

**THE ATTITUDES OF MIDWIVES TOWARDS LEGALIZED  
TERMINATION OF PREGNANCY AT PUBLIC  
AND PRIVATE HOSPITALS  
IN EMPANGENI**

**By**

**Michael Sithembiso Miya**

**January 2008**

**The Attitudes of Midwives Towards Legalized Termination  
of Pregnancy at Public and Private Hospitals  
in Empangeni**

by

**Michael Sithembiso Miya**

A dissertation submitted in partial fulfillment of the requirements for  
the degree of Master of Arts (Counselling Psychology)

in the Department of Psychology

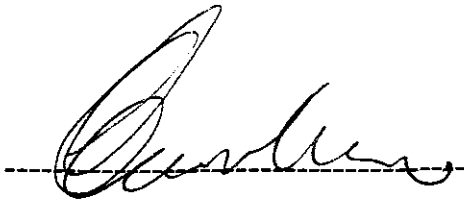
University of Zululand.

Supervisor: DR J. D. Thwala

January, 2008

## **DECLARATION**

I hereby declare that this is my own work and all the sources I have used or quoted have been indicated and acknowledged by means of complete references.

A handwritten signature in black ink, written over a horizontal dashed line. The signature is cursive and appears to read 'Michael Sithembiso Miya'.

**MICHAEL SITHEMBISO MIYA**

January 2008

## **DEDICATION**

Dedicated to my mother, Maqhiki Olga Miya whom is with me in spirit and I love you always.

## **ACKNOWLEDGEMENTS**

Grateful acknowledgements are extended to:

First of all to the almighty for giving me so much, skills, guidance and the patience when I almost lost hope of completing this task.

My gratitude to all the souls that stood close by for support in various aspects of this study.

Special thanks to my family, my gran Hawulekeni, for their unfailing encouragement and faith.

My all in one Lizzy Ziqubu, I am for ever thankful that we met.

Lastly, my supervisor Doctor J.D Thwala. The words of my choice may never convey precisely my appreciation of your supervision throughout the investigation, Thank You.

## **ABSTRACT**

Attitudes determine commitment in their broad sense, though this is rarely understood in this fashion. An abortion decision is influenced by many factors that eventually lead to such a decision, just to mention a few; general health of the mother, rape, occupational status of the expectant mother and the pressure from the society. Termination of pregnancy is sometimes if not most incongruent with one's belief and morale. Midwives as trained individuals to care for the needs of the patients who want to abort have to step over their moral judgement and provide the service (abortion). In the recent past some reports on service delivery (abortion) stated challenges that midwives face within their health institutions, as well the pressure from the general public of South Africa expressing genuine opposition to termination of pregnancy policy, times do change together with the mentality and stereotypes closely attached to termination of pregnancy, although the reproductive policies are a sensitive issue in most countries.

The study focuses on the attitudes of the midwives toward termination of pregnancy and it explores the difference on attitude between public and private hospitals. The findings of the study suggest that there is difference on attitude with regards to termination of pregnancy, amongst the midwives in public and private

## **ABSTRACT**

Attitudes determine commitment in their broad sense, though this is rarely understood in this fashion. An abortion decision is influenced by many factors that eventually lead to such a decision, just to mention a few; general health of the mother, rape, occupational status of the expectant mother and the pressure from the society. Termination of pregnancy is sometimes if not most incongruent with one's belief and morale. Midwives as trained individuals to care for the needs of the patients who want to abort have to step over their moral judgement and provide the service (abortion). In the recent past some reports on service delivery (abortion) stated challenges that midwives face within their health institutions, as well the pressure from the general public of South Africa expressing genuine opposition to termination of pregnancy policy, times do change together with the mentality and stereotypes closely attached to termination of pregnancy, although the reproductive policies are a sensitive issue in most countries.

The study focuses on the attitudes of the midwives toward termination of pregnancy and it explores the difference on attitude between public and private hospitals. The findings of the study suggest that there is difference on attitude with regards to termination of pregnancy, amongst the midwives in public and private

hospitals, this discrepancy also exist amongst senior midwives compared to junior midwives. There are however, a number of reasons for this, but the obvious one maybe that senior midwives have reached self actualization in their careers and view the professional duties beyond egocentric needs and morale, and this facilitate the expected role of the health service providers, which is to cater for the needs of the desperate public.

hospitals, this discrepancy also exist amongst senior midwives compared to junior midwives. There are however, a number of reasons for this, but the obvious one maybe that senior midwives have reached self actualization in their careers and view the professional duties beyond egocentric needs and morale, and this facilitate the expected role of the health service providers, which is to cater for the needs of the desperate public.

## TABLE OF CONTENTS

Declaration of originality	i
Dedication	ii
Acknowledgements	iii
Abstract	iv

### **CHAPTER 1: Orientation and lay out of the study**

1.1 Introduction	1
1.2 Motivation	3
1.3 Statement of the Problem	3
1.4 Assumption of the study	4
1.5 Objectives of the Study	4
1.6 Methodology	4
1.7 Value of the study	5
1.8 Ethical consideration	5

### **CHAPTER 2: Literature Review**

2.1 Introduction	6
2.2 Abortion Attitudes	6
2.3 Requirements for Safe Abortion	10
2.4 Reproductive Policies	11
2.5 Abortion Care Training	16
2.6 Reports on Services (TOP)	17
2.7 Theory of Human Motivation	19
2.8 Impact of Well-Being	22

### **CHAPTER 3: Research Design and Procedures**

3.1 Introduction	24
3.2 Targeted Population	24
3.3 Sampling Method	24
3.4 Data Collection Instrument	24
3.5 Data Collection Method	25
3.6 Data Analysis	26
3.7 Conclusion	26

**CHAPTER 4: Presentation and Analysis of Data**

4.2 Respondents Demographics Profile	27
4.3 Graphic & Statistical Tables	28

**CHAPTER 5: Discussion and Conclusion**

5.1 Introduction	43
5.2 Attitude Toward (TOP)	43
5.3 Discussion of the Results	43
5.4 Significance of results	44
5.5 Conclusion	44
5.6 Recommendations	45

<b>REFERENCES</b>	46
-------------------	----

<b>APPENDIXES</b>	53-55
-------------------	-------

## **CHAPTER 1: Introduction**

### **1.1 Introduction**

After South Africa's first democratic elections in 1994, a unique environment existed in which to alter a range of legislation which had systematically denied rights and services to the most disadvantaged in the country. Under the new Constitution, which recognizes gender and reproductive rights, it became possible for abortion law reforms to be implemented. Before the law was passed, some 425 women died in hospital each year from complications of unsafe abortions and more 14000 per year attended hospitals for treatment of complications. Abortion care programme and the details of a national curriculum and training programme for physicians and especially midwives, who are gradually setting up services. A combination of values clarification workshops for health service providers, and a nationally co-ordinated and localised-controlled implementation plan are ensuring that this legislation is translated into widely accessible services at provincial level and reducing the incidence of abortion-related mortality and morbidity (Dickson & Rees, 1999: 187).

On February 1, 1997, South Africa became the first country in Sub-Saharan Africa, where women had the right to obtain an abortion on request during the first 12 weeks of pregnancy. At that time, 23 countries in the region permitted abortion only to save the women's life, to preserve her physical health and to protect her mental health. Zambia was the sole country to allow abortions on socio-economic grounds. Unlike governments in many other countries, South African governments led the effort to legalize abortion and committed itself to equal access to services for all women (Althaus, 2000). There have been reports indicating that, since 1996 the South African abortion statistics have increased tremendously among the female youth, both in urban and rural areas (Brandt & Razin, 1997).

In survey conducted in 1987, the most common reason for having an abortion (76% of respondents) was that a woman was not ready for how a baby would change her life or interfere with employment, school and other responsibilities. About 68% reported that they could not afford a baby because they were single or students.

Just over half the sample, mentioned that they were seeking abortion because they did not want to raise children alone. Women who have abortions are more likely to be young, poor, non white and unmarried than the average of all women of childbearing age. About 60% of all women who have undergone abortions are under the age of 25 (Jagga & Rothenberg, 1993). Brucker (2000) stipulate that, as women gave birth, they sought and received care from supportive others. At an unknown point in the culture evolution, some experienced women became designated as the wise women to be in attendance at birth. Thus, the profession of midwifery began. Indeed, as historians have noted, midwifery has been characterized as a social role throughout recorded history, regardless of culture or time. In Greek and Roman times, midwives functioned as respected, autonomous care providers to women during their reproductive cycles. Some qualifications for the practice of midwifery began to evolve during this period. For example, in Greece the midwife was a woman who had born children herself, this requirement has remained a commonality in the practice of midwifery throughout several cultures and exist even today. 'Midwife' is a word which in English was translated to mean 'with woman', implying the supportive, not interventive, functions of the practitioner. In French a midwife is a 'sage femme' or a 'wise woman'. A general thread in all of the references regarding ancient midwifery was support of the woman in labor. Labor was perceived as a basically natural process. The profession of midwifery continued without major changes throughout the centuries, even through the Dark and Middle Ages. In their practice midwives routinely used herbs and potions, as forerunners of today's modern pharmaceuticals. The midwives of these centuries generally continued to learn by the apprentice model. As an apprentice, skills and knowledge were shared from generation to generation but without the development of a formalized system of university education. Therefore, midwives did not benefit from the scientific inquiry that developed early in medical schools. Eventually midwifery in most affluent countries developed formalized programs, although apprenticing still may be part of some. Midwives are the most common birth attendant in the world. The average child born in this world is born into the hands of a midwife ([www.utsouthwestern.edu](http://www.utsouthwestern.edu)).

Pregnancy is viewed differently from one continent to another, browsing through the sources of abortion literature, an author was found that paints the experiences of perinatal

loss in a manner rather sensitizing ' Becoming pregnant may fulfill life long wishes of personal power and creativity totally independent of the nurturant's aim of motherhood. A creature whom springs from me, as a fruit from a tree and secures continuity, immortality for my own transient existence'. Pregnancy may normally serve as a vital narcissistic defense, preserving a sense of self worth and permanence. To those who suffer from awareness of their own ego weakness, pregnancy is a welcome opportunity to enhance their own importance. When perinatal loss occurs, there are multiple frustrations, many disappointments and much deprivation. There is profound deprivation of one's instinctual urges to both give and receive, to nurture and grow to feed and be fed. A specific person who can never be replaced has died, a part of oneself an embodiment of the future and the best one has to offer has died as well. A sense of power of having defeated death is extinguished by the occurrence of death when it is least expected (Leon, 1990).

Over the past 10 years there has been improvement in the safety of the abortion procedures used and access to treatment, for complications for some women in developing countries. The number of women requiring treatment for serious complications of unsafe abortion remain relatively high (WHO, 1998).

## **1.2 Motivation**

This study has been motivated by the researcher's exposure to Maslow's theory of self actualization need (Sakoda, 1952) which maintains that human beings are motivated to pursue careers that they enjoy and are passionate about, and which grant them gratification and appreciation. It is generally accepted that midwives have rights to maintain their personal principles (religion/morale) which may oppose the termination of pregnancy, but on the other hand the patients have rights to service (termination of pregnancy) and should not be deprived of access to service solely because of midwives personal principles. The study will thus explore midwives attitude after ten years of legalized termination of pregnancy in new South Africa.

## **1.3 Statement of the problem**

The number of qualified midwives is increasing every year and the South African government has put policies in place that would address abortion related challenges. However, it would be useful to precisely understand the attitudes of the midwives

towards legalizing termination of pregnancy, whether they feel it was right or wrong because this would indicate whether they believe in the service they render or whether they are doing it merely to earn income. South Africa like many other developing countries, changes its policies to suit cultures of its people. Economical discrepancies among the developing countries are rarely considered and most realized when the implementation of these policies produce challenges that are without readily practical alternatives or solutions. Termination of pregnancy was only legalized in the fall of 1996 in South Africa, the health department took a decision that could no longer be postponed nor ignored, because the deaths of women in their reproductive years was not healthy for such a country with hope for prosperity, yet divided by not only color but race and economic class. In the recent past there has been a change on how people perceive abortion, including the nurses but unpleasant incidents of nurses lecturing patients about the negative consequences of abortion are reported from time to time.

#### **1.4 Assumptions of the Study**

- The midwives' attitudes towards termination of pregnancy are negative.
- Incentive does influence attitude regardless of age, experience or sector (private / public).
- There are differences on attitude between newly qualified and senior midwives with regards to Termination of Pregnancy.

#### **1.5 Objectives of the study**

The main objectives of the present study are:

- To establish midwives' attitude towards the termination of pregnancy.
- To explore the difference on attitude between newly qualified and experienced midwives and to establish if incentives influence attitude.

