensure that conception does not occur. The woman's right to decision lies prior to conception'.

Poggenpoel et al (1998) are of the opinion that to avoid abortions, fertility regulations (family planning) should be aggressively propagated in both countries with specific

emphasis on female education and counseling regarding contraceptive information and services. Education programs should begin before young people become sexually active. Parents should be actively involved in sex education for their children. Family planning facilities tend to focus on services for older women and rarely the first choice of young people who may be faced with the turmoil of early sexual experience and too embarrassed to visit such centers.

4-2-4-2 Education for adolescents

Participants expressed a great concern over the number of adolescents who come for TOP. They felt that more needs to be done to educate these adolescents on the importance of preventing unwanted pregnancies.

"They don't go for family planning, 90% of the patients we receive are school going. To tell them about family planning it's like they fear to be called names. So they avoid such. If you try to talk to them they will agree, but afterwards they just shun. So we need to go into schools and teach the students".

(Brenda-Za)

In a study done by Koster-Oyekan in Zambia, schoolgirls said that they were ill informed about sexuality and schools have no formal 'sexual awareness' programs. The girls were eager to learn more about how they can prevent not only unwanted pregnancies but also diseases like HIV/AIDS and other sexually transmitted diseases (STD).

Charity says she takes extra time to talk to the sexually active schoolgirls when they come for TOP and warns them about other sexually transmitted diseases as well.

"The school girls I tell them, if you can't abstain from sex at least use a condom or any other family planning method. You can get away with abortions but you can't get away from diseases like HIV/AIDS and the rest".

(Charity-Za)

While Mwansa feels that the teachers should be involved in the teaching of sex education in the schools to sensitize the students. She feels that is another way of reaching students.

"I think we can reach them through their teachers whom I hear have started going for counseling lessons. Those teachers should educate the school children".

(Mwansa-Za)

Most clinicians concerned with the problems of teenage pregnancy prefer a primary prevention program, avoiding unplanned pregnancies among teenagers rather than unplanned births (Cates, 1989). Eva sympathizes with the schoolgirls when they get pregnant because of their inadequate knowledge on sexual matters.

"Ah..... I know how difficult it is especially for young schoolgirls. You know in some cases I support abortion. Its difficult you know, they also need some education to get somewhere in life. They are still young and in most cases eh..... they were just like acting like grown ups and really they are not".

(Eva-SA)

Young people need to be taught early in life about sexuality issues to help them make the right decision when faced with such problems. A young person's choice will be shaped by his individual values and values are acquired. Parents influence either directly or indirectly their children's moral or value system, so they need to be the key people in instilling these values.

4-2-5 RECOMMENDATIONS REGARDING SUPPORT FOR TOP NURSES.

It became evident in the study that nurses do not receive any form of support as they work in these emotionally stressing units. Nurses expressed that they would like to receive support to help them cope with the situation and care for the patient better. Some of the nurses' sentiments are quoted below.

"If the..... like in OPD there's a counselor who counsels the patients. If they can come around here and speak to us, may be we will..... because most of the nurses don't know the side of gynae. May be they will have a better perspective of what is going on".

(Jill-SA)

Eva received counseling prior to working in the TOP unit and she feels that her counseling helped her to come to terms with abortion. She suggests that if all the nurses could go through counseling they would benefit a lot.

"It would be helpful ya (counseling)..... because not all nurses are open-minded about this, so they need to be counseled".

(Eva-SA)

Eva feels a nurse should be allowed to share her feelings openly and say where she stands on the issue of abortion. She suggested that supervisors should:

"Sit with the nurses, talk to them about their feelings and ya ... I mean, if a nurse is really against abortion you know, don't force her to do something like that, she doesn't like to do".

(Eva-SA)

Most nurses find it difficult to walk into the manager's office and share their feelings. This could be due to the hierarchical system in the medical field. It ought to be the responsibility of each manager to enquire and encourage the nurses to talk. All the nurses denied receiving emotional support.

Carol feels she needs someone to talk to, a 'counselor' whom she can narrate her feelings to. She said she felt better after the interview because for the first time she was able to talk to someone about her feelings. To her the discussion with the researcher was more like therapy.

Cynthia felt that it is the responsibility of the nurse in charge to find out from her TOP nurses how they feel about the procedure. She felt that there is need for emotional support for nurses.

"..... because sometimes the nurses need to talk to the sister how they feel. I think the sister in charge must tell her TOP nurses to feel free to come and talk to her about how they feel".

