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FACTORS INFLUENCING THE IMPLEMENTATION OF TERMINATION OF PREGNANCY POLICY IN GAUTENG DEPARTMENT OF HEALTH: A MULTI-METHOD STUDY

Daphney Tlhabela



WITS
UNIVERSITY

A thesis submitted to the Faculty of Sciences,
University of the Witwatersrand, In fulfilment of the requirements for the degree
of
Doctor of Philosophy

Johannesburg 2025

DECLARATION

I, Daphney Tlhabela declare that the thesis submitted for the degree Doctor of Philosophy at the University of Witwatersrand in Johannesburg is my own work. It has not been submitted before for any degree or examination at any other University.



Signature

Date: 26 March 2025 in Johannesburg

HREC Protocol number: M231001

Provincial Directorate of Health: NHRD GP 202307 064

DEDICATION

I dedicate this study to the following people who were instrumental in supporting me throughout the course of the study.

- My husband, Leonard, supported me morally and emotionally.
- My son, Ntsako, who motivated, supported and kept on praying that I complete the study.
- My friends and colleagues provided moral support and motivation during the study.

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I thank the Almighty God who carried me throughout the difficult times I went through during the study; He gave me strength, wisdom and courage to carry on. 2 Timothy 6:17 *"But the Lord stood with me and gave me strength"*

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- All the participants without whom this study would not have been a success.
- The Gauteng Department of Health gave me permission to conduct the study and funding the study.
- All the CEOs and facility Managers for allowing me to conduct the study in their facilities.
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ABSTRACT

Aim: This study aimed to explore and describe the factors influencing the implementation of the termination of pregnancy policy in Gauteng Department of Health to recommend how to better align the TOP services with guidelines of the Gauteng province under the CTOP (Act of 1996) as amended by the CTOPA 2008.

Method: A multi-method research design included a scoping review, semi-structured interviews with selected stakeholders and an audit of the demand for TOP services and the resources and facilities. The study was conducted in phases, ending with a triangulation of the data derived from the first three phases to answer the research question.

Findings: The scoping review revealed that access to abortions remains a problem in many countries, whether there is legal provision for the practice or not. Negative attitudes abound in societies, and poor knowledge of the legislation and processes exists. The ethical considerations, including the conscientious objection clause found in some policies, result in limited provision of services. Cultural and societal influences impact women wishing to seek termination of pregnancy and the providers of the service.

Participants in the semi-structured interviews indicated that the working conditions were not ideal. They feel there is a lack of managerial support, and working alone without the support of colleagues makes the work stressful.

The audit indicated that most of the equipment listed as requirements in the guidelines is present. Still, the participants in the interviews said that the supply of medications for TOP is intermittent. There is no physical space for providers to offer a confidential service. While providers only assisted an average of one patient an hour, this finding should be seen in the light that they are required to participate in other work in the health establishments. Patients bypass the clinics in their first trimester and choose to attend hospitals meant to provide second-trimester TOP.

Recommendations: Specific recommendations were made for the Gauteng Department of Health based on the findings of this study. Recommendations related to: optimisation and expansion of available space for TOP services; Dealing with conscientious objection and stigma; ensuring the constant supply of abortion drugs;

Management support; the provision of second-trimester abortion services; and reducing complications related to unsafe abortions. In addition, recommendations were made for further research and nursing education.

Conclusion: The constrained working environment and negative attitudes in the community and amongst health professionals negatively influence the implementation of the TOP policy. Based on the recommendations of this study, it is hoped that measures will be put in place to improve access to TOP and implementation of the TOP policy.

Keywords: *Termination of pregnancy (Abortion); TOP providers; TOP services; TOP guidelines.*

CONTENTS

DEDICATION ... iii
ACKNOWLEDGEMENTS ... iv
ABSTRACT ... v
LIST OF TABLES ... xi
LIST OF FIGURES ... xii
LIST OF ABBREVIATIONS & ACRONYMS ... xiii
CHAPTER 1: ORIENTATION TO THE STUDY ... 1
1.1 Introduction ... 1
1.1.1 High-income versus low- and middle-income countries ... 1
1.1.2 Unsafe abortion in low- and middle-income countries ... 2
1.1.3 Situation in South Africa ... 3
1.1.4. The law in South Africa ... 5
1.1.5 Situation in Gauteng at time of study ... 6
1.2 Problem Statement ... 7
1.3 Research Question ... 9
1.4 Purpose of The Study ... 9
1.5 Objectives of The Study ... 9
1.6 Conceptual Definitions ... 10
1.6.1 Abortion ... 10
1.6.2. Medical termination of pregnancy ... 10
1.6.3. Surgical termination of pregnancy ... 10
1.6.4. Termination of pregnancy ... 10
1.6.5. Trained TOP providers ... 11
1.6.6. Unsafe abortion (Unsafe termination of pregnancy) ... 11
1.7. Layout Of Chapters ... 11
1.8. Conclusion ... 11
CHAPTER 2: DESIGN AND METHODS ... 12
2.1. Introduction ... 12
2.2. Research Design ... 12
Table 2.1 below providers a summary of the research methods used in the study. ... 15
2.3 Research Setting ... 19
2.4 Research Phases ... 21
2.4.1. Phase 1: Scoping Review ... 21
2.4.2. Phase 2.1 and 2.2: Semi-structured interviews ... 24
2.4.3. Phase 3: Audit / record review ... 29
2.4.3. Triangulation of data from previous phases ... 32
2.5. Reliability and Validity / trustworthiness ... 33

2.6. Ethical considerations ... 37
2.7. Conclusion ... 38
CHAPTER 3: SCOPING REVIEW ... **39**
3.1. Introduction ... 39
3.2. Framework and study selection ... 39
3.2.1. Stage One: Identification of the Research Question ... 40
3.2.2. Stage Two: Identifying Relevant Studies ... 40
3.2.3. Stage Three: Study Selection ... 44
3.2.4. Stage Four: Charting the data ... 45
3.2.5. Stage 5: Collating, Summarising and Reporting the Results ... 64
3.3. Results ... 64
3.3.1. General Characteristics of the Articles ... 64
3.3.2. Distribution of Publications by Year of Publication ... 64
3.3.3. Author Collaboration in Publications ... 65
3.3.4. Approach used in Reviewed Studies ... 65
3.3.5. Focus of the Study ... 66
3.3.6. Theme 1: Access to SafeAbortions ... 67
3.3.7. Theme 2: Knowledge and Attitudes ... 68
3.3.8. Theme 3:Cultural and Societal Influences on Abortion Practices ... 70
3.3.9. Theme4: Ethical Considerations Abortion Care ... 71
3.3.10. Theme 5: Policy and Legislative Climate ... 73
3.4. Discussion ... 74
CHAPTER 4 FINDINGS FROM SEMI-STRUCTURED INTERVIEWS ... **79**
4.1. Introduction ... 79
4.2 FINDINGS FROM THE TOP PROVIDERS' INTERVIEWS ... 79
4.2.1. Challenges providing TOP services ... 80
4.2.2. Factors impacting on policy implementation ... 88
4.3. Findings from the managers' and doctors' interviews ... 92
4.3.1. Challenges providing TOP services ... 92
4.3.2. Factors impacting on policy implementation ... 95
4.4. Conclusion ... 97
CHAPTER 5: FINDINGS FROM THE AUDIT OF THE DEMAND FOR AND THE RESOURCES AVAILABLE FOR THE PROVISION OF TERMINATION OF PREGNANCIES ... **98**
5.1. Introduction ... 98
5.2. The hospital data ... 98
5.2.1. Number of TOP requests ... 98
5.2.2. Staffing availability ... 99