#### **1.6 Methodology**

##### **1.6.1 Targeted population**

This study will be focusing on the midwives from public and private hospitals in Empangeni.

##### **1.6.2 Sampling method**

A non-probability sampling procedure will be undertaken (Huysamen, 2000).

This method was selected in effort to present important strata such as work experience, religion and age etc, known to be in the corresponding proportions in the sample (Huysamen, 2001).

The attitudes of respondents will be compared against the sectors to determine the differences/relationships between them with regard to termination of pregnancy.

### **1.6.3 Data collection instrument**

A likert type of scale will be used adapted from Hunter, Butler, Noy & Rosser (1980). This study was done in 1978. It looked at the attitudes towards abortion among college women in the United States of America. The questionnaire will be handed to all participants at their convenience.

### **1.6.4 Data analysis**

Data collected from midwives will be analyzed and presented in percentages as well as in Chi-square categories.

### **1.7 Value of the study**

The study will assist the facilities designated and approved for the termination of pregnancy to restructure or enhance if the need arise their services of TOP, as well exploring whether the challenges faced by the institutions of this study can be generalized to other facilities in the nine provinces of South Africa.

### **1.8 Ethical considerations**

The principle of informed consent requires that before the decision to participate in research is made, potential subjects must be fully informed about the nature, duration and purpose of the study (Vadum & Rankin, 1998). The researcher will, therefore ensure that the participants are fully informed about the aim and duration of the study and that they remain anonymous throughout the course of the study.

## **CHAPTER 2: Literature Review**

### **2.1 Introduction**

This chapter focuses on collecting readily available researched information in the past, relevant to the current study. The main objective of the literature review is to indicate, if there was research done in the area of current study and what were the findings of those studies.

### **2.2 Abortion Attitudes**

World wide nurses have attitudes towards TOP'S. In North America it was found that gynecological nurses often have stereotyping and lamenting attitudes towards TOP's and patients under going abortion (Marshall, Gould & Roberts, 1994).

Most people's abortion attitudes are fairly extreme, either pro-life or pro-choice; few people are neutral about the topic. Hollis and Morris (1992) found that most abortion attitudes were at one of the extreme ends, only 28.9% of people surveyed were found to have intermediate attitudes about abortion. When doing their research, they used a seven point, Likert-type scale with hopes of increased variance in the responses. They felt that giving participants a chance to answer on a scale of one to seven would bring forth more answers in the middle range, showing the general ambivalence they thought was felt by a lot of people about abortion. However, the researchers still found polarization of opinions. Most individuals clustered at the low end, always disagree with abortion (answering 1-3 on all scenarios) or on the high end, always agreeing with abortion (answering 6-7 on all scenarios). A study conducted by Harrison, Montgomery, Lurie and Wilkinson (1997;425) in the Hlabisa District, Kwa-Zulu, a rural area with a population off just over 200 000. The district, the majority of which was located in the former Kwa-Zulu homeland under the former apartheid system, is inhabited predominantly by Zulu speaking Black South Africans and contains both remote, rural areas characterized by scattered homesteads (kraal). The study was a community survey on "Barriers to Implementing South Africa's Termination of Pregnancy Act in rural Kwa-Zulu/Natal". With one hundred and thirty eight community members (24 males and 114 females), were interviewed using a structured survey instrument. Respondents came from two discrete geographic areas representative of the district; one close to a major highway and trading centre, and the other more remote and

rural. Respondents were selected from alternate households. within the households women were stratified into two age groups (16-25 and 26-49 years) and then one woman from each age group was randomly selected. Men were randomly selected within half the households; those selected were often migrant workers living away from homes, resulting in a smaller number of male respondents. Interviews were conducted by trained field workers fluent in Zulu. Hospital survey, eighteen of 25(72%) primary care nurses (all females) at the district hospital responded to an anonymous self administered questionnaire containing both close and open-ended questions. The survey was conducted on one day, and all nurses on duty in selected wards were asked to participate. Wards selected included those, such as the maternity ward, where nurses would be most likely to be designated for training to provide abortion. While this may have introduced an element of bias into the study, the researchers wanted to accurately assess the potential for training nursing staff within this hospital and thus selected representatives of those professional groupings most likely to have been selected. while some have suggested that nurse midwives, for instance would be more biased toward saving life of a child rather than ensuring a woman's right to abortion, the researchers felt that this reflected the reality of typical rural hospital setting, and that it would help to assess the situation realistically. The community sample were more likely to support the Act (17 vs 5%  $p=0.04$ ) than older woman and more likely to support abortion on request (26 vs 13%  $p=0.07$ ). The greatest difference observed between younger and older women was with regard to support for abortion in the case of rape or incest (72 vs 47.5%  $p=0.01$ ). Within both the primary care nurses and community groups, there was a clear hierarchy of support for abortion in the case of rape or incest (56% vs 58% respectively) and saving a woman's life (61 vs 56%) received significantly more support than abortion on request (6 vs 18%) or abortion for women in poor social or economic circumstances (5 vs 20%) abortion to save a foetus ranked in the middle for both groups (45 vs 36%). In depth interviews were conducted with nine women from the community and nine primary care nurses regarding their attitudes and beliefs about abortion. These typical women in this rural area, all but one had children and most had husbands who worked away from the area for at least greater part of the year. In the hospital survey, responses about the reasons for opposing abortion revealed strong religious. Many stated that they felt they would be killing another human being if they participated in providing abortions, arguing that the hospital was established to save people's lives, not remove them, several

considered abortion to be against the nurses' professional code, which requires them to save lives. Respondents also noted that the hospital is already busy and that nurses are overworked, others stressed the importance of educating women about family planning, finally, the idea of choice was mentioned with one respondent stating that women have the right to choose, nurses also should have the right to choose. The in-depth interviews with women in the community revealed deep conflict over the new law at many levels. There was a sense that the law would encourage young women to sleep around and be irresponsible. When asked why they thought someone would want an abortion, respondents most often assumed that it would be a young woman seeking the abortion, making statements like 'It's because they don't care for their future, they just leave books and everything go to boys. In-depth interviews with nurses revealed many of these same feelings but with the added dimension of confusion over their professional responsibilities. One nurse summed it up as follows; "If they extend our duties, we are going to be confused ourselves because we want a healthy mother and infant, but at the same time we must do abortions'. None mentioned the clause in the Termination of Pregnancy Act, which permits conscientious objection based on religious or other beliefs. Nurses often used 'they' referring to government, which they perceived as imposing this decision on them. As one said; "Mandela has given them this right, now they are going to kill because they want to enjoy sex'. The conclusion that was drawn from this study was that all nurses and most community members 94% had heard of the TOP Act, but only 11% of both groups indicated full support for the TOP Act. Teenage contraceptive use in South Africa is constrained by attitudes associating sexual involvement with marital commitment and stable relationships, neither of which usually characterizes teenage relationships. However, social changes have led to an increase in age at marriage in South Africa, which has been accompanied by a rise in premarital sexual activity and premarital births. Many of these births occur during teenage years to women who are neither economically nor emotionally ready to deal with parental responsibilities (Mfono, 1998:198).

Nurses provide most reproductive health care services their attitudes could influence women's access and utilization of these services, particularly contraceptive and CTOP services, a nurse who labels teenagers requesting contraceptives, as prostitutes poses an access barrier to the CTOP for the teenagers (Silberschmidt & Varkey, 2001; 1820).

Some women have had to go from one clinic to another to find a sympathetic health worker who would give a referral letter, while others have had to listen to the provider's personal opinion about abortion. One woman recounted her experience: "(The sister) was just telling me 'It's killing, it's murder, your life won't be the same', she even tried to call in a pastor, 'I said, I am sure what I am doing here. I don't need a pastor.' I was angry in a way, she was just wasting my time, just telling me not to do it'. Such judgmental attitudes affect those who provide abortion services as well as those who use them. Health workers involved in these services report feeling unsupported by and alienated from their colleagues. As one provider commented, "Their attitude affects me. At times I tell myself that they are ignorant, why should I be offended. However, they break you, at times'. Willing providers thus have to bear the brunt of understaffed services and an unsupportive environment. This situation underlines the need to destigmatize abortion by making it a basic part of training curricula a strategy that will ensure a larger cadre of technically capable and responsive personnel (Varkey, 2000).

Most nurses live by the international pledge for nurses and feel compelled to uphold the ethics in circumstances that calls for morale. The pledge states, 'In the full knowledge of the obligations, I am undertaking I promise to care for the sick with all of the skill and understanding I possess, without regard to race, color, creed, politics or social status. I will respect at all times the dignity and religious beliefs of the patients under my care and holding in confidence all personal information entrusted to me and refraining from any action which might endanger life or health. I will endeavor to keep my professional knowledge and skill at the highest level and give loyal support and cooperation to all members of the health care team. I will do my utmost to honor the international code of ethics applied to nursing and to uphold the integrity of the nurse'. ([www.uu.edu/org](http://www.uu.edu/org)).

The pledge serves to remind the nurses of their duty, which is to care for the ill and leaves no room for service deviation regardless of the individual motives, though the health department has put reasonable policies in place with regards to termination of pregnancy, that permits nurses to refer patients to TOP designated health institutions when the institution cannot perform TOP or lack TOP personnel.

### **2.3 Requirements for Safe Abortion**

Most developed countries still require a gynecologist to carry out abortion, yet this is not necessary particularly not for abortions performed under 14 weeks of pregnancy, given that the skills needed have been greatly simplified and rate of complication is low (Roe, Francome & Bush, 1999).

With appropriate training nurse midwives or those with comparable training would be the most appropriate abortion providers. In Nigeria manual vacuum aspiration has been used on an outpatient basis for most cases of abortion complications, reducing waiting time for women from 48-72 hours to 10-15 minutes. Vacuum aspiration can also be used for safe, early abortions up to 14 weeks of pregnancy. In South Africa, the training of midwives in manual vacuum aspiration is a key activity of the new national abortion program. The guide lines for training midwives prescribed a 160 hour course combining theory and Clinical practicals. The curriculum includes an overview of the law and the problem of unsafe abortion, professional practice and ethics, communication skills and counseling techniques, patient assessment and preparation, pharmacology, MVA technique, infection control, management of abortion complications, post-abortion family planning, emergency contraceptives, identification and treatment of sexually transmitted infections (STIs) and strategies for dual protection against unwanted pregnancy and (STIs). A study comparing medical abortion using mifepristone-misoprostol with early surgical abortion in China, Cuba and India found medical abortion to be safe. Fully established services for routine surgical abortion are not required prior to introducing medical abortion, although vacuum aspiration is a necessary back up to both first and second trimester medical procedures for the small number of cases of incomplete abortions. It has been persuasively argued that medical abortion can be largely self administered as long as the woman considers the method acceptable, is early enough in pregnancy, can adhere to the protocols, is able to manage minor

adverse reactions and seek help for more serious ones, can notice and cope with the expulsion of the embryo and can recognise a complete abortion, return for a follow up visit. Along with safe methods and trained providers, programmes require locally assessable services in both rural urban areas. In Zambia gynecologists were found to be a major obstacle to the setting up of safe abortion services. The ambivalence of doctors was found to have hampered the implementation of a revised abortion law. In South Africa in

contrast, as cases have arisen where unlicensed providers have continued to offer services (TOP) despite the changed legal status of abortion, criminal charges have been pressed against them. A nationally co-ordinated programme aims to ensure that through out the country, primary and secondary care facilities are prepared to perform abortions. All nine provinces in South Africa have developed provincial plans, each in collaboration with a medical school or a tertiary training hospital. A national advisory group has been set up to co-ordinate and monitor implementation of the new law, including health managers, representatives from medical schools, academics and specialists, the nursing council, researchers and the nongovernmental sector. The group plans to meet every 4-6 months and make recommendations to government and relevant issues (WHO, 1998: 97).

#### **2.4 Reproductive Policies**

In 1974, the government of South Africa officially began implementing Family planning program without racial basis, but this program was widely believed to be linked with white fears of growing black numbers and was attacked by detractors as a program of social and political control. The use of this service by non white women steadily increased. The government initially promoted family planning services as a measure to improve the health of women and their children, it also acknowledged the program was as way to place a check on the high growth rate burdening limited resources. Reports of forced sterilization and coerced contraceptive use furthered the suspicions of the program as a manifestation of another apartheid policy aimed at controlling the lives of blacks. The history of reproductive control and family planning in South Africa is tightly bound with the policies and laws that entrenched social and economic inequality by race (Kaufman,1997).