(Cynthia-SA)

In most busy units due to pressure of work, managers do not find time to talk to their subordinates. Most of the nurses go through stressful moments, which they long to share with someone. Nurses like Carol who had just gone through a stressful moment need to be assured that they can talk to their manager about it. A few nurses like Mwansa have the courage to talk to their supervisors when faced with a difficult situation. Mwansa feels free to discuss with her friends who are counselors, and she feels that if she too were a counselor she would benefit so much as a nurse. She said counseling skills would help her to give better care for her patients. She also suggests that an independent counselor could do for patients.

"I do have friends who are counselors, at times we discuss as we are taking a cup of tea. When it comes abruptly my sister in charge in the ward is the one I talk to. .....Yes I think that counseling will be the most important because some of us at times need to be counseled. I also would like to be a counselor, because at times I feel that may be I am not talking to the patient right or maybe whatever I am saying is hurting the patient instead of helping her. But if there was a counselor, it will be very important even for the patient to receive good counseling. I might talk to the patient when I am annoyed, so whatever I will say later may not help the patient, so an independent counselor would help".

(Mwansa-Za)

Mwansa brought out a lot of points concerning the needs of the TOP nurses in the area of counseling. Negative counseling like 'you have killed or murdered' and 'I don't want to see you again' may not help the patient to respond positively to the post abortion counseling.

The patient will not even desire to come and face the nurses again. This affirms the fact that the way a nurse reacts to abortion does have some effect in the care she will give later to the patient. Unkind and punitive attitudes towards women who have chosen to abort will affect the way women will react to the procedure.

Blain (1993) reported that women who have TOP have reported subjective and negative accounts of nursing care. She suggests that more education on nursing

ethics is needed to help nurses find their way through the moral maze that is not only created by TOP but also by 'new advances in infertility treatment and fetal diagnosis'.

Beatrice agreed that it is very important for her to receive support in order for her to deal with her emotions.

".....because sometimes it affects the rest of my work for the rest of the day. I won't be myself. I will be there working but I won't concentrate. I will be thinking of what I saw. So I feel that it is important for me to have somebody to talk to, to encourage me and not to condemn me. We are just doing our duty. Its not me to decide or make the decision for the woman, its the client herself"

(Beatrice-Za)

In recommending who should give the support or the counseling, most nurses did not mind who should do it. But they all seemed to value the support of their immediate supervisor who they feel should be available all the time. Beatrice emphasized that for her it was very painful to have totally no one to talk to in her area. She suggested that she would like to receive both psychological and spiritual care.

"At least there should be somewhere or somebody who I can go to at the time I am going through emotional stress, to get encouragement and support, instead of me being depressed for the rest of the shift, afraid to open my mouth, they say we are the ones doing TOP. Or if there is just somebody to talk to and tell them what I've gone through".

(Beatrice- Za)

Brenda acknowledged the fact that if she were not supported she would not be able to give adequate support to the patients. She only discusses her feelings with friends.

"There is yes (need for support) because we have to get organized and teach these women before they go home. If we don't support each other its difficult to give support. Its better they know that the step they take to abort is not advisable, even for their own health its not good. Its better that before they get out of hospital they know the dangers of abortion, so that they don't repeat it again".

(Brenda-Za)

Brenda also felt that it was important for her as a TOP nurse after going through emotional stress to receive support and counseling through support groups.

"Its important for me as a nurse to have psychological support and also to learn how to counsel. If we have a support group, we would also have some form of protection or help if the patient misunderstood the counseling. Its very important to have such a group".

(Brenda-Za)

The feeling of insecurity among nurses seem to arise more from the fact that they feel incompetent to give support because they do not possess the necessary skills to do so. While most of the nurses saw the need of a support group and counseling, Charity

feels she can handle her own emotions. She is also free to discuss with her immediate supervisor if she encounters any problems. But she thought that the support group might be necessary for other nurses.

Heitman and Robinson (1997) proposed the importance of having a nursing ethics forum or round table whose main goal is to educate nurses in ethical theory and at the same time provide valuable support for them. On going education helps the nurses to stay alert to the ethical issues and potential problems in their daily work and helps them to cope with some of the frustrations they experience, all of which makes them more effective coordinators of care. These round table sessions bring together staff nurses, a clinical nurse specialist and a medical ethicist to share and synthesize their unique perspectives on ethical issues. What ever their ultimate results one immediate benefit of the round table discussions is that by expressing their frustrations and concerns nurses can work through their feelings. The insights and support from other participants let the affected nurses know that they are not alone.

Nurses like Carol would be helped to confront and resolve her feelings of hopelessness and powerlessness in the abortion situation. A nurse who is in a hopeless and powerless situation will not be able to assist a patient in a similar situation after abortion. Some women after going through TOP develop feelings of regret, self-blame and guilt. They need someone to help them work through their feelings. Someone who is sympathetic and understanding.