5.2.3. Ages of clients requesting TOP 101
5.2.4. Marital status of, and reasons for, clients requesting TOP 102
5.2.5. Race and occupation of clients seeking TOP 102
5.2.6. Number of previous pregnancies prior to request for TOP 102
5.2.7. Gestational age of pregnancies at the time of request for TOP 104
5.2.8. Audit of resources available for TOP at hospitals 105
5.3. The clinic data 105
5.3.1. Number of TOP requests 105
5.3.2. Staffing availability 107
5.3.3 Ages of clients requesting TOP 108
5.3.3. Marital status of, and reasons for, clients requesting TOP 109
5.3.4. Race and occupation of clients seeking TOP 110
5.3.5. Number of previous pregnancies prior to request for TOP 110
5.3.6. Gestational age 111
5.3.7. Audit of resources available for TOP at the clinics 113
5.4. Discussion of the findings of the audit of requests for TOP 114
5.5. Conclusion 119
CHAPTER 6 TRIANGULATION OF THE DATA FROM SCOPING REVIEW, THE AUDIT OF THE DEMAND FOR, AND RESOURCES AVAILABLE, FOR TOP, THE INTERVIEWS OF PROVIDERS AND MANAGERS 121
6.1. Introduction 121
6.2. Objectives of the phases of the study 121
6.3. Lessons learned from the phases of the study 122
6.4. Discussion 124
6.4.1. Content of policy 124
6.4.2. The context 126
6.4.3. The actors 128
6.4.4. Process 130
6.5. Conclusion 135
CHAPTER 7 MAIN FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION OF THE STUDY 136
7.1. Introduction 136
7.2. Main findings of the study 136
7.2.1. Findings of the scoping review 136
7.2.2. Semi-structured interviews with TOP providers, managers and doctors 137
7.2.3. The audit of demand for TOP and available facilities and equipment 138
7.3. Recommendations for the GDoH related to the findings of the study 139
7.3.1. Optimisation and expansion of available space for TOP services 139
7.3.2. Conscientious objection and stigma 140

7.3.3. Intermittent shortage of abortion drugs 140
7.3.4. Management support 141
7.3.5. Provision of second trimester abortion services 141
7.3.6. Complications related to unsafe abortion 142
7.4. Recommendations for further research and nursing education 143
7.4.1. Nursing research 143
7.4.2. Nursing education 143
7.5. Limitations of the study 144
7.5.1. Methodological limitations 144
7.5.2. Data analysis limitations 145
7.5.3. External limitations 145
7.6. Conclusion 146
8. REFERENCE LIST 147
9. LIST OF ANNEXURES 161
Annexure 1A: PRISMA updated Guide 161
Annexure 1B: Data Extraction Sheet 162
Annexure 2A: Demand for Services 164
Annexure 2B: Audit of TOP Resources (Phase 2) 165
Annexure 3: Semi-structured interviews Guide (Phase 2) TOP Providers 172
Annexure 4: Semi-structured Interviews Guide (Phase 2) managers and doctors 203
Annexure 5: Study Information Document 204
Annexure 6: Participant Consent Form 208
Annexure 7: Consent Sheet for Audio Recording of Study Participation 210
Annexure 8: Distress Protocol and Contact Details of Support Person 211
Annexure 9: Request for Permission to Conduct the Study in GDoH 212
Annexure 10: Request to CEOs to conduct the study 214
Annexure 11: Permission letter Thele Mogoerane Regional Hospital 216
Annexure 12: Permission letter to conduct study at Kalafong Tertiary Provincial Hospital 217
Annexure 13: Permission letter to conduct study at West Rand District Health 219
Annexure 14: Permission letter to conduct study West Rand District Health 221
Annexure 15: Permission letter to conduct study at Sedibeng District Health 222
Annexure 16: Permission letter to conduct study at Tshwane District Health 224
Annexure 17: Permission letter to conduct study at Ekurhuleni District Health Thele 225
Annexure 18: Permission letter to conduct study at Tembisa Tertiary Provincial Hospital 226
Annexure 19: Supporting Letter Pending HREC Approval 227
Annexure 20: Approval letter for the Proposal 228
Annexure 21: Ethics Clearance from the University of the Witwatersrand 229

LIST OF TABLES

TABLE 2. 1.: SUMMARY OF RESEARCH DESIGN 16

TABLE 3. 1.: DATABASES SEARCHED, SEARCH STRINGS AND RESULTS 41
TABLE 3. 2.:PCC FRAMEWORK BASED ON RECOMMENDATIONS BY JBI (PETERS ET AL., 2017) 43
TABLE 3. 3.: INCLUSION AND EXCLUSION CRITERIA 43
TABLE 3. 4.: CHARACTERISTICS OF THE INCLUDED ARTICLES (N=16) 47
TABLE 3. 5.: COUNTRIES OF ORIGIN, YEARS AND JOURNAL OF PUBLICATION 65
TABLE 3. 6.: THEMES AND SUB-THEMES ARISING FROM STUDIES INCLUDED IN THE REVIEW 66

TABLE 4. 1.: CATEGORIES AND SUBCATEGORIES DERIVED FROM TOP PROVIDER'S INTERVIEWS 80

TABLE 5. 1.: NUMBER OF TOP REQUESTS PER HOSPITAL 99
TABLE 5. 2.: AVERAGE NUMBER OF CLIENTS SEEN PER HOUR 100
TABLE 5. 3.: AGE RANGE OF PATIENTS SEEKING TOP AT HOSPITALS 101
TABLE 5. 4.: PERCENTAGES OF MISSING DATA REGARDING PREVIOUS PREGNANCIES 102
TABLE 5. 5.: NUMBER OF PREVIOUS PREGNANCIES PRIOR TO REQUEST FOR TOP EXPRESSED AS PERCENTAGES 103
TABLE 5. 6.:THE PERCENTAGES OF THE GESTATIONAL AGE OF THE FOETUSES OF CLIENTS WHO SOUGHT TOP AT THE SIX HOSPITALS 104
TABLE 5. 7.: NUMBER OF TOP REQUESTS PER CLINIC 106
TABLE 5. 8.: AVERAGE NUMBER OF CLIENTS SEEN PER HOUR 107
TABLE 5. 9 AGE RANGE OF PATIENTS SEEKING TOP AT THE CLINICS 109
TABLE 5. 10.: NUMBER OF PREVIOUS PREGNANCIES PRIOR TO REQUEST FOR TOP EXPRESSED AS PERCENTAGES 110
TABLE 5. 11.: THE PERCENTAGES OF THE GESTATIONAL AGE OF THE FOETUSES OF CLIENTS WHO SOUGHT TOP AT THE EIGHT CLINICS 112
TABLE 5. 12.: PERCENTAGE OF CLIENTS PRESENTING ACCORDING TO GESTATIONAL AGE 113

TABLE 6. 1.: LESSONS LEARNED FROM THE PREVIOUS PHASES OF THE STUDY 121

LIST OF FIGURES

FIGURE 1. 1.: ACTIVISTS REMOVE FLYERS PROMOTING 'UNSAFE ABORTIONS' IN THE JOHANNESBURG CBD ON THURSDAY.(SOURCE COURTESY TIMES LIVE NEWSPAPER) 3

FIGURE 1. 2.: POSTER ADVERTISING ILLEGAL ABORTION SOURCE HTTPS://;WWW.IOL.CO.ZA>NEWS>SOUTH AFRICA>POSTERS) 9

FIGURE 2. 1.: ADAPTED POLICY IMPLEMENTATION TRIANGLE (WALT AND GILSON, 1994) 13

FIGURE 2. 2.: MAP OF GAUTENG PROVINCES AND THE POSITIONING OF THE FIVE HEALTH DISTRICTS (SOURCE HTTPS://WWW.SA-VENUE.COM 19