In the early 1980s, the President's Council commissioned an extensive report on demographic trends in South Africa (Republic of South Africa,1983). As a result of that report, the Population and Development Program (PDP), the population policy arm of the government, was initiated in 1984 charged with the responsibility of popularizing the consequences of high population growth in South Africa and promoting the small family ideal. The objectives of the program, as outlined by the Minister of Health and Welfare, were (1) to stabilize a population of 80 million by the end of the next century; (2) to accelerate social and economic development in order to achieve parity in the

development levels of the different population groups by the middle of the next century; (3) to achieve a total fertility rate of no more than 2.1 children per woman of reproductive age and thus target the sectors of the population growing fastest; and (4) to ensure an “orderly spatial distribution” of the population through coordinated involvement in health, education, and economic programs, and urban and rural development schemes(Hansard’s, 1984: 6,529 as cited by Kaufman (997).

The South African Constitution states that all people should have a right to health care, including access to reproductive health care, and the government has begun a process of transforming legislation that denied rights and services to the most disadvantaged. The inequity of race and class has been clearly demonstrated in South Africa in relation to women’s access to safe abortion. Before the change of government, access to safe, legal abortions was limited to a few wealthy women who could afford to pay a willing gynaecologist to guide them through the bureaucracy required by the State before a pregnancy could be terminated. Of a total of 868 legal (reported) abortions in 1988, 69 per cent of the women were white women (whites were just over 12 per cent of the South African population at that time)(Rees, 1991). Some laws stipulated that health professionals can refuse to participate in a legal abortion on grounds of conscience. In Great Britain, this is the case unless the woman’s life is at risk. Moreover, no one applying for a gynecology post in Great Britain, can be asked his or her views on abortion, provision appears on the job description. However, providers may opt out of less than conscientious reasons, leaving women vulnerable and putting the onus on them to find a provider, which can be difficult and time-consuming (Roe, Francome & Bush, 1999).

In South Africa, a draft of the new law made it mandatory for anyone who objected on grounds of conscience to refer the woman to another provider, but this was omitted in the final text (Stevens & Xaba, 1997), which says only that the woman shall be “informed of her rights” (CTOP Act, 1996). A balanced law would protect both a true conscientious objection and a woman’s right to obtain a legal abortion without delay. Nevertheless some advocates argue that health professionals have an obligation to perform all socially sanctioned medical services, including abortion (Meyers, 1996). Similarly, it can be argued that abortions should be carried out by dedicated service providers and only those

who are sympathetic to women's need for abortion, should be employed as a matter of quality of care and respect for women's feelings. A certain proportion of women change their mind and decide to continue their pregnancies after having arranged for an abortion (Soderbera, 1997). This does not justify imposing a waiting period between arranging an abortion and having the procedure, as is the case in France and in Netherlands, where this regulation is meant to prevent women crossing their national borders for abortions, where counseling is to be provided, laws may specify what it should consist of and whether it is mandatory counseling can be directive, to try to influence or control a woman's decision. Thus, antiabortion organizations sometimes offer counseling services in the some developed countries. In Singapore, the abortion law was liberalized in 1974 as part of national policy to encourage small families, in 1986 mandatory counseling was introduced in order to encourage those who could afford it to have more children, which led to a decrease in the number of abortion (Singh, 1996), in contrast, the aim of non-directive counseling, which is considered the most ethical form of counseling, is to help women to decide what is best for them. The new South African law says that the state shall promote 'non-mandatory and non-directive counseling before and after the termination of pregnancy', (CTOP Act, 1996). In Viet Nam, very few women who have had abortions receive information on how to avoid future pregnancies, although they would like to have this. Some are forced to seek information elsewhere, others are left knowing as little as they did before their abortions (Belanger & Khuat, 1999). In Guyana, in contrast the 1995 law stipulates counseling before and after abortion, stresses the importance of use of contraception, suggests including the woman's partner in counseling to foster male responsibility and spells out in details the content of counseling, it even imposes a 48 hour waiting period before an abortion is carried out, to allow time for

counseling (Nunes & Delph, 1995), in the year after the law was changed, however doctors' records showed that counseling was concentrated almost exclusively on offering contraception (Nunes & Delph, 1997), this is not surprising in that these doctors were not trained as counselors. Striking a balance and finding out what women require is advisable. Abortion services that are openly available have the opportunity to offer family planning and sexual health information and services to give women the means to protect themselves. In developed countries, experience has shown that few women who seek an abortion actually need 'counseling' as regards the abortion decision, but they do need information. This includes information on and choice of abortion method before the

abortion, and on what happens during the procedure, information on possible complications and seeking help for these afterwards, information about resuming sexual intercourse, prevention of HIV infection and other sexually transmitted infections and the offer of a choice of contraceptive methods, but only at the woman's request, so as to protect her right to privacy (World Health Organization, 2000).

After South Africa's first democratic elections in 1994, a unique environment existed in which to alter a range of legislation which had systematically denied rights and services to the most disadvantaged in the country. Under the new Constitution, which recognises gender and reproductive rights, it became possible for abortion law reform to be implemented. Before the law was passed, some 425 women died in hospital each year from complications of unsafe, clandestine abortions and some 14,000 or more per year attended hospitals for treatment of complications (Dickson & Gringle, 1998).

South Africa now joins Botswana, Ghana and Zambia as African countries with liberal abortion policies with South Africa and Zambia the only countries in Sub-Saharan Africa that permit abortion for social reasons. Zambia where abortion became legal for medical and social reasons in 1972, provides an interesting comparison with South Africa and may offer lessons regarding access, implementation and provision of safe services for all who want them. Studies that have examined abortion in Zambia have found a continued high proportion of illegal abortions, together with an extremely high induced abortion mortality ratio

in some areas. One community based study that examined the reasons for this found that legal abortion services are inaccessible and unacceptable, and that women resort to illegal abortion for fear of being expelled from school or unwilling to reveal a secret relationship (Harrison, Montgomery & Lurie, 2000)

After the law was passed, increased numbers of legal abortions were requested and performed, indirectly indicating that the incidence of unsafe abortion was declining. However, women's access to safe services remained restricted and unequal, as not all hospitals and clinics in the country were prepared to meet this demand. In the first three months after the law was passed, 60% of all legal abortions were performed in Gauteng

Province, where South Africa's capital, Johannesburg, is located. After a year, only one-third of the hospitals and clinics designated by the Department of Health to provide abortion services were actually doing so. Of the 31,312 legal abortions performed in 1997, almost all were carried out in hospitals located in urban areas, as services were not available at that time in the community-based clinics that provide most primary care in South Africa. To counteract resistance among health care workers, the Planned Parenthood Association of South Africa, the Reproductive Health Research Unit (RHRU) of the University of the Witwatersrand and the Reproductive Rights Alliance conducted workshops with more than 4,000 health care providers throughout the country during the year after the law was passed. The workshops addressed providers' feelings about abortion, educated them about the provisions of the law and encouraged them to approach abortion in a nonjudgmental way and to treat women seeking an abortion with dignity and respect. In Cape Town, 70% of workshop participants said they would be able to interact with patients having an abortion "quite a bit" or "a lot" better than before attending the workshop (Dickson & Gabriel, 1998). In 1997, authorities in all of the provinces reported difficulty in implementing the new Act because of the lack of health care providers trained to provide abortion care. To ensure that providers would be trained in all provinces and at all types of facilities, in 1998 the government established the National Abortion Care Programme, which encompassed the Midwifery Abortion Care Training Programme. The RHRU was responsible for coordinating the national program, which was carried out through a partnership among the Maternal, Child and Women's Health Directorate, of the Department of Health, the RHRU and provincial health departments and academic institutions. Ipas, an international nongovernmental organization with extensive experience in training and research on abortion care, collaborated in the design of the training content and process as well as in the evaluation of midwives' skills. The main purpose of the program was to develop the capacity of public clinics and health centers to provide safe, high-quality and accessible abortion services, treatment of abortion complications, contraceptive services and counseling, and other reproductive health services abortion clients need. In doing so, the program aimed to bring services closer to the communities where women live, particularly poor women and women living in rural areas. The Midwifery Abortion Care Training Programme consisted of three major activities: developing an abortion care curriculum and training manual; training registered midwives in comprehensive abortion care services; and

conducting a process evaluation of the quality of midwives' service provision after they had been trained.

## **2.5 Abortion Care Training**

As required by the South African Nursing Council, midwives are considered for *certification in abortion care after completing 160 hours of training—80 hours of theoretical training and 80 hours of clinical training under the supervision of experienced practicing physicians in accredited hospitals. The clinical training must be completed within three months of the theoretical training. Training of registered midwives took place from November 1998 through May 1999. During the first course, RHRU and Ipas trained 22 midwives to provide abortion services and to act as trainers for other midwives in their provinces. The two-week course emphasized both clinical and psychosocial skills and included a didactic introduction to clinical issues and abortion techniques, classroom instruction in counseling and interpersonal communication skills, and training in clinical techniques using pelvic models. RHRU conducted similar national-level workshops in March and May 1999. (Participants in these workshops were not trained to be trainers.) After the theoretical training, all midwives received manual vacuum aspiration kits to use in their clinical training and to provide services once they were certified. Provincial authorities were responsible for ensuring that clinics provided midwives with space and equipment for their services (Dickson & Gabriel,1998). By the end of 1999,*

at the time of our evaluation, 81 (88%) of the 92 midwives who had participated in the two-week theoretical training had completed their clinical training and were certified to provide abortion care services . Sixty-nine (85%) of the certified midwives were providing services in 39 public-sector health care facilities and in three Marie Stopes International clinics in South Africa's nine provinces. Gauteng province had the most trained, practicing midwives (16), mainly because a very dedicated obstetrician in Gauteng had taken the initiative to train some midwives using the approved manual outside of the national workshops. The other densely populated provinces, KwaZulu Natal and Western Cape, had the fewest (five each). Twelve trained midwives were not practicing for various reasons: One had died, one had left South Africa, one had left the public sector for the private sector, one had been transferred to night duties, one was on

sick leave, others had not yet been able to establish services and a few had experienced administrative barriers that prevented them from providing services (Dickson & Gabriel, 1998).

## **2.6 Reports on Service (TOP) Delivery**

At the Kalafong Academic Hospital in Pretoria, in the first year of the new Act, there was a significant decrease in both the total and relative number of patients admitted with complications of abortion. The complication rate decreased from 50.7 per cent in 1996 to 29.4 percent the following year. Conversely, when the same hospital stopped doing second trimester terminations, the rate of complications rose again from 25.9 per cent to 35.3 per cent, another indication of the importance of access to safe services for women.<sup>16</sup> National Guidelines for Contraceptive Services are currently being drawn up to help improve contraceptive service delivery within the country. Along with these, the Choice on Termination of Pregnancy Act is part of the government's commitment to promoting an holistic approach to reproductive health care, reducing maternal mortality and the number of unwanted pregnancies, promoting reproductive choice and sustaining and improving the quality of women's lives. The long-term aim, which is beginning to be realised, is to make reproductive choice a reality for all South African women, without fear of death, through safe, legal and high quality services (Dickson & Rees, 1999).

A study by Dickson & Billings (2002;198-219) from October 1999 through January 2000, an evaluation was conducted at 27 public health care facilities in South Africa's nine provinces to assess the quality of care provided by midwives who had been trained and certified to provide abortion services. Data were collected by observing abortion procedures and counseling sessions, reviewing facility records and patients' charts, interviewing patients and certified midwives. The result of 96 abortion procedures performed by 40 midwives, 85 involved manual vacuum aspiration. Midwives' clinical practice was rated 'good' in 75% of the procedures. No complications occurred during abortion procedures or as a result of the procedure, and no abortion clients died. Midwives consistently provided women with contraceptive counseling after the abortion, and most clients (89%) received a contraceptive method before leaving the facility. The injectable was the only method that was available at all facilities; of the 90 clients who were interviewed about the contraceptive method they received after their abortion, 75%

had received this method. Few had received condoms (1%). It was concluded by that midwives can provide high-quality abortion services in the absence of physicians. Training in abortion care should be systematically integrated into midwives' basic training. This training should use postabortion counseling as an opportunity to inform women about dual protection from unwanted pregnancy and sexually transmitted infections. Prior to the implementation of an intervention to train providers and upgrade services, state health-ministry officials and health-facility staff developed indicators to enhance their ability to measure changes in access to postabortion care. These indicators included the number and distribution of facilities offering comprehensive postabortion-care services (use of manual vacuum aspiration for uterine evacuation and provision of postabortion contraceptive services); facility locations were plotted on maps at pre- and postintervention points. Ultimately, comprehensive postabortion-care services became available in at least one site in each subregion of the state. An additional indicator focused on the number and proportion of sites, by level of facility (hospital, health center, primary-care center), at which a trained postabortion-care provider was available. Access to services within specific health-care facilities also was tracked by monitoring reductions in waiting time for care achieved by shifting to outpatient postabortion-care services \*(Huapaya et al. 2003). Health-care-facility surveys in Ethiopia, India, Kenya, Nicaragua, and elsewhere have improved understanding of service availability

(Gebreselassie & Fetters 2002; Onyango, Mitchel, Nyanga, Turner & Lovell, 2003; Padilla, McNaughton & Gomez, 2003; Barge, Bracken, Elul, Kumar, Najahat, Verma & Camlin 2004). Furthermore, geographic information systems technology holds promise for mapping of service sites to assess availability and distribution of services. In Limpopo Province, South Africa, this technology has been used to map individual sites designated by the government to offer abortion services and those actually offering services, according to population density. Overall, South Africa's service capacity to provide emergency obstetric care received a rating of 61 out of 100, showing the rating of the capacity of health facilities to provide specific services. The least available service among those assessed at health centers is providing vacuum aspiration of the uterus (MVA) for postabortion care. Use of the partograph is the most commonly available service in health centers. District hospitals in South Africa received moderate ratings for providing a range of health center functions (64), performing Cesarean-sections (63), and providing blood transfusions (61). Both health center and district hospital services in

South Africa generally received higher ratings when compared to services in other countries from the sub-Saharan Africa region (Benson, 2005).