"I knew I had done something really horrible, to happen to me". (regrets of a woman after abortion).

One of the nurses recommended a separate TOP unit where only willing people will work. A unit which only deals with TOP and not combine with infertility patients. This she says will help them not to end up with mixed emotions as nurses.

A doctor in South Africa also recommended the establishment of separate abortion facilities, staffed by willing employees as well as mandatory counseling in institutions (Caelers, 1998). More clinics like Marie Stopes private clinics in South Africa could be opened.

A research done by Blain (1993) in a newly established TOP unit at St James Hospital on nurses attitudes to women undergoing TOP, showed mostly positive attitudes and general satisfaction with the quality of the nursing services, although there were some areas of concern. This was so because these nurses were all willing to work in the unit. But some TOP nurses in Blain's study felt that some women were more deserving to have TOP than the others and this revealed judgmental attitudes on the part of the nurses. These nurses also felt that the woman was not always the best person to decide whether she should be allowed a legal TOP.

CHAPTER FIVE: DISCUSSION OF THE FINDINGS

5-0 INTRODUCTION

For summary of results see Appendix D.

To understand the data as it unfolded, and to find patterns within the data, the researcher accepted tentative patterns, which were constructed to suit the subject matter, while being constantly aware that there was a lot more information that could be recognized and analyzed by another person in a different way. Some selection and interpretation of the data involved weaving descriptions, participants' words, observations and the researcher's own interpretation into a rich and believable descriptive analysis (Maykut and Morehouse, 1994). The present discussion therefore, focuses on some key issues that have brought some light to the objectives of the study, while recognizing the value of a lot more information that could be discussed exhaustively by other people.

5-1 SUMMARY OF RESEARCH FINDINGS.

This study presents eight TOP nurses' voices as they describe their experiences of therapeutic abortion, and how these influence the care they give to the aborting woman.

The study confirmed that the experiences most nurses go through during TOP are negative. It confirmed the complexity of the abortion experience and revealed that it varies in the amount and type of stress it generates for the nurse. The study accentuated that several factors determine the reaction of the nurses. The manner in which the nurses respond to the procedure was found to be a joint function of their

psychological state and the reason for which abortion is done. The summary will be discussed according to themes.

1. Factors associated with nurses' experiences towards abortion.

The study confirmed that nurses are disturbed during the termination of pregnancy (TOP) procedure by the sight of the aborted fetus or fetal parts. After the procedure the nurses remain with the fetus and have to handle it and arrange for its disposal. In the study Carol was particularly more disturbed as she had gone through a disturbing experience the day before. During the interview she was still disturbed, as she kept referring to the previous day's experience. She said she was 'very upset' by the incident.

Beatrice confessed that she refused to assist in TOP when a pregnancy is beyond eight weeks of gestation, for fear of seeing the fetal parts. Marshall et al, (1994) observed in their study that specific anxiety was expressed over the handling of the fetus after the procedure. They noted that nurses tended to over-identify with the fetus because they are the ones who dispose them.

Price (1983:154) described one of the psychodynamic sources associated with emotional reactions of nurses as follows: "over-identification with the fetus and lack of identification with the aborting woman on a conscious/unconscious level". Nurses remain unfamiliar with the problems of the aborting woman due to her short stay in the ward. This was particularly true in Carol's situation who was completely at a loss with the fetus in her hands. The nurses confirmed that the patients do not stay long in the

ward, so they hardly know their patients. There is no opportunity for them to talk to the patients especially the South African situation where patients are admitted in a different ward.

The study confirmed that the participants' perception of abortion greatly influenced their attitudes towards the client. To some nurses abortion is 'crime' and 'murder' so the women who come for TOP are 'murderers'. This was more peculiar with Charity and Brenda who displayed judgmental attitudes when describing their experiences. Brenda even confessed that her attitude towards the TOP women is negative. These attitudes confirmed the findings of the previous research.

The findings in Walker's study (1995) on Primary Health Care Nurses (PHCNs) showed that the overwhelming majority of nurses expressed a strong opposition to abortion. 'This opposition took the form of anger, hostility and judgmental responses which the nurses directed at women who face the predicament of an unwanted pregnancy'. Walker observed that the nurses have a close contact with the patients, their families and members of the community and that they confront key social problems such as abortion on a daily basis. The way abortion is managed as a social problem will continue to be influenced by their views as care givers.

In a study by Poggenpoel et al, (1998) a large group of nurses refused to be involved in any way with the woman who has had an abortion.