FIGURE 2. 3.: MAP OF NINE PROVINCES IN SA SOURCE : HTTPS://WWW.SOUTHAFRICA.TO/PROVINCES/PROVINCES.PHP 20

FIGURE 2. 4.: PRISMA DIAGRAM 23

FIGURE 2. 5.: FIGURE 2.5 AN EXAMPLE OF THE FILING ROOM IN THE HEALTH ESTABLISHMENTS 30

FIGURE 3. 1.: OVERVIEW OF THE FIVE-STAGE FRAMEWORK OF ARKSEY AND O'MALLEY (2005) 39

FIGURE 3. 2.: THREE-STEP SEARCH STRATEGY ACCORDING TO THE JBI (PETERS ET AL., 2015) 40

FIGURE 3. 3.: PRISMA-SCR 2020 FLOW CHART (PAGE ET AL.,2021) 45

FIGURE 5. 1.: NUMBER OF TOP REQUESTS PER HOSPITAL 99

FIGURE 5. 2.: NUMBER OF CLIENTS SEEN PER NURSE PER HOUR 101

FIGURE 5. 3.: NUMBER OF PREGNANCIES PRIOR TO REQUEST FOR TOP 103

FIGURE 5. 4.: PERCENTAGES OF GESTATIONAL AGE OF CLIENTS SEEKING TOP 105

FIGURE 5. 5.: NUMBER OF TOP REQUESTS PER CLINIC 106

FIGURE 5. 6.: AVERAGE NUMBER OF CLIENTS SEEN PER HOUR 108

FIGURE 5. 7.: NUMBER OF PREVIOUS PREGNANCIES PRIOR TO REQUEST FOR TOP EXPRESSED IN PERCENTAGES 111

FIGURE 5. 8.: THE PERCENTAGES OF THE GESTATIONAL AGE OF THE FOETUSES OF CLIENTS WHO SOUGHT TOP AT THE EIGHT CLINICS 112

FIGURE 6. 1.: ADAPTED POLICY IMPLEMENTATION TRIANGLE (WALT AND GILSON, 1994) 122

LIST OF ABBREVIATIONS & ACRONYMS

ANC	African National Congress
ARV	Antiretroviral
CTOP Act	Choice on Termination of Pregnancy Act (no 92 of 1996 as amended
CTOPA	Choice on Termination of Pregnancy amendment Act (no 1 of 2008
CTOP	Choice on termination of pregnancy
CEO	Chief executive office
CHC	Community health centres
DHIS	District Health information system
DRC	Democratic Republic of Congo
EMA	Early medical abortion
GDoH	Gauteng department of health
Hb	Haemoglobin
HIV	Human immunodeficiency virus
HW	Health worker
MEC	Member of executive council
MM	Maternal mortality
MMR	Maternal mortality rate
MVA	Manual vacuum aspiration
MWP	Mandatory waiting period
N/A	Not applicable
NDoH	National department of health
NGO	Non organisational organisation
PCC	Population, Content, Context
PHC	Primary health care
PO	Professional organisation
RM	Registered midwife
RN	Registered nurse
RSA	Republic of South Africa
SSA	Sub-Saharan Africa
SDGs	Sustainable Development Goals

SRHM	Sexual reproductive health matter
SRHS	Sexual and reproductive health services
SSA	Sub Saharan Africa
Stats SA	Statistics South Africa
TOP	Termination of pregnancy
UN	United Nations
UK	United Kingdom
USA	United States of America
UNFPA	United nations population fund
VCT	Voluntary counselling and testing
VTP	Voluntary termination of pregnancy
WHO	World Health Organization

CHAPTER 1: ORIENTATION TO THE STUDY

1.1 Introduction

Unsafe abortions remain significant cause of maternal morbidity and mortality globally. The World Health Organization (WHO) confirmed as far back as 2008, that “half of the forty-four (44) million abortions obtained annually across the world were as a result of unsafe abortions” (Thompson, et al., 2018). More than a decade later, the dilemma of unsafe abortion is still “a major public health problem” (Burtscher, et al., 2020) in terms of maternal morbidity and mortality in the developing world.

Despite the emphasis on women’s reproductive rights, and despite ongoing awareness campaigns of the danger of self-induced or “backstreet” abortions, thousands of pregnant women and girls in the developing world still opt for clandestine or self-induced abortion methods (Burtscher, et al., 2020; Harries, et al., 2015; Rehnström Loi, 2018; Singh, 2010; Singh, et al., 2017; Yokoe, et al., 2019).

This may be ascribed to poor socioeconomic circumstances, a failing public health system, a lack in the development or implementation of legislation, a lack of political will and/or poor knowledge about sexual and reproductive healthcare services (SRHS) and human rights. Certainly, barriers exist in developing world countries that prevent or prohibit women of reproductive age access to safe abortion. Singh et al., (2017) observe that unsafe abortion is a challenging and sensitive topic to research due to its stigmatised nature. Kaswa and Yogeswaran (2020) add that “unsafe abortion is a preventable phenomenon and continues to be a major public health problem” and the prevention thereof is the main issue of concern.

1.1.1 High-income versus low- and middle-income countries

Estimates obtained from global surveys, reports, and research studies show the highest maternal mortality rate (MMR) occurs in developing countries (240 maternal deaths per 100 000 births) whereas in developed countries the MMR count is 16 maternal deaths per 100 000 births. Worldwide, of all maternal deaths occurring in developing countries, more than half occur in sub-Saharan Africa (SSA) (Grimes, et

al. 2006; Singh, et al. 2017, WHO 2014) of which more than three-quarters (77%) are estimated to be unsafe abortions (Guttmacher Institute, December 2020).

According to the WHO (2014), the high number of maternal deaths in the developing world are related to the relatively high number or rural dwellers and in rural areas there is a higher risk of dying compared to their counterparts who live in urban societies. In developed countries fewer women may have unintended pregnancies because they have access to readily available SRHS. Bearak, Popinchalk, Ganatra et al. (2020e: 1152) propose that the reason for the differences in MM between developed and developing countries may be that women in developing countries suffer socioeconomic constraints and must depend highly on the availability of and accessibility to SRHS. It reaffirms the WHO's (2019) stance that disparities exist between populations in terms of developed versus developing countries and whether women live in urban or rural areas. Limited access to SRHS contributes to unintended or unwanted pregnancy (Bearak, et al. 2020e: 1152).

1.1.2 Unsafe abortion in low- and middle-income countries

The risk factors for their future health associated with unsafe abortion are apparently not well understood by women of childbearing age. The high numbers of unsafe abortions in the developing world, i.e., in countries like India (Yokoe, et al., 2019), Tanzania (Norris, et al., 2016), and the Democratic Republic of Congo (DRC) (Burtscher, et al. 2020) indicate women of childbearing age are not aware of, or apparently do not understand, the risk factors for their future health associated with unsafe abortion. For example, Norris et al., (2016) found 17–21% maternal mortality (MM) in Tanzania was attributed to botched self-abortion methods. The authors further note 60% of Zanzibari women who had miscarried after being admitted in Tanzanian hospitals (Zanzibar being a "semi-autonomous region of Tanzania") had first tried and failed self-induced abortion (Norris, et al 2016: 23).

Grimes et al. (2006) and Singh, et al. (2017) cited in (Burtscher, et al. 2020: 441) confirm unsafe abortion is avoidable, yet the high maternal mortality rate (MMR) due to unsafe abortion in the developing world (low- and middle-income countries) is an ongoing and controversial issue (Burtscher, et al. 2020; Guttmacher Institute, 2017; HEARD, 2016; Singh, et al. 2017).

1.1.3 Situation in South Africa

Despite abortion being legally available in South Africa after a change in legislation in 1996, barriers to accessing safe abortion services continue to exist. Despite reforming the abortion law almost two decades ago, unsafe abortion remains an integral factor leading to thousands of unnecessary maternal deaths in South Africa.

In 2019 the United Nations Population Fund classified the Republic of South Africa (SA) as an 'Upper Middle-Income Country' (UNFPA, 2019, 01 of 04). The WHO reports that the number of maternal mortalities in countries where abortion is legal shows a dramatic decline in MM: 73% in the United States of America (USA) and 91% in SA (Thompson et al 2018). The number of maternal deaths in SA continues to fall each triennium – from 2008–2010 to 2011–2013 it reduced by 12.8%; from 2011–2013 to 2014–2016 by 12.5% with an overall reduction of 24% (1 152) from 2008–2010 to 2014–2016 (Saving Mothers report, 2014–2016: 2). Denial of access to legal, safe Termination of Pregnancy (TOP) services for an unwanted or unintended pregnancy has serious repercussions on a woman's whole future life, her mental and physical health, and her family life.



FIGURE 1. 1.: ACTIVISTS REMOVE FLYERS PROMOTING 'UNSAFE ABORTIONS' IN THE JOHANNESBURG CBD ON THURSDAY. (SOURCE COURTESY TIMES LIVE NEWSPAPER)

There are many diverse and ongoing clinical and socioeconomic barriers that prevent women in their first trimester of pregnancy obtaining safe and legal TOP services in public health facilities in Gauteng. Pregnant women who seek abortion go to the facilities early in their pregnancies to book for the procedure but the long waiting periods which the women are given to return for the procedure to be done increases

the gestational age at which a TOP can be performed. This means they cannot have an unwanted or unplanned pregnancy safely and legally terminated at a Community Health Centre (CHC). Owing to the unavailability of second trimester abortion services, many women opt for an unsafe, illegal abortion and pay for it with their lives. It is evident that this is still a problem because 30 women died in 2019 for every 100 0000 unsafe abortions in the developed world regions whereas for the same year (2019) 220 deaths per 100 000 unsafe abortions occurred in developing regions. For the same period StatsSA indicated 520 deaths per 100 000 unsafe abortions in SA. As noted in their 2019 MM fact sheet, the WHO (2019) states that females most at risk to have complications or even die due to an unsafe abortion are young adolescent girls between 10 and 14 years.