A range of positive steps have been taken to reduce deaths and morbidity from abortion in a growing number of countries, over the past 15 years, since 1980, abortions laws have been liberalized in some form in Algeria, Belgium, Bostwana, Canada, China, Malaysia, Mongolia, Pakistan and South Africa. In other countries there have been attempts to change highly restrictive abortion laws or major national debates on abortion. In Brazil, for example, a congress considered 46 bills on abortion between 1946 and 1995; 13 of 16 bills over the period 1991-95 were favourable towards making abortion legal under some circumstances. In some countries, women themselves started to use safer methods for self induced abortions in particular, this has been well documented in Brazil, such changes have succeeded in reducing at least some of the more appalling examples of morbidity and mortality arising from the insertion of stickx, roots and sharp instruments into the uterus (Baltar da Rocha, 1996).

## **2.7 Theory of Human Motivation**

Maslow's theory (1943) stipulates that integrated wholeness of the organism must be one of the foundation stones of motivation theory; such a theory should stress and center itself upon ultimate or basic goals rather than partial or superficial ones, upon ends rather than means to these these ends. Such a stress would imply more central place for unconscious than for conscious motivations. Human needs arrange themselves in hierarchies of prepotency. That is to say, the appearance of one need usually rests on the prior satisfaction of another, more pre-potent need. Man is a perpetually wanting animal. Also no need or drive can be treated as if it were isolated or discrete; every drive is related to the state of satisfaction or dissatisfaction of other drive. The 'physiological needs' are usually taken as the starting point for motivation theory, they are the so-called physiological drives. Two recent lines of research make it necessary to revise our customary notions about these needs, first, the development of the concept of homeostasis, and second, the finding that appetites (preferential choices among foods) are a fairly efficient indication of actual needs or lacks in the body. Once the physiological are well gratified, the new set of needs emerges which are categorized as safety needs. Everything practically looks less important than safety, even the physiological needs being satisfied are now underestimated a man in this state, if it is extreme enough and chronic enough may be

characterized as living almost for safety alone. The third need is for love and belonging, included are the needs for friends and companions, supportive family, identification with a group and an intimate relationship. The fourth need is the esteem need, which requires both recognition from others and the self which often results in feelings of prestige, acceptance and status, the lack of satisfaction of the esteem needs results in discouragements and feelings of inferiority. Finally the self actualization, sits at the apex of the original pyramid. This is the need to create and experience beauty. People who reach self actualization will sometime experience a state he referred to 'transcendence' in which they become aware of not only their own fullest potential but that of others at large, but even if all these needs are satisfied, we may still often expect that a new discontent and restlessness will soon develop unless the individual is doing what he is fitted for. Pinder (1998) says 'people have feelings at work and that they have feelings about their work, emotions serve to communicate with one's self and others'. It would be fascinating to know how the midwife's feelings about abortion

interferes with their duties and to what extent does this affect their perception of abortion, or should it be assumed that their feelings/ attitude do not interfere with the manner, midwives treat the desperate patients who have no elsewhere to go for abortion. Dipboye, Smith and Howell (1994) founded that work for both, intrinsic rewards, such as pride in one's work and a sense of accomplishment. Miller (2002) also mentions recognition (including praise and rewards) as a common incentive but asserts that it discourages intrinsic motivation. Green (2002) says employees are motivated by what they intrinsically believe is going to happen, not by what managers promise (extrinsic) will happen. This was fascinating in expanding knowledge about factors that motivate human beings and maintain job satisfaction, so that we do not limit job satisfaction/dissatisfaction to be only dependent on self actualization. The same is true for attitude at work, people hold diverse beliefs which influences their attitude. Working conditions for public health institutions are influenced by government policies. However, each institution is responsible for creating a caring and supportive environment for its staff, this is highlighted by Stoter (1997) who states that effectiveness of any staff support system is influenced by the culture of an organization, this author further states that such a system must be built into the organisation's philosophy. An institution can create a caring and supportive environment by removing or minimizing stressful situations. for example; (1) ensuring adequate staffing to prevent work overload for nurses,

(2) setting clear policy guidelines and work standards, (3) providing opportunities for continuing education, (4) providing adequate equipment and supplies for patient care, (5) arranging counseling services for staff and providing adequate remuneration and accommodation. If the working conditions are poor basic necessities for patient care not available, a supportive environment cannot thrive. Within the scope of professional nursing, care refers to 'those cognitively learned humanistic and scientific modes of helping or enabling an individual, family or community to receive personalized services through specific culturally defined or ascribed modes of processes, techniques and patterns to improve or maintain a favourable health condition for life or death', (Leininger,1988). The emphasis by this author is on helpful and enabling activities which are culturally acceptable to the person being cared for. The literature on abortion suggest that in the past, all around the world nurses gave lectures on 'morale' to patients that resorted to abortion, instead of being respectful of the patient's decision to abortion.

Bevis refers to caring as a 'feeling of dedication to another to the extent that it motivates and energizes action to influence life constructively and positively by increasing intimacy and mutual self actualization', (Bevis and Leininer, 1988: 50). According to this definition, caring is a feeling which is translated into behaviors that enhance improvement in the condition and experiences of the person being cared for. Ryden and Krichbaum (1996) state that the basic nursing education cannot adequately meet the growing needs for newknowledge and skills. Nurses need to have adequate information about the diseases (complications), prevention, management and care to be able not only to function effectively but also to educate patients/clients and primary care givers. Many studies have identified job dissatisfaction to the cause of stress among nurses. Job satisfaction is influenced by a wide range of factors such as job security, work environment, work schedule, salary, peer relations/teamwork, supervision and relationship with supervision, recognition, personal growth and challenging work (Buys & Muller, 2000). Lack of teamwork and poor working relations is a major causes of dissatisfaction such as disrespect of patients was identified as a course of dissatisfaction among committed nurses (Fletcher,2001). The importance of good interpersonal relationships among nurses and its effect on job satisfaction, needs to be emphasized to nurses from the time they join the profession as students. If nurses do not learn to value teamwork among themselves from the outset, it may become very difficult to correct such

attitudes later on. Having stressed staff create a stressful atmosphere, which easily passed on to patients, relatives and colleagues around them. However, for any support interventions to be meaningful, the nurses should acknowledge their vulnerabilities and recognize their need for support (Jackson, 2000; Stoter, 1997 & Vachon, 1998). Due to the differences in work environment nurses's personalities, attitudes, cultures and past experiences it is necessary to explore what the nurses perceive to be their needs as far support is concern.

## **2.8 Impact of Well Being**

A study carried out by Da Els and Da la Rey (2006) titled 'Developing A Holistic Wellness Model', consisted employees of major life insurance company in South Africa with the scientific objective of constructing and psychometrically assess the validity of a holistic wellnessmodel that might, serve as frame of refence for major organizations in South Africa, that wanted to implement a series of health and wellness care interventions on behalf of their employees. Psychology as a profesion acknowledges the importance of a holistic understanding of the strengths, coping patterns, adaptive abilities and growth potential of individual (Antonovsky, 1987; Strumperfer, 1995; Seligman & Csikzentmihaly, 2000). Wellness is understood as a total person's approach towards improving the quality of his or her life, health and psychological strengths in proactive and positive ways-both as a member of a community and as an employee (Witmer & Sweeney, 1992). It is aknowledge that wellness is characterrised by optimal physical health as a psychological and social well being and not by the mere absence of illness (Da Els & Da la Rey, 2006).

The problems that workers perceive and experience as arasing from their physical, emotional, intellectual, social and familial as well as spiritual life domains are currently becoming dilemmas that organizations have to face. All of these quandaries emphasise the fact that wellness is being neglected and that organizations are preoccupied with only illness management. *The condition of health of employyes and their family members significantly affect absenteeism, productivity in the work place and employment costs (Gemson & Eng, 2004).* Awareness of the negative impact of illness-health wellness mismanagement, clarifies the importance of and economic benefit derived from the prevention of illness and the promotion of wellness. If management is to invest some of its resources in work wellness, the implementation of strategies and organizational

development interventions that focus on managed health and wellness care, contribute a great deal to the bottom line of achieving excellence in organisations. Optimum health and wellness management can lead to productivity (service deliver) and flourishing organizations. The required interventions should be based on recognition of and support for the rights of individuals to determine and manage their own quality of life and the promotion of it in the working environment (Huikamp, 2004). The paradigm of positive psychology provided a valuable framework for studying wellness in organizations as an emerging field. Controlled venture into this field of study could lead to the formulation of new theories and to expansion of existing ones, thus enabling researchers of wellness to broaden their understanding of the functioning of human wellness. Research that could and analyse and describe how people develop wellness could lead to a richer and deeper understanding of their experiencing of wholeness and their job demands that are under their personal control (Da Els & Da la Rey, 2006).

## **CHAPTER 3: Research design and procedures**

### **3.1 Introduction**

Methodology or research method is the plan according to which data are to be collected to investigate the research hypothesis or question in the most economical manner (Huysamen, 2001).

To obtain answers to research questions, it is necessary that a research design, which is the plan, structure and strategy of the investigation, be executed. Hence this chapter, the methodology of the current study will be discussed. This will include describing the composition of the sample, the data collection procedure, the instrument and procedures used to score and analyze data.

### **3.2 Targeted Population**

Target population for the study was professional nurses (Midwives) from public and private hospitals within the Lower Umfolozi region. A group of nineteen midwives was used.

### **3.3 Sampling Method**

Convenience sample was used (Terre Blanche, Durrheim & Painter, 2006) this method was selected due to the sensitivity of the nature of study. The interviews were conducted with the professional nurses some in their place of work during lunch, others after working hours. All participants were from health institutions (1, public & 1 private-hospital).

### **3.4 Data Collection Instrument**

The participants completed a questionnaire that has been adapted from Hunt, Butler, Noy & Rosser cited by (Rouf, 1980). This study was done in 1978, it looked at the attitudes toward abortion among college women in the United States of America. The instrument is a 10-item likert-type scale designed to measure favourable versus unfavourable attitude toward termination of pregnancy. Most people's abortion attitudes are fairly extreme, either pro-life or pro-choice; few people are neutral about the topic. Hollis and Morris (1992) found that most abortion attitudes were at one of the extreme ends, only 28.9% of people surveyed were found to have intermediate attitudes about abortion. When doing their research, they used a seven point, Likert-type scale with hopes of increased variance

in the responses. They felt that giving participants a chance to answer on a scale would bring forth more answers in the middle range, showing the general ambivalence they thought was felt by a lot of people about abortion, the researchers still found polarization of opinions. Most individuals clustered at the low end always disagree with abortion (answering 1-3 on all scenarios) or on the high end, always agreeing with abortion (answering 6-7 on all scenarios). Additionally, Werner \*(1983) found that the vast majority of the respondents could easily be categorized into one of the four categories (principled pro-choice, practical pro-choice, principled pro-life, practical pro-life) suggesting that individual's beliefs about abortion tend to be very distinct and uncompromising. In previous research, cognitive complexity has been studied in relation to factors such as dogmatism (Rouff, 1975), measures on the least-preferred co-worker scale (Hoffman and Roman, 1984), and sensation seeking (Domangue, 1984) found those with a high need for sensation seeking, also tend to develop a highly complex thinking process. One of the more interesting studies of cognitive complexity was Hoffman and Roman's (1984), they studied the relationship between cognitive complexity and the least preferred co-worker scale, a measure of task or relationship orientation toward co-worker. Individuals with poor relationships with their co-workers (task orientated) were hypothesized to see only the negative aspects of their co-worker's personalities; those with good relationships (relationships orientated) were hypothesized to see both the bad and good aspects of that co-worker in addition, those with high cognitively complexity were thought to be more likely to have good co-worker relationships. The argument is that these individuals are more likely to be able to see the 'shades of gray' involved in others with personalities instead of viewing their co-workers in only one light. However, it was not just those with good relationships with co-workers that scored low on the relationships orientation towards their least favorite co-workers were found to have higher cognitive complexity. The results give an example of a u-shaped relationship because those with extreme attitudes (either high or low) about a co-worker scored higher on levels of cognitive complexity.