However, while other nurses were judgmental in their attitudes, others decided that they will put their 'feelings aside' and deal with the patient. Though some of them confessed that they felt angry but they preferred not to take it out on the patients. Jill, Mwansa and Charity said they will not take it out on the patients, while Carol and Cynthia found it very hard to describe their feelings.

Nurses in McQueen's study (1997) indicated that, irrespective of their personal views on abortion, they tried to meet the needs of the patients having TOP. Despite their reactions some of the nurses felt that they could still assist in TOP, especially the South African nurses. They considered that it must be very difficult for a woman to make a decision to abort, therefore they will support the woman's choice. Eva only expressed fear that if the counseling is not properly done, the patient might suffer negative post-abortion responses.

In a study by Suffla (1996) on women's responses to abortion, she noted that participants' descriptions reflected that the greater the difficulty of deciding to terminate a pregnancy, the more likely there will be negative responses after abortion.

Furthermore, it was evident in the study that each nurse needed to find a way of dealing with her feelings after TOP. Most of them talk to each other about their experiences. Others like Brenda takes it out on the patient, by letting the patient know that what they have done is 'bad'. While Beatrice has completely no one to talk to about her feelings, and sometimes she lives with the negative feelings for the rest of the day.

Price (1983) observed that nurses appear to react with the most discomfort towards TOP. Price further says that the acute identity crises have been demonstrated by most nurses who are discomforted and distressed by the contradiction they perceive between their training to preserve life and their role in abortion work, which aids the ending of life. In terms of coping responses, nurses' descriptions revealed that they were inclined to deal with the abortion experience in terms of their usual defensive and coping strategies.

For women Suffla (1996) found that more favorable the social environment associated with legal abortion has been found to minimize women's vulnerability for the experience of poor post-abortion adjustment. For nurses like Eva who went through counseling, the better she coped with the TOP procedure.

2. Nurses' perception of abortion.

None of the nurses in the study supported abortion completely. The issue of abortion was found to highlight a serious tension within nurses' socialization. To most of them, when a woman aborts, she is denying herself the privilege of being a mother. They support abortion only in certain circumstances. Jill and Carol wondered how a mother could get rid of her own baby, while Brenda totally condemns abortion. Nurses like Beatrice feel that the TOP is being used as a form of contraception, and feel that TOP is being 'abused'. Eva also wonders how a woman with a stable job can request abortion. She only supports abortion for teenagers whom she feels are ignorant of family planning services.

Marissa and Ventura (1999) noted that more nurses today are opposed to abortion except in cases of rape, incest or threat to mother's life or health, given the numerous options available to prevent pregnancy. In this study all the nurses felt that it is the responsibility of the woman to prevent an unwanted pregnancy. As Figa- Talamaca (1989) noted that the way a woman reacts to abortion depends not only on her subjective attitude but also on the attitudes of the health service personnel (like nurses) with whom she is in contact.

In Walker's study (1995) the PHCNs interviewed felt that motherhood is the essence of womanhood. Therefore abortion symbolizes that a woman has denied her true calling. In the nurses terms abortion 'epitomizes a reckless and reprehensible woman, whose pregnancy is a symbol of her lack of control, irresponsibility and self negation' (: 2). This approach by nurses challenges the reason why abortion was legalized, governments' commitment to women's health and empowerment (Reproductive Health Matters, 1993).

The attitudes of nurses towards the women requesting abortion depended on the circumstance in which abortion is done. Others like Cynthia, if they had an opportunity, they would try to make the patient change their mind and 'keep the baby'. The researcher feels that generally the South African nurses adopted a conservative attitude, because of trying not to be judgmental. One can still identify some judgmental elements in their statements. Like Carol said, "if they (women) came for the second time, I think it will be a bit too much.... I mean..." Jill also emphasized that she will warn the woman not to 'come again'.

Some of the nurses feel that women probably struggle to arrive at a decision to abort, so they try not to take out their anger on the patients. As indicated before, previous studies have shown that the responses of nurses and doctors will affect the woman's responses to post abortion adjustment (Walker 1993, Suffla 1996, McCulloch 1996 and Haffajee 1997).

Generally the Zambian nurses were more judgmental in their reaction towards abortion. They were hostile especially Brenda and Charity. They express their feelings by telling their patients that what they have done is 'bad'. Their reaction is similar to that of the nurses in Walker's (1993) and Poggenpoel et al's (1998) studies. In fact Walker expressed shock at the reaction of the nurses in her study, she confessed that she had mistaken assumptions. She expected the nurses to empathize with and understand the very difficult and often traumatic experiences women have when faced with the predicament of an unwanted pregnancy.