The perception of trained TOP professional nurses and midwives is that the demand of women seeking abortion care is often overwhelmingly high. Subsequently the trained TOP providers feel they cannot cope with the situation (Tlhabela 2017: 37). Teffo and Rispel (2017) found that trained TOP providers often experience feelings of anxiety because they fear acts of discriminations and/or even violence. The TOP providers worry about being stigmatised and labelled or encountering discourteous behaviour from colleagues who reject them and avoid being in their company. Many professional nurses practise conscientious objection. Trained TOP professional nurses and midwives know they cannot openly advocate for the safe provision of TOP services because there is nobody at work or even at home they can talk to about their work. These fears and feelings of neglect and oppression can demoralise them to the extent that they eventually suffer burnout. Teffo and Rispel (2017) found that trained TOP provider participants were stigmatized and suffered psychological victimisation which resulted in them feeling isolated in both their workplace and their community. Tlhabela (2017) confirmed that trained TOP professional nurses and midwives are under a lot of stress on a daily basis. The majority continue doing their work diligently while some contemplate resigning or opt to be allocated to other units in public hospitals (Tlhabela, 2017).

A gap found in several studies is that trained TOP professional nurses and midwives lack managerial support (Teffo and Rispel, 2017). It is important to engage the managers of the TOP providers in order to ascertain that they are being supported.

1.1.4. The law in South Africa

Although the intention with both the Termination of Pregnancy Act (Act no 92 of 1996 as amended) (CTOP Act) and the Choice on Termination of Pregnancy Amendment Act (Act no 1 of 2008 as amended) (CTOPA 2008) was to save women's and young girls' lives, the implementation thereof soon demonstrated critical clinical, socioeconomic, and legislative challenges. Importantly, the strict margin where TOP can be performed (according to the gestational ages) is different in the clinics and CHC's and the hospitals and this remains a constant and ongoing dilemma. First trimester TOPs are usually done in the clinics and CHC's and are, according to the Guidelines for TOP done using either a combination of Mifepristone and Misoprostol or Misoprostol alone. They are done by registered and trained nurses and midwives. Pregnancies between 12 and 14 weeks are also conducted using Misoprostol, but the medication needs to be administered every 3 hours until the products of conception are passed. Second trimester TOPs are done by registered and trained medical practitioners. Manual vacuum aspiration (MVA) is done at 14 weeks plus in the hospitals.

As in the rest of SA, all public health facilities (CHCs and public hospitals) in Gauteng are designated by the National Department of Health (NDoH) to provide TOP services – whether as a stand-alone service provider or as an integrating part of SRHS (Teffo and Rispel, 2017). However, of the 37 provincial hospitals in Gauteng Province, only 26 have maternity wards. Under the law, they are designated to offer TOP services as stipulated in the section a-j of the Choice on Termination of Pregnancy Act, (Act no. 1 of 2008. Any health facility that has a 24-hour maternity service and that complies with the requirements referred to in subsection (l) (a) to (j) may terminate pregnancies up to and including 12 weeks without having to obtain the approval of the MEC. The person in charge of a health facility contemplated in paragraph (a) is automatically designated to offer the service.

The CTOPA 2008 stipulates termination of pregnancy may only be provided at a facility where:

(a) there is access to medical and nursing staff

(b) there is access to an operating theatre

(c) appropriate surgical equipment is available

(d) there are sufficient supplies of drugs for intravenous and intramuscular injections

(e) there is emergency resuscitation equipment and access to an emergency referral centre or facility

(f) there is access to appropriate transport should the need arise for emergency transfer

(g) there are facilities and equipment for clinical observation and access to in-patient facilities

(h) are appropriate infection control measures available

(i) there is a safe waste disposal infrastructure

(j) there are telephonic means of communication

(k) and there has been given approval by the Member of the Executive Council (MEC) via notice in the Government Gazette. The Member of the Executive Council may withdraw any approval granted in terms of subsection (l) (k).

1.1.5 Situation in Gauteng at time of study

Only six out of the twenty-six (26) designated hospitals offered second trimester TOPs, and then only on request. Thus, in Gauteng, the most populous province, (Census 2023) the dire lack of and extremely limited access to second trimester TOP service provision act as barriers to safeguarding women's lives and averting abortion-related morbidity and mortality. The fact is that the female population of SA has no choice or voice.

The researcher observed in most of the 26 designated hospitals, there seemed an unwillingness among medical practitioners to perform a 'late' TOP (at second trimester gestational age). This was a dilemma that led to much frustration among the trained

TOP providers. Harries and Constant (2019) argue that, if all TOP providers are willing and demonstrate a high level of involvement, it can lead to much improvement in TOP service provision. In the opinion of these two authors, it is critical to understand the individual inherent beliefs and values of healthcare providers when exploring a sensitive issue such as abortion. For many the termination of a pregnancy is closely related to their own personal, moral and religious beliefs and their choices need to be respected and accepted (Harries and Constant, 2019).

Teffo and Rispel (2017) included two provinces, Gauteng and Northwest, in their study on factors influencing the provision of TOP services. Of the four barriers they mention, all of them are applicable to the current research study: health system deficiencies, human resource challenges, lack of prioritisation and lack of management support. All professional nurses and midwives trained in TOP provision have the necessary experience and are knowledgeable about termination of pregnancy emergency procedures and possible problems that may arise. While this is the case, Tlhabela (2017) argued that lack of support from management caused them to experience stress and burnout and expected the managers to give them full support they needed morally).

1.2 Problem Statement

There are many diverse and ongoing clinical and socioeconomic barriers that prevent women in their second trimester of pregnancy to obtain safe and legal TOP services in public health facilities in Gauteng, the study setting. This phenomenon occurs despite specific amendments made in terms of Sections 1, 3, 7 and 8 of the CTOP Act 1996 (widely referred to as the ‘Principal Act’). These amendments are clearly and exactly stipulated in the CTOPA 2008 and relate to the implementation (or lack of implementation) of the specific amendments in practice, that is, in both CHCs and public hospitals. It is argued by Lince-Deroche et al (2017) that despite the liberal laws of termination of pregnancy, a quarter of TOPs are done in the second trimester because pregnant women present to the clinics and CHCs too late for a first trimester TOP.

Long waiting periods increase the gestational age at which a TOP can be performed. This means a woman cannot have an unwanted or unplanned pregnancy safely and

legally terminated at a CHC. Owing to the unavailability of second trimester abortion services, many women opt for an unsafe, illegal abortion and pay for it with their lives. If abortion services were readily available and accessible, this cumbersome, frustrating and very traumatic experience would not happen because women would be assisted early in the first trimester of their pregnancy and when requested. The immense distances and broad topographical locations of the CHCs and hospitals place an extremely heavy burden on the GDoH to safely assist every woman who request a TOP on demand and in time. To illustrate, the GDoH recorded there were more than twenty-three thousand (23 000) teenage pregnancies between April 2020 and March 2021 with nine hundred and thirty-four (934) girls between the ages of 10 and 14 giving birth. It is impossible for the small workforce of about 56 TOP professionals to provide safe TOP services to 100 clients on any given day. However, living in a country where the legality of abortion "affords women reproductive autonomy and the right to access safe abortion procedures on demand" (HEARD, 2016: 02 of 04), it is imperative for the legal system and policies to vigorously campaign for the former's survival rights (UNFPA, 22).

The roll-out of medical abortion would greatly benefit impoverished women in their first trimester of an unwanted or unplanned pregnancy and who do not have the time, money or means to wait, or be sent to, an unknown facility far away for a medical procedure. Of major concern is the misuse of misoprostol (a medical abortifacient drug used in the health sector) for self-induced abortions which may lead to a woman's death. Making recommendations to the GDoH to fully implement and thereby improve the provision of TOP services in Gauteng would reduce the number of MM and so assist the province to comply with the CTOP (Act of 1996) as amended by the CTOPA 2008. Many of cross-border immigrants are ignorant of the liberal abortion laws in SA and willingly "respond to street advertisements for abortion services placed by illegal service providers in the false belief that they are accessing safe abortion services" (HEARD, 2016: 02 of 04). In this regard, specifically migrant women and girls should be informed of the availability of safe TOP clinics and hospitals to save their lives and ensure that they have a healthy future ahead of them. Unsafe abortions are one of the major causes of MM. Unfortunately, posters advertising 'quick and cheap' abortions is one of the worst enemies that the GDoH health services encounter on a daily basis. Additionally, poor women, or those who do not want to extend their families as well as

young teenagers opt for such illegal and dangerous abortions guaranteeing that the whole process takes only one day, and promising is the idea of getting rid of an unwanted pregnancy as shown in the following photograph.



FIGURE 1. 2.: POSTER ADVERTISING ILLEGAL ABORTION SOURCE HTTPS://;WWW.IOL.CO.ZA>NEWS>SOUTH AFRICA>POSTERS)

1.3 Research Question

How can the TOP services in the GDoH be better aligned with the TOP guidelines of the Gauteng province in accordance with the CTOP (Act of 1996) as amended by the CTOPA 2008?