### **3.5 Data Collection Method**

Each participant was supplied with a letter, which described the research goals, the approximate time needed to complete the interview, as well as guaranteed confidentiality due to the sensitivity of the subject. In order to maintain confidentiality, the questionnaires were handed back in hand to the researcher, so that the co-workers

including the supervisors would not have the access to the information provided by the staff.

### **3.6 Data Analysis**

The data was analyzed using the *Statistical Package for Social Sciences (SPSS)*, which yielded descriptive statistics and Chi Square, which analyses frequencies concern particular categories or classifications (age, work experience and the influence of incentives over attitude in different sectors).

### **3.7 Conclusion**

This chapter indicated how the process of analysis data has been done and what instruments have been used for the entire study.

## **CHAPTER 4: Data analysis and presentation**

### **4.1 Introduction**

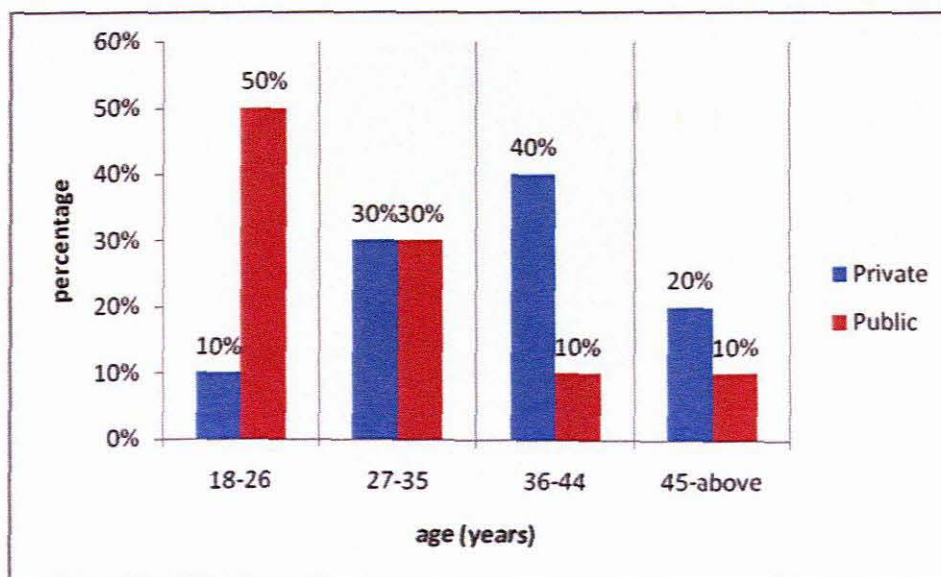
*Analysis and interpretation of data involves presentation of the data collected. It is of great importance to unpack the information as clear as possible for comprehension. The goals and aims of the current study will be reviewed based on the findings of the study. Thus, the objectives of the study will be discussed in relation to the data of the current data.*

### **4.2 Respondents Demographic Profile**

Respondents were asked to indicate their demographic profiles. Figure 4.1 below shows the respondents demographic profiles. The participants in the study were 19 (n= 19).

### Age

Figure 4.2 below shows a comparison of respondents age in both the private and public hospital.



*Figure 4.2*

*A comparison of the age of respondents as presented in figure 4.2 above for both private and public hospitals shows that:*

The public hospital had a majority of respondents (50%) compared to the private hospital (10%) in the age group 18-26 years;

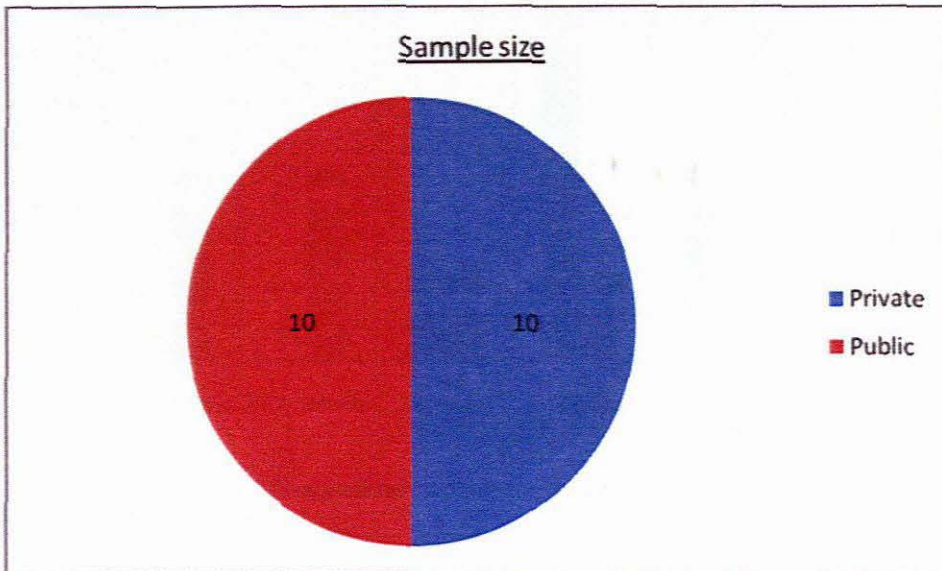
both the private and public hospital had equal percentage (30%) in the age group 27-35 years;

the private hospital had more respondents (40%) compared to the public hospital (10%) in the age group 36-44 years; and

the private hospital had more respondents (20%) than the public hospital (10%) in the age group 45-above years.

### Population sample size

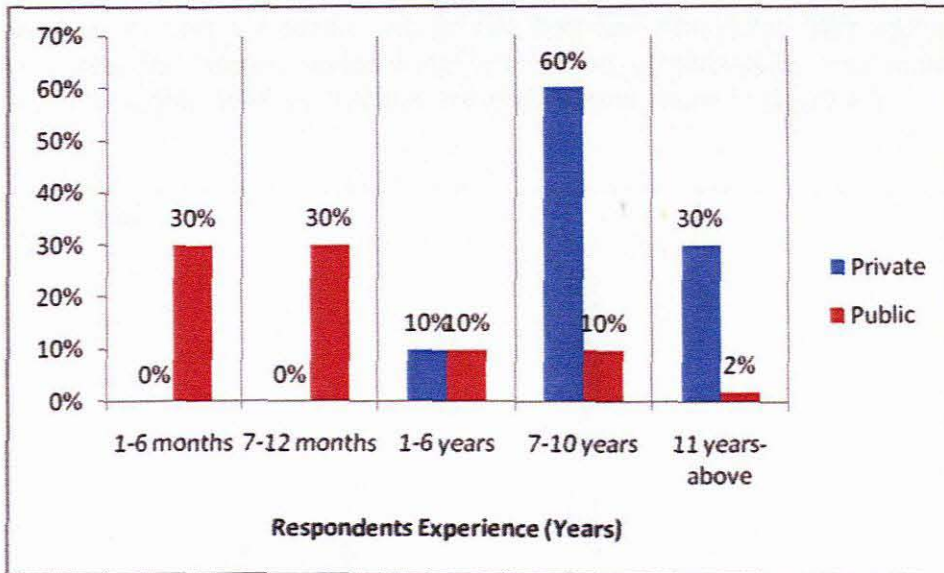
Figure 4.3 below shows the sample size



*Figure 4.3 (sample size)*

Study findings as presented in figure 4.3 above shows that an equal sample size ( $n=10$ ) was drawn from both the private and public hospital.

### Respondents Experience



*Figure 4.4: Respondents years of Professional service*

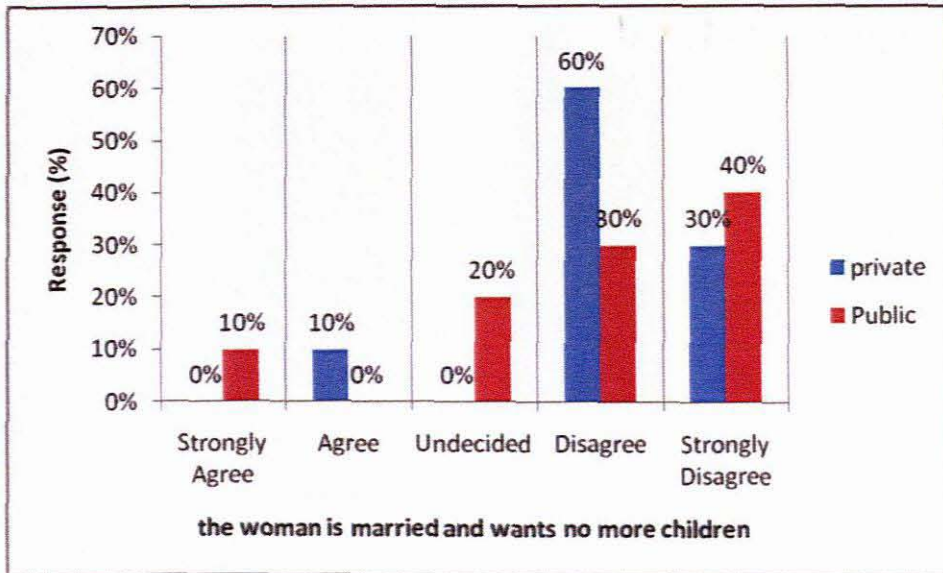
Study Findings are presented in figure 4.4 above shows that:

- (i) All the respondents with 1-6 months of professional practice were from the public hospital
- (ii) All the respondents with 7-12 years of professional practice were from the public hospital
- (iii) An equal proportion of respondents (10%) from both private and public hospital had 1-6 years of professional practice
- (iv) The private hospital had the most (60%) respondents compared to the public hospital (10%) with 7-10 years of professional experience
- (v) The private hospital had the most (30%) respondents compared to the public hospital (2%) with 11-above years of professional experience.

## Section 2

### Statement1: The woman is married and wants no more children

Respondents from both the public and private hospital were asked their opinion as to whether or not, the woman undertaking termination of pregnancy was married and wanted no more children. Study findings are as presented below in figure 4.5.



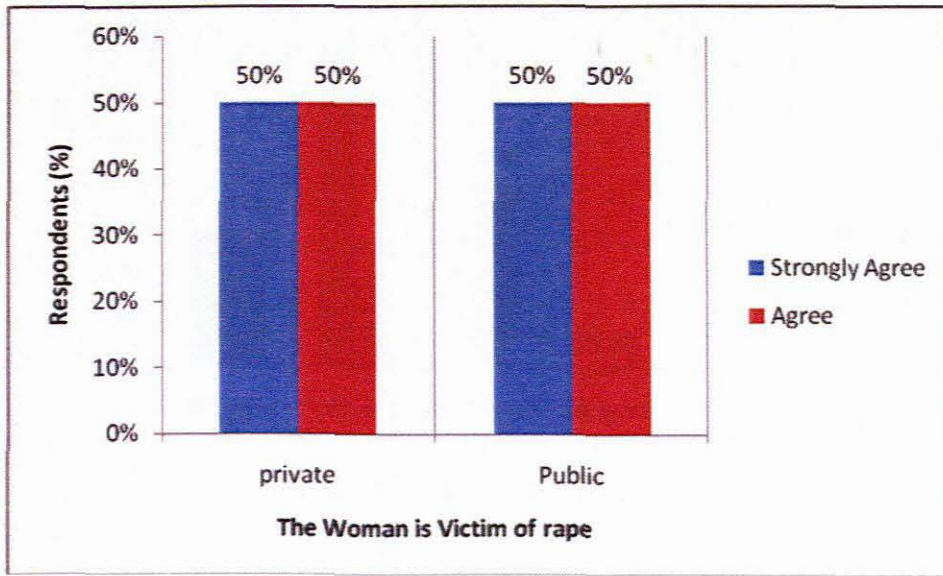
*Figure 4.5: The woman is married and wants no more children*

From figure 4.5 above study findings regarding as to whether or not a woman undertaking TOP was married and wanted no more children shows that:

- (i) 10% of the respondents from public hospital compared to 0% from private hospital strongly agree,
- (ii) 0% of the respondents from the public hospital compared to 10% from the private hospital agree,
- (iii) 20% of the respondents from the public hospital compared to 0% from the private hospital were undecided,
- (iv) 30% of the respondents from the public hospital compared to 60% from the private hospital disagree, and
- (v) 40% of the respondents from the public hospital compared to 30% from the private hospital strongly disagree.