It must be understood that the nurses in the present study did not go to work in the TOP units on their own will. They responded to a change list in their respective hospitals. The researcher had assumed that these nurses had willingly gone to work in these units. Therefore their reaction is not so much different from the other general nurses, except that some of them do sympathize with the women. The other interesting thing in this study is the way the nurses brought out some religious sentiments as they described their experiences.

In the study done by Haffajee (1997) he observed that religious beliefs emerged as being associated with negative attitudes towards TOP both within the general population and amongst health professionals. Gardner (1972) in his book also noted that all decisions of abortion are religious decisions. These findings contradicts with Walker's (1993) findings where she expected the reaction of the nurses in her study to be influenced by religion, but only two nurses cited religion as the central reason for their opposition to TOP.

3. Nurses dilemma surrounding abortion.

According to the Nursing Act (no 10 of 1997) and its related regulations, the nurse has a professional and ethical obligation to nurse the patient before, during and after the procedure despite conscientious objections to abortion.

Most nurses in this study appear to assist in TOP because they are obliged by the professional laws to do so. They just assist the doctor to help save the patient or fulfill the choice of the woman. They have admitted showing bias in the manner in which they care for the patients who have aborted. They are more sympathetic towards the woman who has gone through spontaneous abortion. Most times they have to nurse these women in the same room where they find it difficult to give equal care. Jill confessed that she ends up with mixed 'emotions' at the end of the day. She suggested that a separate room be found for TOP patients so that they can be comfortable to give care accordingly. While Brenda said that her care towards TOP women is not the same as the other patients.

The Zambian nurses said that they only assist in TOP related procedures simply because they want to save the lives of the women who normally come bleeding after going through illegal abortions. While their South African colleagues simply do it to assist the doctor fulfill the woman's choice to abort. To most of them it is like any other nursing duty. There is no attachment to the patient.

Jill feels that the fact that people know nurses to be lifesavers, assisting in TOP should be done in private place where the public will not know. In a study done by Marissa and Ventura (1999) they observed that more and more nurses are withdrawing from the works around abortion. This study has confirmed that very few nurses are willing to participate in TOP procedure. Many TOP nurses are opposed to abortion.

In a study by Poggenpoel et al (1998:5) nurses 'verbalized that they experience inner conflict because they work in a hospital where babies are born in one unit and murdered in a unit directly opposite the first one'.

The nurses have a duty to 'practice their profession within the constraints of the laws of their country and the ethical code of their profession' (Searle and Pera, 1997:269). As observed by Webb in McQueen's (1997) study, some nurses try to meet the needs of the patients going through TOP and not let their views affect the care that they give to the patients because the legal status of the procedure leaves them 'little choice'. Nurses in both countries seem to share the same dilemma seeing that no deliberate step is taken to ensure that their psychological needs are met. Most of them only

share their experiences among themselves, and they longed even for their immediate supervisors to just listen to their experiences.

Webb in McQueen (1997:47) also noted that the depth of engagement in the nurse/patient relationship in termination of pregnancy (TOP) may not be so intense as could be possible if the nurses experienced a natural empathy because 'attitudes can leak through into behavior and inadvently influence care'. Nurses face the professional as well as the personal dilemma of how to uphold their duty to care for patients while remaining true to their personal convictions. As can be seen, opposing views on abortion constitute a moral dilemma - a dilemma that often finds the nurse in the middle, hence the need for support for the nurse.

4. Abortion awareness.

It became evident in the study that all the nurses feel that not much has been done in terms of educating the public especially women and the teenagers on issues concerning abortion and family planning (FP). Nurses were concerned over a number of women coming for repeat abortions and a high number of schoolgirls coming for TOP or with incomplete self induced abortions. They all suggested massive campaigns to educate teenagers in schools on prevention of unwanted pregnancies and the complications of abortions.

In educating teenagers Cates (1989) suggests some of the factors that should be taken into consideration such as:

I) Sex education early in grade school to underscore the important decision points involved in making reproductive choices.

2) Parental education programs to enhance their understanding of teenage motivations.

3) Public education programs to dramatize the realities of teenage sexuality and pregnancy.

Though in both countries contraception is available to teenagers without parental consent or knowledge and government supported family planning counseling and contraceptive services are available, the rate of teenage pregnancies is still high according to the nurses. They all feel that not much is being done to address this issue. They suggest that all the interested parties to join hands and teach the teenagers. These are parents, teachers, churches and medical personnel.