1.4 Purpose of The Study

The purpose of the study is to establish the factors influencing the implementation of termination of pregnancy policy in the Gauteng Department of Health. Uncovering the factors influencing the implementation of the termination of pregnancy policy will assist in developing support interventions. As a result of the study, recommendations will be made to the Department of Health (GDoH).

1.5 Objectives of The Study

- Objective 1: To review international literature on factors affecting implementation of TOP policy.

- Objective 2: To explore and describe the TOP providers' perceptions of factors impacting on the successful provision of TOP services in Gauteng
- Objective 3: To explore and describe the nurse managers and doctors' perceptions of factors impacting on the successful provision of TOP services in Gauteng.
- Objective 4: To audit the demand for, and the resources available in the GDoH for the provision of TOP

1.6 Conceptual Definitions

The concepts that will be used throughout the study are clarified below.

1.6.1 Abortion

Abortion is legally defined as the termination of pregnancy through medical or surgical means, as regulated by the Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996)

1.6.2. Medical termination of pregnancy

The use of medication (such as mifepristone and misoprostol) to induce the termination of pregnancy, typically within the first 12 weeks of gestation.

1.6.3. Surgical termination of pregnancy

A procedure performed by a trained healthcare provider to remove the pregnancy, usually through methods like manual vacuum aspiration (MVA) or dilation and evacuation (D&E), depending on gestational age.

1.6.4. Termination of pregnancy

The "termination of pregnancy" is defined in the Choice on Termination of Pregnancy Act of 1996 (Act no. 92 of 1996) as "the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman" (South Africa, Choice on Termination of Pregnancy Act no. 92 of 1996). The term termination of pregnancy and abortion will be used interchangeably in this study. In this study

termination of pregnancy or abortion will mean both medical and surgical termination in this study unless specified.

1.6.5. Trained TOP providers

The registered practitioners and counsellors who have completed the prescribed termination of pregnancy services training and who are offering TOP services at the health establishments in Gauteng.

1.6.6. Unsafe abortion (Unsafe termination of pregnancy)

A procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both, and which does not comply with the legislation.

1.7. Layout Of Chapters

- Chapter 1: Orientation to the study
- Chapter 2: Research methodology
- Chapter 3: The scoping review
- Chapter 4: Qualitative phase
- Chapter 5: Quantitative phase
- Chapter 6: Triangulation of the data findings
- Chapter 7: Conclusions, Summary, Main Findings, Limitations and Recommendations.

1.8. Conclusion

This chapter outlined the overview of the study, problem statement and indicated the purpose of the study which is to establish the factors influencing the implementation of termination of pregnancy policy in Gauteng Department of Health. The research question was also posed, and the conceptual definition of terms were clarified.

Chapter 2 will focus on the research methods used to conduct the study.

CHAPTER 2: DESIGN AND METHODS

2.1. Introduction

This chapter of the thesis outlines in detail the study design and methods used to answer the research questions and achieve the set objectives. The research design, research setting, population, sampling, data collection, data analysis, trustworthiness and ethical considerations are discussed.

2.2. Research Design

Polit and Beck (2021) defined 'research design' as a structured framework for action that guides the research process to answer the research question of the study. The authors further state that the type of research design guides the researcher with relation to the selection of the population, sampling procedure and plans for data collection to achieve the intended research goal of the study. The authors further argue that "the type of study design used to answer a particular research question is determined by the nature of question, the goal of research, and the availability of resources." It is important to understand the different types of study designs because it affects the validity of the results and their strengths and limitations. In essence, the research design must be able to address the research problem and ensure a suitable framework or set of methods are used to collect and analyse the data. This study followed a multi-method approach and included a scoping review, semi-structured interviews, which helped explain the context of the audit findings, and an audit of the demand for TOP and the resources in the facilities – both human and physical. The findings from all three phases of the study were triangulated to increase the robustness of research results. This study was carried out in four phases (see Table 2.1). Phase 1 responded to the first objective which was, "to review international literature on factors affecting implementation of TOP policy research question by conducting a scoping review". Phase 2 and 3 used a qualitative approach, where TOP providers, nurse managers and doctors were interviewed to respond to the objectives, "to explore and describe the TOP providers perceptions of factors impacting on the successful provision of TOP services in Gauteng" and "to explore and describe the managers and doctors' perceptions of factors impacting on the successful provision of TOP services

in Gauteng" respectively. Phase 4 responded to the third objective which was, "to audit the demand for, and the resources available in the GDoH for the provision of TOP". This phase consisted of an audit of files (document review) of clients requesting TOP and an audit of the equipment available.

The data was triangulated by categorising the data from the four aspects of Walt and Gilson's Policy Implementation Framework (1994) as illustrated in Figure 2.1. below. The relevant objectives of the study are superimposed onto the figure to explain how the framework assisted in pulling the data together to answer the research question.

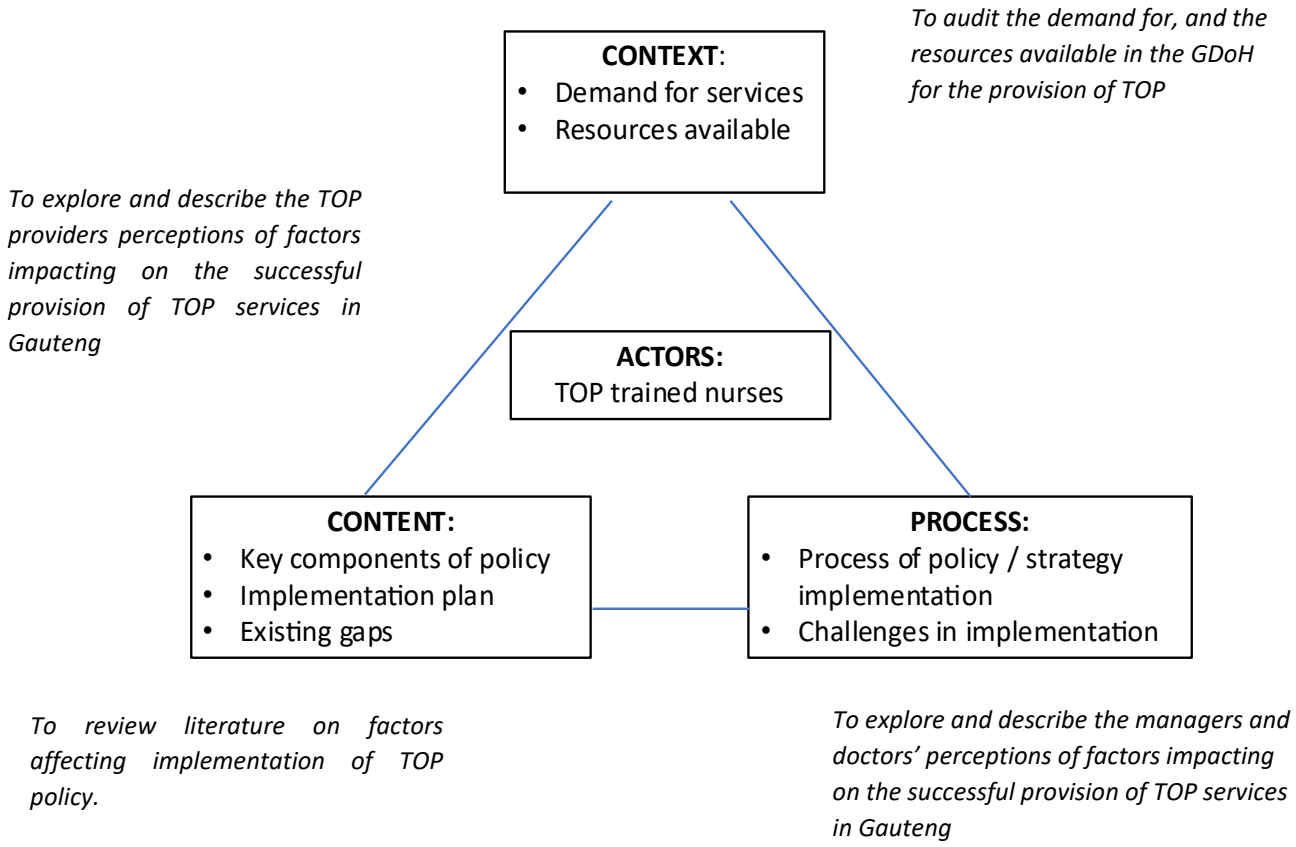


FIGURE 2. 1.: ADAPTED POLICY IMPLEMENTATION TRIANGLE (WALT AND GILSON, 1994)

A multi-method approach to the study which involves using multiple methods of data collection within a study was useful in this study as it allowed for the incorporation of a document review which although it involved collecting "numbers" was not a strictly quantitative approach hence the decision not to refer to mixed method methodology for this study. In multi method research, each phase of the study is typically carried

out independently to address the particular objective and after completion results are triangulated to form a complete picture. Vivek & Nanthagopan (2021) found that the use of multi-method triangulation eased the incorporation of the findings of the studies and helped to create new theories and challenge existing theoretical assumptions. As it was the intention of this study to provide new insights into the apparent failures of the Gauteng Department of health to implement the CTOP policy, this approach was relevant and useful.