**Statement 2: The Woman is a victim of rape.**

Respondents from both the public and private hospital were asked their opinion as to whether or not, termination of pregnancy was only undertaken when Woman is a victim of rape or not. Study findings are as presented below in figure 4.6.



*Figure 4.6: the woman is a victim of rape*

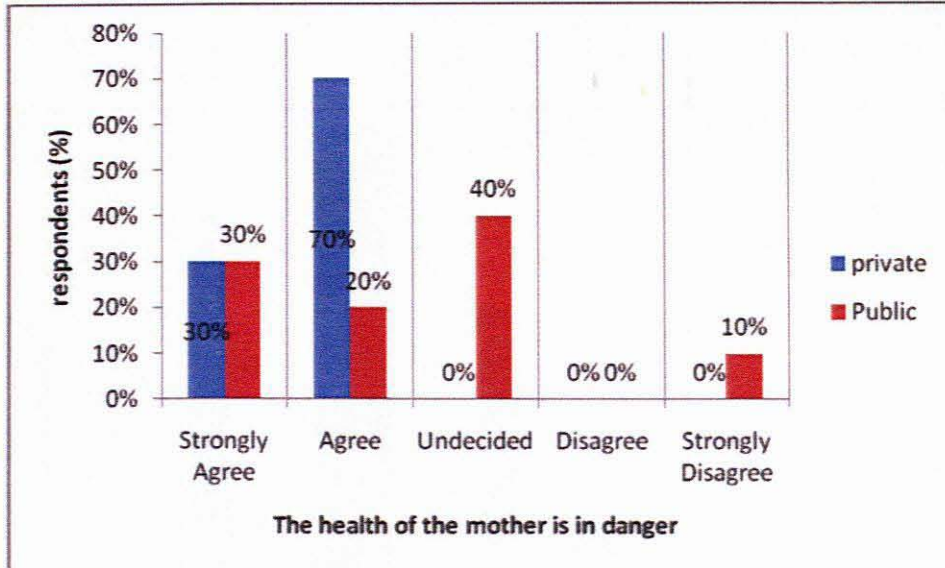
From figure 4.6 above study findings regarding as to whether or not a woman undertaking TOP was as a result of rape or not shows that:

- (i) Equal proportions (50%) of respondents from the private and public hospital strongly agreed ;
- (ii) Equal proportions (50%) of respondents from private and public hospital agreed.

Thus the findings show that respondents both from the private and public hospital were in agreement that TOP was usually undertaken when a woman was a victim of rape.

**Statement 3: The health of the mother is in danger.**

Respondents were asked to indicate whether they agreed or disagreed with the statement that TOP was undertaken when the health of the mother was in danger or not. Findings are as presented in figure 4.7 below.



*Figure: 4.7 the health of the mother is in danger.*

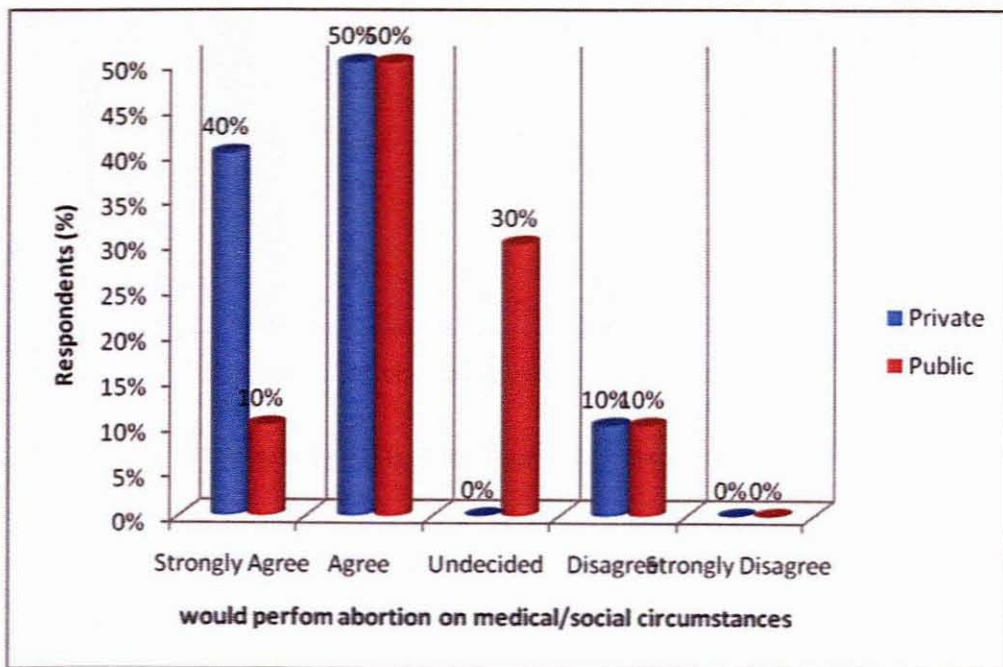
Findings as presented in figure 4.7 as to whether respondents agreed or disagreed with the statement that TOP was undertaken when the health of the mother was in danger shows that:

- (i) An equal proportion (30%) of respondents from the private and the private hospital strong agreed;
- (ii) More (70%) respondents from the private hospital compared to public hospital (20%) agreed;
- (iii) 40% of the respondents from the public hospital were undecided; and
- (iv) 10% of the respondents from the public hospital strongly disagreed.

The findings show that all the respondents from the private hospital agreed that TOP was undertaken when the life of the mother was in danger. While, the findings from the Public hospital shows that only 50% agreed.

**Statement 4: I would Opt for abortion on medical / social compelling circumstances**

Respondents from both the private and public hospital were asked to indicate their opinion whether or not they agreed with the statement that they would opt for abortion on medical /social compelling circumstances. The study findings are as presented in figure 4.8 below.



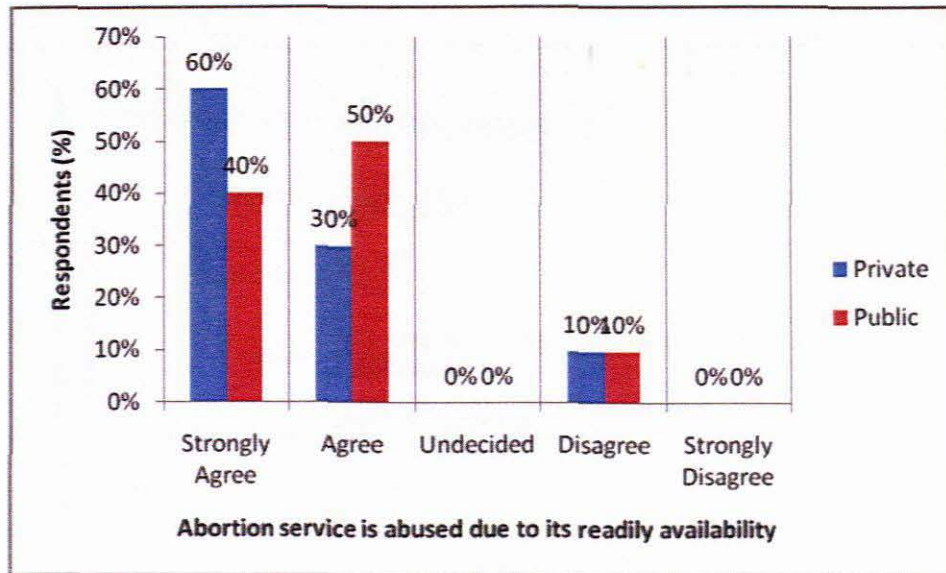
*Figure: 4.8: Would perform abortion on medical /social circumstances*

Findings as presented in figure 4.8 above shows that:

- (i) More respondents from the private hospital (40%) compared to the public hospital (10%) would perform abortion on medical/social circumstances;
- (ii) An equal proportion of respondents (50%) from both the private and public hospitals will perform an abortion on medical/ social circumstances;
- (iii) 30 % of the respondents from the public hospital were undecided; while
- (iv) An equal proportion (10%) of respondents from the private and public hospital strongly disagreed that they would perform an abortion on medical/ social circumstances.

**Statement 5 : Abortion service is abused due to its readily availability**

Respondents from both the public and private sector were asked to indicate whether or not they agreed with the statement that Abortion service is abused due to its readily availability. The study findings are as presented in figure 4.9 below.



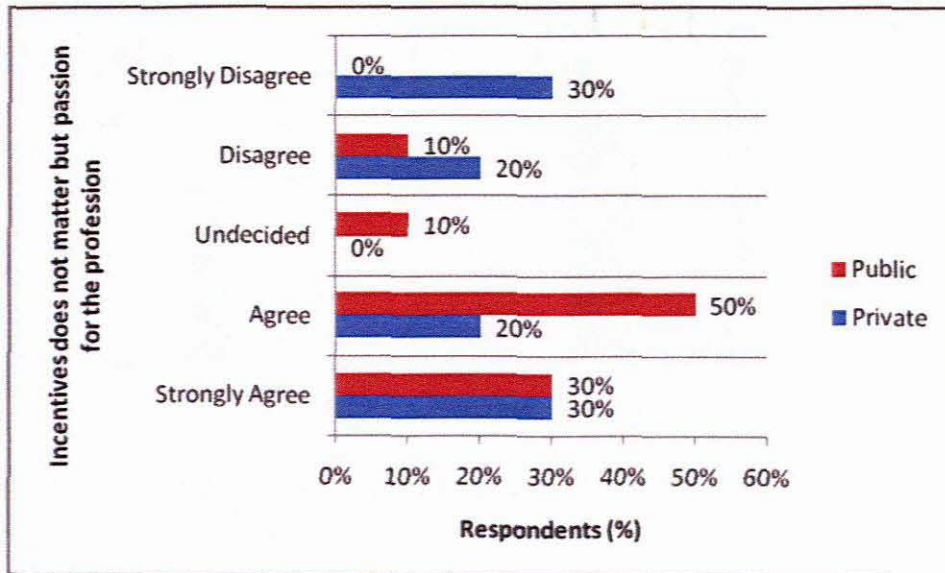
*Figure 4.8: Abortion service is abused due to its readily availability*

Findings as presented in figure 4.8 shows that:

- (i) More respondents (60%) from the private hospital compared to the public hospital (40%) strongly agreed;
- (ii) Fewer respondents (30%) from the private hospital compared to the public hospital (50%) agreed;
- (iii) An equal proportion (10%) of respondents from both the private and public hospital; disagreed.

**Statement 6: Incentive do not matter but the passion for the profession**

Respondents from both the private and public hospitals were asked to indicate whether or not they agreed with the statement that incentives do not matter but the passion for the profession. The study findings are as presented in figure 4.9 below.



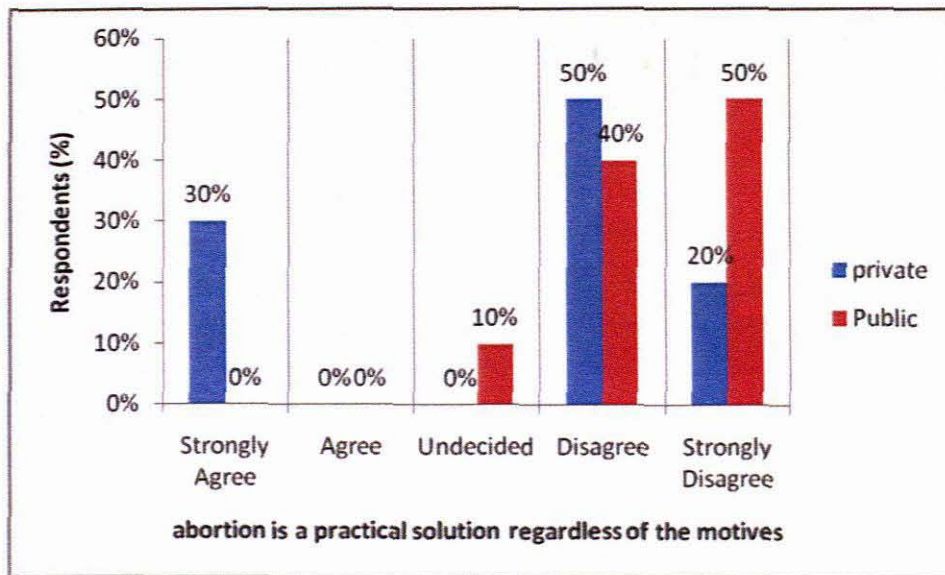
*Figure: 4.9- Incentives do not matter but the passion for the profession*

From figure 4.9 above findings shows that:

- (i) An equal proportion (30%) of respondents from both the public and the private hospitals strongly agreed
- (ii) More respondents (50%) from the public hospital compared to the private hospital (20%) agreed
- (iii) 10 % of the respondents from the public hospital were undecided
- (iv) More respondents (20%) from the private hospital compared to the public hospital (10%) disagreed that incentives do not matter but the passion for the profession, while
- (v) 30% of the respondents from the private hospital strongly disagreed.