5. Recommendations regarding support for TOP nurses.

It is evident in this research that TOP nurses have either conservative or judgmental attitudes towards TOP and the women undergoing TOP in both countries. Despite their attitudes these nurses are willing to assist in the procedure. But none of these nurses except for one in South Africa has ever received some form of counseling or support to help them cope in the units. None of the nurses was consulted before being sent to work in TOP units or gynecology wards. The nurses confessed that they do not possess the necessary skills to enable them handle TOP patients.

The TOP nurses experiences revealed that most of them are negatively affected by the abortion procedure especially when they see the fetal parts and the born alive fetuses. The handling and disposal of the fetus came out as one of the factors that disturb nurses.

Nurses felt that they would like to be better equipped in counseling skills in order for them to give better support to the clients. In the researcher's opinion the judgmental and conservative attitudes lay in the fact that nurses do not know how to deal with the issue of TOP. They do not know how to deal with their own dilemmas when they go through negative experiences. They expressed that they would like to share their feelings openly with someone. Nurses like Jill, Eva and Mwansa felt that nurses would benefit from the services of a counselor with whom they would share their feelings. The South African nurses seemed to have a relationship among themselves where they share their experiences, but when they go through extreme stress like Carol had, they need someone else to talk to like Carol expressed.

Cynthia felt that it should be the responsibility of the nurses in charge to get their nurses to talk about their experiences. The nurses in charge are the immediate supervisors to the TOP nurses with whom they should be free.

The Zambian nurses also felt that it was very important for them to receive support and help them deal with their abortion dilemma. Beatrice affirmed that most times she has completely no one to share her feelings with, which sometimes affects her for the rest of the day.

She said, "So I feel that it is important for me to have somebody to talk to, to encourage me and not condemn me".

Out of the eight nurses only two said that they are free to approach their nurses in charge for support if they had a problem. One nurse felt that she could handle her own emotions but she felt that there was still a great need of having support groups for other nurses.

In a study by Poggenpoel et al (1998) nurses expressed the need to be fully informed about the abortion as well as the legislation involved. They reiterated that they did not know how to nurse a woman who has undergone TOP. They said that it makes them feel uncomfortable and angry. No literature is available about support for the nurses and it is clear that their experiences call for need of possessing counseling skills (Poggenpoel et al, 1998).

Poggenpoel et al (1998) states that the Medical Association of South Africa only recommends compulsory counseling for a woman undergoing TOP and there is no indication as to who should give this mandatory counseling. But this still leaves the nurse at the center, as she is the one who spends longer time with the patient.

Brenda felt that within the support group nurses could offer some protection for one another and help on how to properly counsel the patient. She also felt that it would be

more encouraging to see some of the senior nurses like matrons and nursing services managers to come and give support.

Blain suggested that more education on nursing ethics is needed to help nurses find their way through the moral maze that is created by TOP. Studies have confirmed that unkind and punitive attitudes towards women who have chosen to abort will affect the way the women will respond to the termination of pregnancy (Walker 1993, Suffla 1996, McCulloch 1996 and Haffajee 1997).

In the present study only Eva had some form of counseling before working in TOP unit. She confirmed that her counseling prepared her psychologically to work in the TOP unit. She strongly recommended that other nurses need to go through the counseling, which unfortunately was discontinued. In Suffla's research (1996) the women she interviewed said that they valued pre and post-abortion counseling because they were assisted both in making their decision and in coping with their post-abortion experiences.

The nurses in the present study said that they would like to be equipped with counseling skills in order for them to care for the women requesting abortion with a non-judgmental attitude despite the differences in opinion.

The preceding discussion then represents eight TOP nurses experiences in assisting in therapeutic abortion. Therefore no attempt is made to generalize these findings. In conclusion of the above summary, it is reiterated that qualitative mode of inquiry was

found to be the most meaningful in exploring TOP nurses experiences of therapeutic abortion. It allowed for the uncovering of complexity and nuance, it allowed participants to reclaim their voices and most importantly it honored lay people's interpretation of social reality.

It is also recognized that the findings reported here begin to explore the TOP nurses experiences from two hospitals only, one in South Africa and one in Zambia. However with the legalization of abortion in South Africa and the increasing numbers of women coming with induced abortions in Zambia plus the number of nurses and doctors refusing to assist or perform abortions, these issues are likely to become of increased importance. Accordingly, the implications of these findings deserve attention.

5-2 SIGNIFICANCE OF RESEARCH FINDINGS.

The findings summarized here have a number of implications for both policy makers and clinical practice on abortion. Many countries including South Africa have heeded the calls for non-restrictive legislation on abortion. Many governments have shared the concern of high maternal mortality and morbidity.

Many medical personnel directly involved in the implementation of abortion laws have refused to participate in the procedure and feel that they need to have been consulted before the legislation was passed. The present study has confirmed that most nurses are indifferent towards women who undergo TOP and have either judgmental or conservative attitudes.