A qualitative research approach is the exploration of the phenomena under study using a comprehensive method for the collection of non-numerical data in a form of text or an audio and thereafter writing the narratives using a flexible design. (Polit & Beck, 2021).

A qualitative research approach that is exploratory and descriptive was adopted to explore and describe the perceptions of the TOP providers, nurse managers and the doctors in selected facilities that offer TOP in Gauteng. In this study, the factors impacting the implementation of TOP policy in GDoH was explored. A qualitative approach is subjective because it investigates the perceptions, experiences of the participants. The qualitative approach is based on sociology, anthropology and psychology (Burns & Grove 1999; Polit & Beck 2021). Through a qualitative approach, the TOP providers' perceptions and perceptions including their assumptions and fears were explored and discussed as they experience the phenomena under study daily. The qualitative aspect of this study focused on the exploration of the factors that affect the implementation of the TOP policy in GDoH by means of individual face-to-face interviews with the TOP providers, nurse mangers and the doctors as guided by an interview guide (Annexures 3 and 4).

Document review is typically seen as a qualitative research approach; however, documents can provide a useful source of data which is objective and appropriate for field research. Morgan (2021) points out that when document analysis is used for the purposes of collecting quantitative data, researchers conduct a content analysis using numbers and statistics to make sense of the data and facilitates comparison and aggregation of data which was required in this study to understand the demand for TOP.

A quantitative research approach puts emphasis on quantification and objectivity of phenomena. According to Zyoud, Bsharat and Dwelkat “(2024) the focus on quantifying variables and relationships that characterize quantitative methods allows researchers to measure and analyse data objectively and methodically.” The authors further state that the ’quantitative approach frequently entails the collection of data and formulation of conclusions through the use of structured surveys, and statistical methods”. Furthermore, patterns, trends and correlations can be found by quantifying data that may not be visible by using only qualitative data. Quantitative methods provide the precision, objectivity, and capacity to extrapolate results to larger populations. Additionally, the “reliability and validity of research findings are increased when studies are replicated and findings are applied to broader populations using quantitative methods” (Zyoud et al., 2024).

In this study the original intention of the document review was to review patient files. However, the state of the storage of files in the clinics did not lend itself to this approach. Instead, the patient registers were used to collect data. These provided limited data but were nevertheless useful to gai insight into the profile of clients seeking TOP. An audit of the facilities was also undertaken using a checklist (Annexure 2B) to determine whether the facilities and equipment required in the TOP guidelines were available to the TOP providers. The audit of the files guided by a checklist based on the policy requirements.

Table 2.1 below providers a summary of the research methods used in the study.

TABLE 2. 1.: SUMMARY OF RESEARCH DESIGN

Phase	Objective	Research methods	Sampling/sample	Data collection	Data analysis
1	To review international literature on factors affecting implementation of TOP policy.	Scoping review according to the JBI guidelines	Peer-reviewed literature published between 2012 and 2022; published in English, as full texts	**Data bases**: PubMed, ProQuest, PsycINFO, MEDLINE, Cochrane Library Google Scholar and CINAHL. **Search words / terms:** Factors, impacting, abortion, termination of pregnancy, induced abortion and unsafe abortion Policy, healthcare policy, national health policy and health policy Health personnel and healthcare provider	The data was analysed by extracting the evidence, charting the data, and summarising results according to objective. (Peters et al, 2015)

2.1	To explore and describe the TOP providers perceptions of factors impacting on the successful provision of TOP services in Gauteng	Semi-structured interviews	Population: all trained professional TOP nurses and midwives working in the GDoH. Sample: One purposively selected TOP trained R/N/RM at the 14 CHC's and 6 hospitals that offer first and/or second trimester TOPs. n=20	A semi-structured interview was conducted using an interview guide. The main questions were: What factors do you believe impact on the successful implementation of the TOP policy in the GDoH services? Are there any other challenges you face in trying to implement the policy?	Qualitative data was analysed by means of a thematic analysis according to the steps suggested by Braun and Clarke (2006) viz: 1. Familiarising oneself with the data. 2. Generating initial codes. 3. Looking for themes. 4. Reviewing themes. 5. Defining and naming themes. 6. Writing the report
2.2.	To explore and describe the managers and doctors' perceptions of factors impacting on the successful provision of TOP services in Gauteng	Semi-structured interviews	One purposively selected doctor and one purposively nurse manager from each of the 5 districts of the GDoH was interviewed as well as a senior clinical manager (doctor) in each of the 6 hospitals offering TOPs. N = 16		

3	To audit the demand for, and the resources available in the GDoH for the provision of TOP	Document review and audit of facilities	Seven (7) CHCS, one (1) PHC and six (6) hospitals where data was available and collected.	• The register of patients requesting TOP was analysed according to the information given in **annexure 2a.** • An audit of the facilities eligible to offer TOP services was conducted according to the information in **annexure 2b** (checklist from the CTOPA)	Descriptive statistics were used
4	To answer the research question: How can the TOP services in the GDoH be better aligned	Triangulation of the data according to Walt and Gilson's Policy	Data from phases 1, 2.1 & 2.2 and 3.	An iterative process was used	An iterative process was used

	with the TOP guidelines of the Gauteng province in accordance with the CTOP (Act of 1996) as amended by the CTOPA 2008?	Implementation Framework (1994).			

2.3 Research Setting

The research setting was the hospitals and CHCs situated in the Gauteng province - geographically the smallest of the nine provinces in SA, yet the wealthiest and most densely populated. Gauteng's population comprises diverse multi-ethnic groups representing a wide variety of cultures, languages, and religions. Due to an immense populace growth between 2016 and 2022 caused by internal (provincial or cross-border) migration as well as international immigration, Gauteng received more than "a third of all internal migrants" (Census, 22: x). During the data collection period, of the approximate 15 million people who lived and worked in Gauteng, about 7.5 million were women (Census, 2022: x, 3) who relied heavily on the GDoH health care delivery system to cater for their specific health needs, including termination of pregnancy. There are five district health in Gauteng, namely: Johannesburg District Health, Tshwane District Health, Ekurhuleni District Health, West Rand District Health and Sedibeng District Health. (See Map of Gauteng).