**Statement 7: Abortion is a practical solution regardless of the motives**

Respondents from both the private and public hospital were asked to indicate whether or not they agreed with the statement that abortion is a practical solution regardless of the motives. Findings are as presented in figure 4.10 below.



*Figure 4.10: Abortion is a practical solution regardless of the motives*

Study findings as presented in figure 4.10 above shows that;

- (i) 30% of the respondents from the private hospital strongly agreed that abortion was a practical solution regardless of the motives
- (ii) 10% of the respondents from the public hospital were undecided
- (iii) 50% of the respondents from the private hospital compared to 40% of the respondents from the public hospital disagreed, while
- (iv) 20% of the respondents from the private hospital compared to 50% of the respondents from the public hospital strongly disagreed.

**Statement 8: Midwives are adequately trained to manage abortion related matters**

Respondents from both the private and public hospitals were asked to indicate whether or not they agreed with the statement that midwives are adequately trained to manage abortion related matters. The findings are as presented in figure 4.11 below.

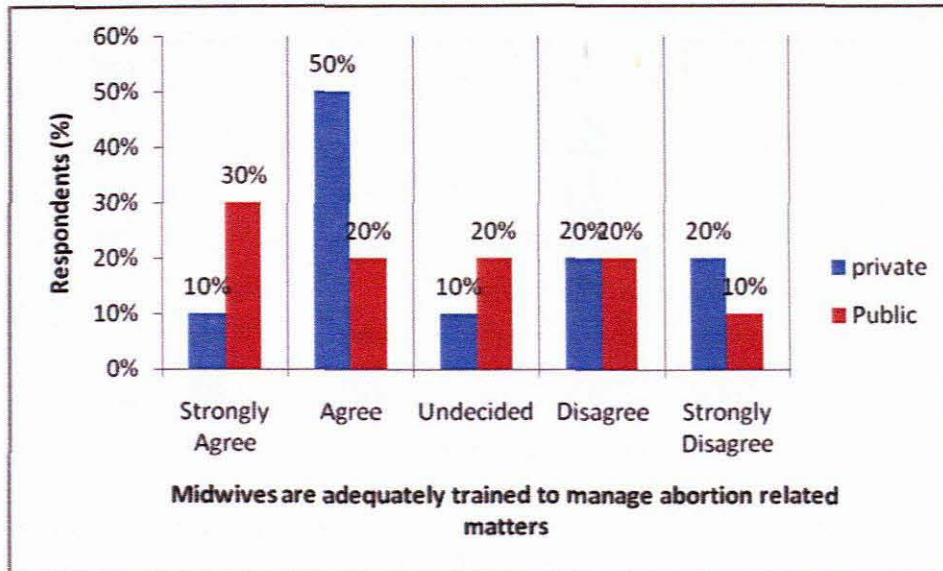


Figure 4.11: Midwives are adequately trained to manage abortion related matters

From figure 4.11 above:

- (i) 10 % respondents from the private hospital compared to 30% of the respondents from the public hospital strongly agreed that midwives are adequately trained;
- (ii) 50 % respondents from the private hospital compared to 20% of the respondents from the public hospital agreed that midwives are adequately trained;
- (iii) 10 % respondents from the private hospital compared to 20% of the respondents from the public hospital were undecided that midwives are adequately trained;
- (iv) An equal proportion (20%) of the respondents from the private hospital and the public hospital disagreed that midwives are adequately trained; and
- (v) 20 % respondents from the private hospital compared to 10% of the respondents from the public hospital strongly disagreed that midwives are adequately trained.

**Statement 9: Abortion service matters most than the attitude of the health personnel**

Respondents from both the private and public hospitals were asked to indicate whether or not they agreed with the statement that abortion service matters most than the attitude of the health personnel. The findings are as presented in figure 4.12 below.

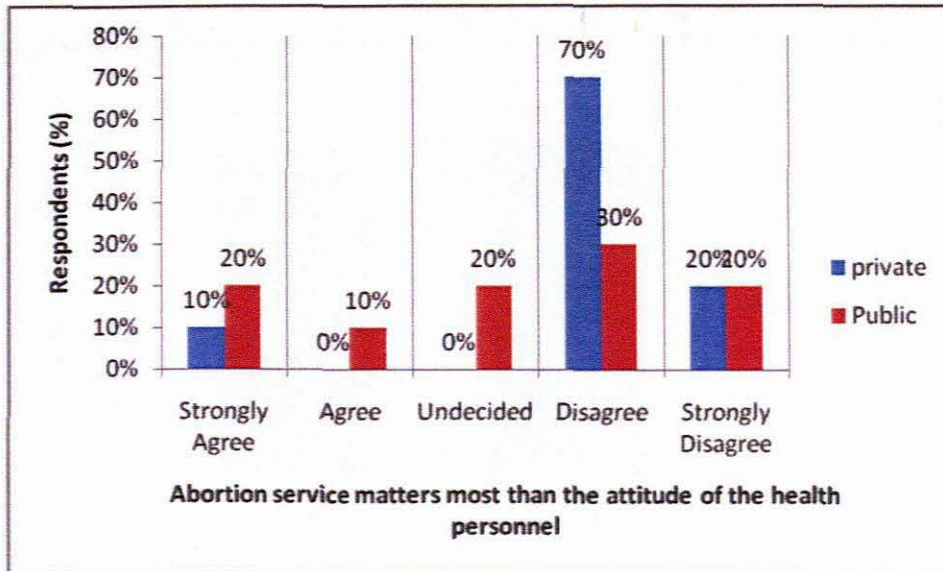


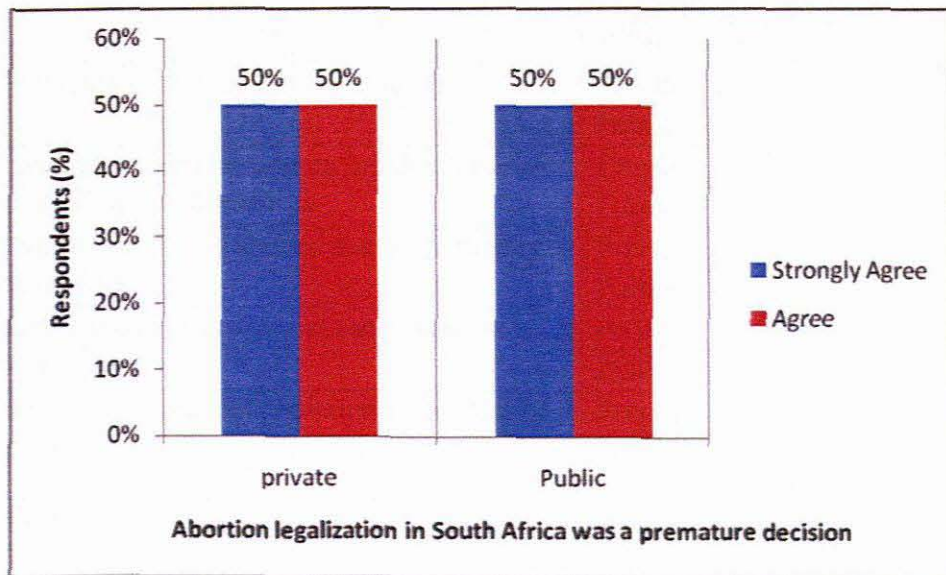
Figure 4.12: abortion service matters most than the attitude of the health personnel

From figure 4.12 above:

- (i) 10% respondents from the private hospital compared to 20% of the respondents from the public hospital strongly agreed that abortion service matters most than the attitude of the health personnel;
- (ii) 10% respondents from the public hospital agreed that abortion service matters most than the attitude of the health personnel;
- (iii) 20% respondents from the public hospital were undecided that abortion service matters most than the attitude of the health personnel;
- (iv) 70% respondents from the private hospital compared to 30% of the respondents from the public hospital disagreed that abortion service matters most than the attitude of the health personnel
- (v) An equal proportion (20%) of the respondents from both the private and public hospitals strongly disagreed that abortion service matters most than the attitude of the health personnel.

**Statement 10: Abortion legalisation in South Africa was a premature decision**

Respondents from both the private and public hospitals were asked to indicate whether or not they agreed with the statement that Abortion legalisation in South Africa was a premature decision. The findings are as presented in figure 4.13 below.



*Figure 4.13: Abortion legalization in South Africa was a premature decision*

From figure 4.13 above:

An equal proportion (50%) of respondents from both the private and public hospitals strongly agreed that abortion legalization in South Africa was a premature decision;

- (i) An equal proportion (50%) of respondents from both the private and public hospitals agreed that abortion legalization in South Africa was a premature decision.

**A comparison of responses from both the public and private hospital using Chi-Square**

	<b>Statement</b>	<b>Hospital</b>	<b>Chi-Square</b>	<b>d.f</b>	<b>Asymp. Sig.</b>
Q1	The woman is married and wants no more children	Private	3.8	2	0.1
		Public	2	3	0.6
Q2	The Woman is a victim of rape	Private	0	1	1
		Public	0	1	1
Q3	The health of the mother is in danger.	Private	1.6	1	0.2
		Public	2	3	0.6
Q4	I would opt for abortion on medical / social compelling circumstances	Private	2.6	2	0.3
		Public	4.4	3	0.2
Q5	Abortion service is abused due to its readily availability	Private	3.8	2	0.1
		Public	2.6	2	0.3
Q6	Incentive do not matter but the passion for the profession	Private	0.4	3	0.9
		Public	4.4	3	0.2
Q7	Abortion is a practical solution regardless of the motives	Private	1.4	2	0.5
		Public	2.6	2	0.3
Q8	Midwives are adequately trained to manage abortion related matters	Private	3.6	3	0.3
		Public	1	4	0.9
Q9	Abortion service matters most than the attitude of the health personnel	Private	6.2	2	0.04
		Public	1	4	0.9
Q10	Abortion legalisation in South Africa was a premature decision	Private	0	1	1
		Public	0	1	1

Figure 4.14 Chi square summary of statements.

## **CHAPTER 5: Discussion and Conclusion**

### **5.1 Introduction**

In this study the researcher examined the attitudes of midwives towards legalized termination of pregnancy at public and private hospitals in Empangeni area. This chapter discusses the findings and their significance in understanding midwives' attitude.

### **5.2 Attitudes towards TOP**

Attitudes towards TOP seem to be influenced by many factors, to mention the few; *values and beliefs of the person. Unplanned and unwanted pregnancies constitute a serious public health responsibility. The motivation to control and space births has risen faster than the rates of contraceptives use. Once people decide they want fewer children, they use a combination of approaches to achieve this, including modern and traditional methods of contraception and abortion (Bongaarts, 1997).*

Midwives have adjusted to the ever-changing laws of human reproductive but, this is never sudden. In the recent past it was a common practice for midwives to give lectures to women who wanted to abort than offering the service at first hand or without the morale lecture. Such incidents have declined which could be a positive response to governmental programmes aimed at enhancing the knowledge of TOP and ensuring service delivery (TOP).

### **5.3 Discussion of the results**

More participants from the private hospital disagreed with the statement implying that abortion by married women would only be as a result of not in need of any more children. Participants from both institutions showed sympathy towards the rape victims. Thirty person (30%) of the participants from both institutions strongly agreed that a pregnant mother's health was important while 70% from the private hospital agreed that abortion should be performed if the mother is at risk. The circumstances under which abortion is done was regarded as more important by the participants from the private institution. Abortion services seem to be abused as viewed by participants from both institutions although private hospital seemed to stand out in their opinion. It was interesting to note a split in responses with regard to incentives as an influencing factor towards providing a

service of this nature. One would assume that the public sector is more secure than the private because of securities such as housing subsidies etc. The majority of the respondents did not regard abortion as a solution. However 30% of the participants from the private hospital felt it could be a solution. The analysis of the study explicitly reveal that midwives are for the opinion that there are other means of preventing unwanted pregnancies regardless of whether they belong to private or public hospital. It was also interesting to note that both private and public hospital participants agree that legalization of TOP came rather too early before the personnel and the infrastructure was put in place. (See figure 4.13)

#### **5.4 Significant results**

Of significance, the private hospital participants clearly indicated the importance of attitudes in relation to service provision. The results in this aspect were statistically significant (0.04). The reader is referred to figure 4.14 above.