Studies on women's experiences of abortion have shown that their response to abortion is affected by the way they are treated by nurses and doctors. Punitive and unkind attitudes towards women who have chosen to terminate their pregnancies lead to poor post abortion adjustment and no proper counseling takes place in such circumstances. Lack or poor post-abortion counseling may lead some of these women to return for repeat abortions because they were not informed about family planning services as shown in the studies done in Zambia, Uganda and Malawi (Zambia Health Information Digest, 1997).

Inadequate support and lack of counseling skills for nurses that assist in therapeutic abortion has greatly contributed to loss of interest in the work around abortion, low self esteem, lack of confidence and judgmental attitudes among nurses. No form of counseling exists for them. Counseling services will help the nurses to understand and address those aspects of the abortion experience that they have difficulties to cope with.

Nurses as care givers both at primary and secondary level play an important role in the care and recovery of the patient. It is evident that they require counseling and psychological support in order for them to perform according to the professional standards. Counseling will also help those nurses who cannot assist with the procedure due to moral objections identify areas in the abortion work where they can offer help to the clients like counseling and teenage education. Because counseling provides further information about contraception and focus on women's post-abortion contraceptive practice (Suffla, 1996).

The first objective was achieved, as the nurses were able to describe their experiences regarding therapeutic abortion. They identified some of the factors that make them uncomfortable during the procedure. They gave their views on abortion and their attitudes towards the women who seek abortion. The second objective was also achieved as the willingness of the TOP nurses in participating in TOP was assessed. Very few nurses are willing to assist in TOP. Some do it only to fulfill duty, while others can only assist in certain circumstances as shown in the study. The third objective was partly achieved, in that the specific support necessary for the TOP nurses was partly identified. This area needs to be explored further in order for the specific support strategies to be identified.

Finally, the challenge for social science researchers is to advance inquiry in the area of abortion and abortion providers (nurses and doctors) so that outcome may impact on policy and service delivery in a way that enhances the women's well being. Once nurses are helped to communicate their realities about their abortion experiences and how they could cope, they will be able to be better counselors for the women and teenagers who are in a dilemma concerning unplanned pregnancies.

5-3 RECOMMENDATIONS FOR FUTURE RESEARCH.

Several issues were raised in the previous chapter from which indicators for future research in the experiences of TOP nurses should be directed. It is hoped that the nursing professional bodies and hospital administrators will use some of the recommendations to introduce support system for nurses and other health personnel who are working in stress environments.

1. More research efforts are needed in order to confirm the themes identified in this study and to test their clinical utility with nurses from a wider range of cultural, ethnic, socio-economic and geographical backgrounds. Similar research needs to be done in similar private TOP clinics where nurses are working willingly and compare the results. Further research will increase the repertoire of knowledge on nurses' abortion experiences, illuminating factors that are not explored in the study.

2. More research efforts are needed into working out the kind of support that will be suitable for nurses who assist in TOP. Heitman and Robinson (1997) suggest developing a nursing ethics round table that should give valuable support, further the nurses' professional development and strengthen their voices in interdisciplinary affairs. The main aim of these round tables would be to educate nurses in ethical theory and principles through an analysis of cases (like TOP) and help them to bring such cases to an ethical resolution.

Heitman and Robinson (1997) recommended that the round table sessions should bring together staff nurses, a clinical nurse specialist and a medical ethicist to share and synthesize their unique perspectives on ethical issues. This will give the group a better chance to influence the various parties involved in a problem than if any of them acted independently. Counseling and support guidelines could be developed in these round table meetings.

3. Opinions about abortion will always differ and nurses and other health personnel need to be tolerant and supportive of each other's and patients' views in this regard. More value clarification workshops need to be organized whose main objective is to contribute to the effective implementation and management of TOP. The general objectives of these workshops if met would assist the nurses to cope with the TOP dilemma. These are:

-To gain understanding of health workers' concerns regarding TOP.

-To develop a framework for assisting health workers relate their values and belief systems to the needs of their clients.

-To test the utility of the training module for different levels of health workers.

-To develop recommendations for the integration of values clarification in pre-service and in-service training of health workers (Marrais, 1997).

A research needs to be done among the nurses who have attended these workshops and compare their reactions with those who have not.

4. Several other areas remain to be explored fully in future, like focusing on interventions that address issues around contraception, given that findings indicate low usage, contraceptive failure and non-use may contribute to the use of induced or therapeutic abortion as an alternative to unwanted pregnancy for both women and teenagers. Nurses in the present study strongly felt that education in family planning and sexual issues is not being adequately covered.