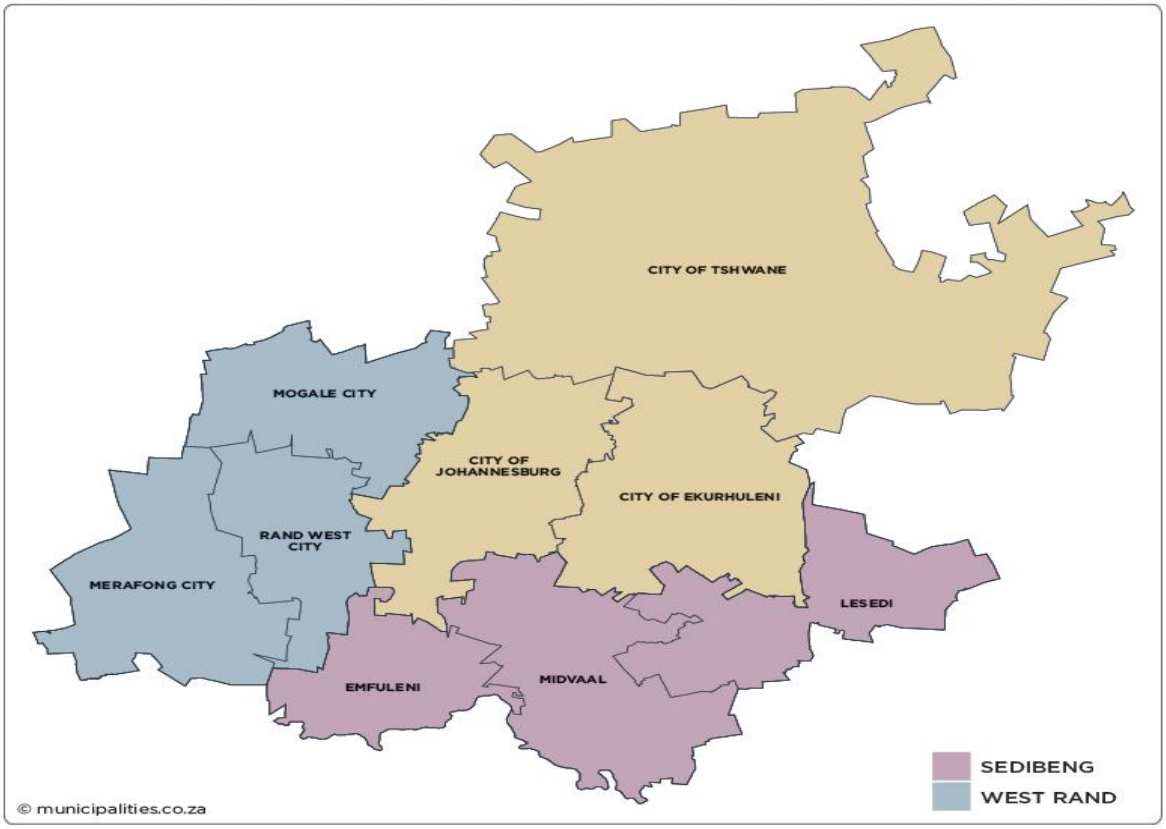


FIGURE 2. 2.: MAP OF GAUTENG PROVINCES AND THE POSITIONING OF THE FIVE HEALTH DISTRICTS (SOURCE HTTPS://WWW.SA-VENUE.COM

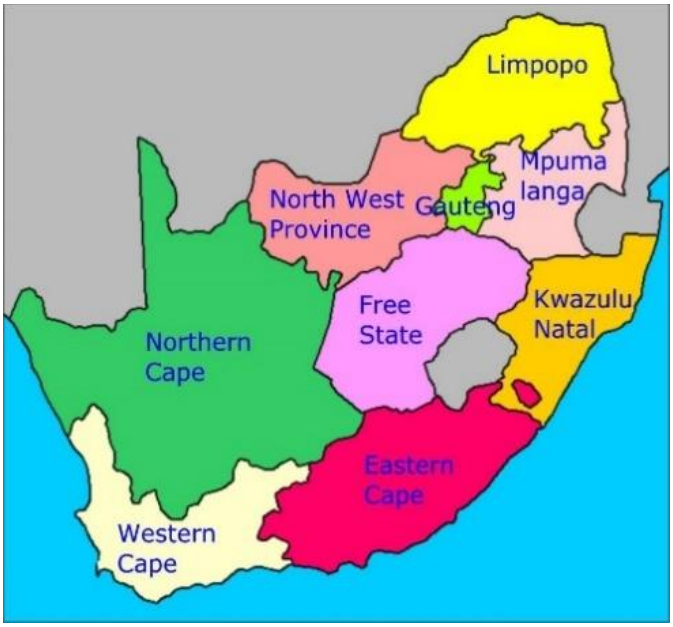


FIGURE 2. 3.: MAP OF NINE PROVINCES IN SA SOURCE : HTTPS://WWW.SOUTHAFRICA.TO/PROVINCES/PROVINCES.PHP

At the time of study there were three hundred and seventy-two (372) clinics spread over the five (5) Districts Health. In terms of the clinics, thirty-three (33) were CHCs and 37 hospitals. In the whole of the province, only eighteen (18) of the thirty-seven (37) hospitals, and thirteen (13) out of the thirty-three (33) CHCs, including one (1) primary health centre (PHC), provided TOP services. Approximately fifty- six (56) TOP providers work in the province. It is estimated that approximately 100 clients access the CHCs per day to request termination of pregnancy. The thirteen (13) CHCs provide TOPs up to twelve (12) weeks gestation and refer women and girls above twelve (12) weeks gestation to the six (6) hospitals that offer second trimester TOPs. Second trimester abortions are provided between thirteen (13) and twenty (20) weeks gestation.

More than twenty-three thousand (23 000) teenage pregnancies were recorded between April 2020 and March 2021 with nine-hundred and thirty-four (34) girls between the ages of 10 and 14 giving birth. The country “affords women reproductive autonomy and the right to access safe abortion procedures on demand” (HEARD, 2016: 02 of 04), so, whatever the demand, it is imperative for the system to cater for the demand. (UNFPA, 22).

2.4 Research Phases

The study was conducted in three phases. Details about population and sample used for all phases are described under each phase. A summary of methods used for each phase is presented in Table 2.2 below. The discussion of methodology relating each phase follows in the subsequent paragraph.

2.4.1. Phase 1: Scoping Review

The objective for this phase was: To review international literature on factors affecting the implementation of TOP policy.

Scoping reviews (where the purpose is to systematically investigate a concept in the literature) offer a methodologically rigorous alternative to concept analysis with their results perhaps being more useful to inform practice. On the other hand, the systematic reviews uncover the international evidence and confirm current practice to address any variation while identifying new practices Peters et al., (2015) state that scoping reviews are conducted to get information that has been previously researched, summarized and disseminate the research and provide recommendations. Peters et al., (2021) observe two of scoping reviews' high-quality reporting features are transparency and reproducibility. The authors emphasise the urgency for researchers who attempt scoping reviews to recognise and understand the purpose and methodology of such studies. This is because when it comes to the reporting stage, clarity and consistency are critical. Further, rigour and utility are enhanced when reporting is "in line with a recognised methodology or checklist" is more likely than not to enhance rigour and utility" (Peters et al., 2021).

Furthermore, a scoping review is an instrument to determine the scope of body of literature on a given topic which provides a clear indication of the volume of studies available on the subject which gives the researcher a great understanding of the work done by other researchers on the topic under study. A scoping review was crucial in this current study where the purpose was to present and outline of factors that could potentially impact on the implementation of TOP policy in GDoH.

The four steps of the Joanna Briggs Institute were followed which are as follows: identification of records in the databases, screening for duplicates and their removal,

eligibility of content to the subject matter and lastly a record of articles to be included (Peters et al., 2015).

In scoping reviews, making use of an approach “to synthesis a large sample of studies” (Walt, et al., 2008) is done by employing quantitative and qualitative methods to address, initiate, support, and manage health policy analysis. This approach may ultimately result in health policy changes to the benefit of the targeted population and country or even across the wider world. The scoping review was guided by Arksey and O’Malley (2005) which has five steps namely: identification of the research question, finding relevant studies, selection of the study, charting the data, and collating, summarizing and reporting of the results. The data were extracted and entered the data extraction sheet (Annexure 1 B).

2.4.1.1. Identification of the research question

The first step according to Arksey and O’Malley (2005) is to identify the question that is linked to the purpose of the study. For this review, the question, “What factors affect the implementation of Termination of Pregnancy policies”.

2.4.1.2. Identifying relevant studies

The Joanna Briggs Institute for scoping reviews (JBI) manual (Peters *et al.*, 2017) suggest using the acronym PCC (Population, concept and context) to guide the identification of relevant studies for a scoping review. The population in this case was International Termination of Pregnancy Policies, the concept was factors influencing the implementation of the TOP policies and the context was health care settings of all types and in all countries). Articles published in English of all types of research methods and published between the years 2012 to 2022.

2.4.1.3. Search strategy

An electronic search of the databases, PubMed, ProQuest, PsycINFO, MEDLINE, Cochrane Library Google Scholar and CINAHL (hosted in EBSCO host), was conducted. The search string included the terms: factors, impacting, abortion, termination of pregnancy, induced abortion and unsafe abortion, policy, healthcare

policy, national health policy and health policy, health personnel and healthcare provider.

The initial search identified 2185 articles which included 289 which were duplicates and therefore removed. Of the 1896 whose titles were screened, 1809 were removed as they did not fit the inclusion criteria. The abstracts of eighty-seven articles were scanned and 66 eliminated. Of the remaining 21 articles 16 were finally included for the review. The details can be seen in figure 2.4.

2.4.1.4. Study selection

The details of this process and subsequent charting and collation of the data gleaned from the 16 articles will be discussed in chapter 3.