#### **5.5 Conclusion**

There was a clear difference across the ages of the respondents, 18 – 26 year old (26%), did not hold a positive attitude toward abortion, whilst amongst the 27- 35 year olds (32%) there was a fair difference with regards to attitudes towards abortion, the 36 – 44 year olds (26%) did have a positive attitude together with 45 years + (16%) the positive attitude could be attributed to years of practice and coming to terms with reality. The 26% of the respondents lack experience and very conforming to societal pressures where as the 32% is composed of individuals who are exercising their rights and less concern about the social pressure. It was also clear that newly qualified midwives were incentive driven. However, in a study by WHO (2000) it concluded that much more can be done, despite the difficulties of changing national abortion laws. Women health groups and other advocates, parliamentarians and health professionals, can work together to support the right of women not to die from unsafe abortions and to ensure that they receive treatment for complications. The study did address the assumptions that were drawn from the researcher's interest, just to touch on these assumptions; midwives attitude toward termination of pregnancy is not entirely negative but seem to be influenced by the institution (Public/Private) and individual maturity, on the other hand incentive does play a role and the attitude amongst junior and senior midwives do differ.

## **5.6 Recommendations for future studies**

1. Future studies should be conducted around midlife's stressors
2. Studies on attitudes towards giving permission to researchers in formal health institutions in South Africa would be interesting.
3. The sample of the present study would yield interesting results if it was bigger than nineteen participants.

## References

- Althaus, A. F. (2000). *International Family Planning Perspectives*. London: Cambridge University Press.
- Antonovsky, A. (1987). *Unravelling the mystery of health: how people manage stress and stay well*. San Fransisco: Jossey-Bass.
- Baltar da Rocha, M. (1996). The abortion issue in Brazil, a study of the debate in Congress. *Reproductive Health Matters*, 4 (2) 505-521.
- Barge, S., Bracken, H., Elul, B., Kumar, N., Wajahat, U., Verma, K. & Camlin, C. (2004). *Formal and Informal Abortion Services Rajasthan, India: Results of a Situation Analysis*. New York: Population Council.
- Belanger, D. & Khuat, T. (1999). Singlewomens' experiences of sexual relationships and abortion in Hanoi. *Reproductive Health Matters*, 7(1) 71-82.
- Benson, J. (2005). Evaluating Abortion-care Programs: Old challenges, New Directions. *Studies in Family Planning*, 36 (3) 189-202.
- Bevis, O. (1988). *Caring: a life force, in caring an essential human needs*. Wayne State University Press.
- Bongaarts, J. (1997). Trends in unwanted childbearing in the developing world. Paper presented at Annual Meeting, Population Association of American. Washington, DC 27- 29 March.

Brandt, M. A. & Razin, P. (1997). *Mortality and Health*. Columbia: Routledge.

Brucker, S. (2000). *School of Midwifery*. Retrieved April 03, 2007,  
from <http://www.utsouthwestern.edu>.

Buys, R. & Muller, M. (2000). The experiences and perceptions of  
nursing service managers regarding transformation of health services in selected  
provincial academic health complexes. *Curationis*, 23(2) 50-81

Clark, E. (2000). *Abortion Services in South Africa*. Retrieved March  
26, 2007, from <http://www.hst.org.za>, [utsouthwestern.edu](http://www.utsouthwestern.edu). & [uu.edu.org](http://www.uu.edu.org).

Da Els, A. & Da Rey, R.P. (2006). Developing A holistic Wellness Model.  
*South African Journal of Human Resource Management*. 4 (2) 46-56.

Dickson-Tetteh, K. & Rees, H. (1999). *Efforts to reduce abortion  
- related mortality in South Africa*. London: Blackwell Science.

Dickson-Tetteh, K. & Billings, D (2002). Abortion care services provided by  
Registered Midwives in South Africa. *International Family Planning  
Perspectives*. 23 (3) 144- 160.

Dickson-Tetteh, K. & Gabriel, M. & Gringle, R.(1998). Abortion Care Manual:  
*A guide for the training of registered midwives in termination of pregnancy,  
The management of incomplete abortion and related reproductive health  
Matters*. Reproductive Health Research Unit/Ipas. South Africa.

Dipboye, R. L. & Howell, C.H. (1994). *Understanding an Industrial  
integrated Organizational Approach Psychology*. London: Harcourt Brace  
College Publishers.

- Domangue, B. B. (1984). Sensation seeking and cognitive complexity. *Perceptual and Motor Skills*, 59, 749-750.
- Fletcher, C. E. (2001). Hospital R N's job satisfaction and dissatisfactions. *JONA*, 31(6) 324-331.
- Gemson, D. H. & Eng, B. (2004). The impact of allergic rhinitis on employee health and productivity. *The Business and Health Institute*, August.
- Green, T. (2002). *HR Magazine*, Alexandria: US 45 (11) 155-157.
- Gebreselassie, H. & Fetters, T. (2002). *Responding to Unsafe Abortion in Ethiopia: A Facility-Based Assessment of Postabortion Care Services in Public Health Sector Facilities in Ethiopia*. Ipas: Chapel Hill.
- Harrison, A., Montgomery, E., Lurie, M. & Wilkinson, D. (2000). Barriers to Implementing South Africa's Termination of Pregnancy Act in rural Kwa-Zulu/Natal. *Health Policy and Planning*, 15(4) 424-430
- Hoffman, E. & Roman, P. M. (1984). Criterion-related validity of the least preferred co-worker measure. *The Journal of Social Psychology*, 122, 79-84.
- Hollis, H. M. & Morris, T. M. (1992). Attitudes toward abortion in female undergraduates. *College Students Journal*, 26, 70-74.
- Huapaya, V. Espinoza, K. & Benson, J. (2003). 'A model to scale up postabortion care in rural Peru'. Paper presented at the annual meeting of the American Public Health Association San Francisco, 15 – 19 November.

Huiskamp, A. A. (2004). *A framework for an empowerment approach to workplace, health promotion of wellness*. Paper presented at 2<sup>nd</sup> South African Work Wellness Conference, Potchestroom: South Africa, 26 May 2004..

Hysamen, G.K. (2001). *Methodology for the social and behavioural sciences*. Oxford: Oxford University Press.

International Pledge for nurses. Retrieved September 20,2007.  
From <http://www.uu.edu/org/sigmathatau>.

Jackson, H. (2002). *AIDS Africa Continent in Crisis*. Harare: Southern Africa AIDS Information Services.

Jagga, M. A. & Rothenberg , P.S. (1993). *Feminist Frameworks*. 3<sup>rd</sup> Ed. London: McGraw Hill.

Kaufman, C. A. (1997). Reproductive Control in South Africa. *Social Movements and Social Change in A Globalizing World*, 97 9-45.

Leininger, M. M. (1998). *Caring: an essential human need proceedings of the three national caring conferences*. Detroit: Wayne State University Press.

Leon, I. G. (1990). *When a baby dies, Psychotherapy for Pregnancy and Newborn Loss*. London: Yale University Press.

Maslow, A. H. (1943) 'A Theory of Human Motivation'. *Psychological Review*, 50, 370-396.

Marshall, L., Goud, D. & Roberts, J. (1994). Nurses' attitudes towards termination of Pregnancy . *Journal of Advanced Nursing*, 20, 567-574.

- Meyers, C. & Woods, R.D. (1996). An obligation to provide abortion services: what happens when physicians refuse? *Journal of Medical Ethics*, 2, 115 – 120.
- Mfono, Z. (1998). Teenage Contraceptive Needs in Urban South Africa: A Case Study. *International Family Planning Perspectives*, 24 (4): 180 – 183.
- Miller, J. F. (2002). *Executive Excellence*. Dec. Provo: US 19 (12): 15-16.
- Nunes, F. E. & Delph, Y. M. (1995). Making abortion law reform happen in Guyana: *Reproductive Health Matters*, 3, 612-23.
- Nunes, F. E. & Delph, Y. M. (1997). Making abortion law reform work, steps and slips in Guyana. *Reproductive Health Matters*, 5, (9) 66-76.
- Onyango, S., Mitchel, E., Nyanga, N., Turner, K. & Lovell. R. (2003). *Scaling up Access to High-Quality Postabortion Care in Kenya: A Facility-Based Assessment of Public and Private Facilities in Western and Nyanza Provinces*. Chapel Hill: Ipas.
- Padilla, K. McNaughton, L. & Gomez, R. (2003). *Undiagnostic nacional de la atencion postabortion*. Managua Nicaragua; Ipas.
- Rouff, L. L. (1975). Openness, creativity and complexity. *Psychological Reports*, 37, 1009-1010.
- Roe, J. Francome, C. & Bush, M. (1997). Recruitment and training of British Obstetrician-Gynecologists for abortion provision: conscientious objection versus opting out. *Reproductive Health Matters*, 7 (4) 97-105.

- Ryden, M. B. & Krinchbaum, K. (1996). Employer support for the educational development of nurses in long-term care facilities. *Gerontology and Geriatrics Education*, 17(2) 3-19.
- Sakoda, J. M. (1952). Human Motives, *Journal of Abnormal & Social Psychology*, 47 (2) 262-279.
- Seligman, M. E. P. & Csikszentmihalyi, M. (2000). Positive Psychology: an introduction. *American Psychologist*, 55(1) 5-14.
- Singh, K. (1996). Abortion trends in Singapore: a 25- year review. *Journal of Pediatric and Adolescent Gynecology*, 9 (1) 27-30.
- Soderberg, H. (1997). Continued pregnancy among abortion applications. A study of woman having a change of mind. *Acta Obstetrica Gynecological Scandinavica*, 76 (10) 942-947.
- Stevens, M. & Xaba., M (1997). Commentary. *Reproductive Health Matter*, 5 (9) 119.
- Stoter, D. J. (1997). *Staff support in health care*. Oxford: Blackwell Science.
- Strumpfer, D. J. W. (1995). The origins of health and strength: from salutogenesis to fortigenesis. *South African Journal of Psychology*, 25 (2) 81-89.
- Terre Blanche, M., Durrheim. K.& Painter, D. (2006). *Research in Practice*. Cape Town: UCT Press.
- Vachon, M. L. S. 1998 (May). *Caring for the caregiver in oncology and palliate care*. *Seminars in Oncology Nursing*, 14 (2) 152-157.

- Varkey, S. J. (2000). Abortion Services in South Africa. *International Family Planning Perspectives*, 26(2) 87-88.
- Werner, P. D. (1983). A q-sort measure of beliefs about abortion. *Educational and Psychological Measurement*, 53, 513-521.
- Witmer, J. M. & Sweeney, T.T. (1992). A holistic model for wellness and prevention over the life span. *Journal of Counselling and Development*, 71, 22-35.
- World Health Organization. (1998). *Global and regional estimates of incidence and mortality due to unsafe abortion*. Geneva: World Health Organization.
- World Health Organization. ( 2000). *Unsafe abortion: Global and Regional*. Geneva: World Health Organization.
- World Health Organization. (2000). *Unsafe abortion: Global and regional estimates of incidence and mortality due to unsafe abortion*. Geneva: World Health Organization.

## APPENDIX A

To the Hospital Manager

### Request to conduct a study within the hospital

I am a registered Counselling Intern Psychologist at the University of Zululand. I would appreciate it if I could be permitted to conduct a study entitled: The Attitudes of Midwives (PN) towards Legalized Termination of Pregnancy at Public and Private Hospital. Midwives (PN) who choose to participate, will be seen during their spare time. The interview takes 10 to 15 minutes and participants are assured of confidentiality.

Your positive response in this request will be highly appreciated.

Yours faithfully

Sithembiso Miya

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Thesis supervisor

Dr J.D Thwala

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## APPENDIX B

### QUESTIONNAIRE

The Attitudes of Midwives towards Legalized Termination of Pregnancy at Public and Private Hospitals in Empangeni.

#### Section 1: Demographics.

Please tick the appropriate box:

- 1.1 Gender:     Female                       Male
- 1.2 Age:         18-26 years                       27-35 years  
                      36-44 years                       45 years and above
- 1.3 Institution  Private                       Public
- 1.4 Status       Trained to abort                       Not trained to abort
- 1.5 Years of professional practice  
                      1-6 months                       7-12 months  
                      1-6 years                       7-10 years                       11 years and above

#### Section 2: Questionnaire statements

	Strongly Agree	Agree	Undecided	Disagree	Strongly disagree
1 The woman is married and wants no more children					
2 The woman is a victim of rape					
3 The health of the mother is in danger					
4 I would opt for abortion on medical / social compelling					

circumstances					
5 Abortion service is abused due to its readily availability					
6 Incentive do not matter but the passion for the profession					
7 Abortion is a practical solution regardless of the motives					
8 Midwives are adequately trained to manage abortion related matters					
9 Abortion service matters most than the attitude of the health personnel					
10 Abortion legalization in South Africa was a premature decision					

Thank you for your participation in this study.