5. In addition it would be instructive to explore the effects of pre and post-abortion counseling given to women seeking abortion by nurses, and find out how these have

assisted the women in adjusting from the effects of TOP. This will help to assess whether or not the counseling is adequate and effective.

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APPENDIX A: **INTERVIEW GUIDE**

TOP NURSES EXPERIENCES IN ASSISTING WITH THERAPEUTIC ABORTION

Demographic details and personal questions. (All respondents are strictly confidential).

Gender: Male……Female……

Age: 30-40years, 40-50years, 50-60years

Position in nursing .....

Religion .....

1. Experience:

Describe your experience ie: how you feel;

a) During abortion procedure (what disturbs you most ?)

b) How do you deal with your feelings?

c) Do your feelings affect the way you care for the woman?

2. Perception:

a) What do you think about abortion?

b) What motivates you to assist with abortion?

c) What are your thoughts towards the woman who is undergoing abortion?

d) How do you care for the woman before and after abortion

3. Support:

a) Do you receive any emotional support to help you cope with your experiences?

b) Who gives you the support?

c) What kind of support do you get?

d) Is the support adequate?

APPENDIX B SUMMARY OF RESULTS

NAME	TOP EXPERIENCES	PERCEPTION OF ABORTION
CYNTHIA (SA)	Assists when there is shortage. Cannot share feelings	Does not support abortion but will support client.
CAROL (SA)	Gets upset. Affected by sight of fetus. Appeared disturbed.	Fears to be judgmental. Not comfortable with repeat abortions.
JILL (SA)	Mixed emotions when nursing clients with TOP and those with infertility.	Does not like abortions. Will assist doctor. Hides her feelings.
EVA (SA)	Not affected by TOP. Only doing her job. Client's mind made up.	Supports abortion only for schoolgirls. Older clients to utilize FP clinics.
BEATRICE (Za)	Disturbed at sight of fetus. Can only assist up to 8 weeks.	TOP is being abused. Supports TOP for medical reasons.
MWANSA (Za)	Affected by sight of fetus. Cannot assist TOP on demand.	Does not support TOP. Women must take precautions.
BRENDA (Za)	Offended by TOP clients. Lets out feeling on clients.	Abortion is crime. Has negative attitude towards TOP clients.
CHARITY (Za)	Feels bad during TOP. Nature of nursing compels her to assist.	Abortion is murder. Sympathetic towards clients with miscarriage.

NAME	NURSES' DILEMMA	ABORTION AWARENESS	SUPPORT NEEDS
CYNTHIA (SA)	Can avoid TOP if chances allowed.	Organize support groups for clients.	Nurses in charge to talk to TOP nurses.
CAROL (SA)	Avoids reading clients' files.	Too disturbed to make suggestions.	Counselor to be available.
JILL (SA)	Not consulted about TOP. Biased care.	Needs time to speak to clients.	Counselor to be available.
EVA (SA)	Contented with TOP. Fulfilling duty.	Advice on contraceptive important.	Nurses to be counseled. Had counseling.
BEATRICE (Za)	shows fetal parts to clients. Gives last chance in theatre.	To be strict on family planning.	Support group important. Needs someone to talk to.
MWANSA (Za)	Not sure about advice to give client.	Education on FP using community nurses. Involve teachers.	Nurses to have counseling skills. Counselor to be available for clients
BRENDA (Za)	Woman must know that abortion is murder.	Education to community and adolescents.	Support group important for better client care.
CHARITY (Za)	Biased care towards clients with miscarriages.	Education on family planning not enough.	Handles own needs. Support group needed for other nurses.

APPENDIX C: LETTER OF PERMISSION

28th July 1999.

The Medical Superintendent,

Dear Sir,

Re: RESEARCH ON THE EXPERIENCES OF NURSES ASSISTING IN TOP.

I am a Zambian post graduate student in the department of nursing at the University of the Western Cape. I am doing a research on the experiences and perceptions of nurses assisting with TOP. The research is an essential component of my programme and will be submitted in fulfilment of the requirements of a research masters to the university senate. The aim of the study is to explore and describe the experiences of nurses involved in assisting with TOP, and hopes to come up with strategies or suggestions for supporting those that are negatively affected by the procedure.

I am requesting for your permission to conduct interviews with 4 nurses at your institution. The interview will take about one hour and will be tape recorded. Confidentiality and anonymity will be ensured. The participants will be free to withdraw from the study any time they feel like.

I will be very grateful if my request will meet your favourable consideration.

Yours faithfully,

Martha P. Ndhlovu Mrs.

Noma Mkwelo Ms.

Research supervisor.