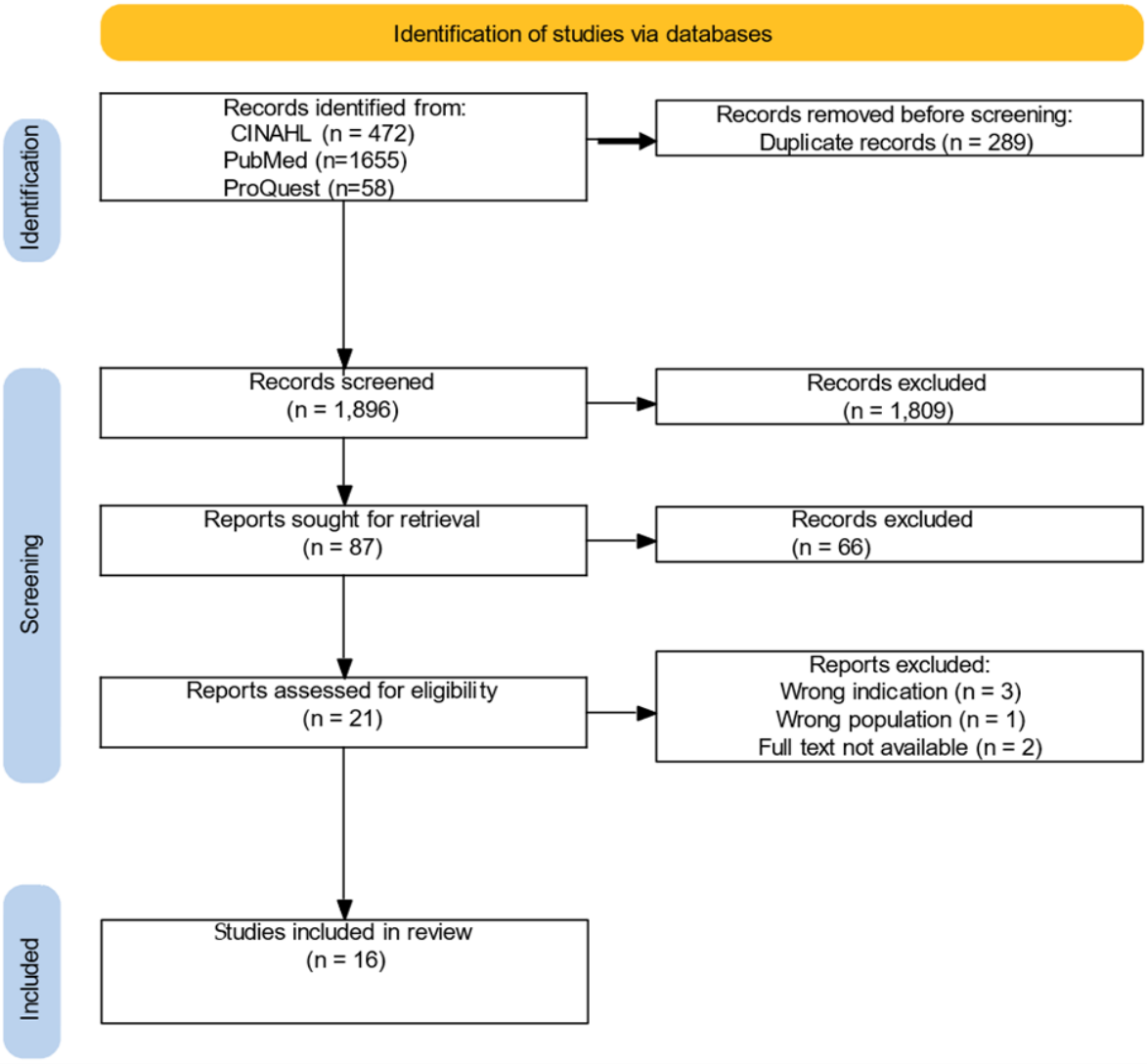


FIGURE 2. 4.: PRISMA DIAGRAM

2.4.2. Phase 2.1 and 2.2: Semi-structured interviews

The objective for phase 2.1. was: To explore and describe the TOP providers perceptions of factors impacting on the successful provision of TOP services in Gauteng

The objective for phase 2.2 was: To explore and describe the managers and doctors' perceptions of factors impacting on the successful provision of TOP services in Gauteng.

2.4.2.1. Population

The population for the qualitative phase of this study was all professional nurses and midwives, managers and doctors in GDoH facilities that provide TOP services.

2.4.2.2. Sampling

Non-probability sampling was used to select the TOP providers for the study sample. According to Polit and Beck (2021), purposive sampling is a non-probability sampling method used by researchers to select participants based on their personal judgement and knowledge of the participants' experience of the phenomenon under study. In this method of sampling the researcher enrols the participants according to the latter's availability and accessibility. Elfil and Negida (2017) confirm it is the most convenient, respectful, and easiest approach in research to make use of non-probability sampling when prospective participants have full schedules. Lambert and Lambert (2012) and Moser and Korstjen (2018) agree that a typical sample size for a qualitative descriptive study can be limited to "at least three (3) and not exceeding twenty (20) participants". Data saturation occurs when the collection of data is at the point where closure is attained because new information becomes redundant (Polit and Beck, 2021).

The inclusion criteria for the qualitative interviews were as follows:

i. Registered professional health workers (nurses and midwives) who provided TOP services in the CHCs with at least one year's experience.
ii. Nurse Managers of the TOPs providers who were trained and involved in TOPs.
iii. Doctors who performed second trimester TOPs in the hospitals.

The researcher purposefully selected the TOP providers from all five Health Districts.

The sample size for phase 2.1. were fourteen (14) TOP providers (that included13 registered nurses and midwives – one each from the 13 CHCs, and one (1) PHC) and one from each of the six (6) hospitals that offer TOPs. Total sample size of twenty (n = 20).

The sample size for phase 2.2. was one purposively selected doctor and one purposively nurse manager from each of the 5 districts of the GDoH (10) as well as a senior clinical manager (doctor) in each of the 6 hospitals offering TOPs. Total sample size n = 16).

The reason for selecting the nurse managers and the doctors was to obtain a different perspective from the people who were managing and assisting the TOP providers who performed TOP.

2.4.2.3. Data collection methods

Data collection is a systematic way of gathering information relevant to the research purpose or question (Burns and Grove, 2011). The most frequently used data collection qualitative methods that a researcher can use are participant observation, interviews, and focus group discussions.

The proposed participants were accessed during the unit meeting in their facilities after permission to conduct the study had been obtained from the Ethics Committee of the university and permission to conduct the study was given by the Chief Executive Officers (CEOs) of the 6 hospitals and the chief directors and research committee chairpersons of the 5 District health services. The operational manager of the five Community Health Centres (CHC) was contacted in advance and shown the documents permitting the study to be conducted.

Prior to commencing data collection for this phase, an information sharing session was conducted with all the TOP providers (Annexure 5) who showed an interest to participate. The researcher informed the participants telephonically of the time and place where each interview would take place. The researcher ensured that the TOP providers fully understood that their participation was voluntary. A distress protocol and contact details of support person (Annexure 8) was shared with the participants to

inform them that should they experience distress during the interview the interview would be stopped, and they would be referred to a counsellor. The researcher explained the nature and purpose of the study, how the study process was going to work, what was expected of them and that interviews were going to take between 30 to 60 minutes. The researcher assured the participants that they would remain anonymous and that the information they shared regarding their experiences was going to remain confidential even after the study had been completed with only the researcher and her supervisors having access to the data. Any article or report emanating from the study would use codes to identify participants to ensure anonymity.

The researcher phoned the participants and secured an appointment with them a week before the interview and then a day before the interview and assured each one that the interview would be done on an afternoon to assure that service delivery would not be negatively affected. All the interviews were done at the workplaces of the participants which were CHCs, clinic and hospitals respectively.

An informed consent form (see Annexure 6) was given to each participant to make an informed decision on whether to participate or decline participation in the study. The participants were treated fairly and with dignity. They were further informed that they had a right to withdraw from the study without fear of being victimised.

The participants elected to be conducted at their places of work. The researcher travelled to the different settings by car. She made sure to select settings clustered together in areas to save travelling and accommodation. A glass and a jug of water were available for each participant should they have needed a drink. The researcher conducted the interviews in the CHCs' duty room where the participants felt safe and secure.

The interview room was prepared in such a way that there was a table and two chairs, one for the researcher and the other one for the participant. The room was well ventilated with good lighting and a "Do not disturb" sign was hung on the outside of the door. The door remained closed throughout every interview, and nobody was allowed to enter.

In this study, semi-structured interviews were conducted directed by an interview guide (Annexure 3). The semi-structured interviews allowed the researcher to ask questions in a naturalistic environment where they feel free and safe. The interviews were held

face-to-face as it gave the participant room to respond in detail and raise all the issues they deemed to be important. The researcher was able to probe further, and the participants were encouraged to give information of their experiences in their own words. The use of an interview guide ensured that the relevant content was covered. (Moser, et al., 2018).

The questions aimed to ensure that participants related their "personal experiences, including feelings and emotions and often focused on a particular experience or specific event" (Moser et al, 2017). As the researcher wanted to gather as much detail as possible, she also asked follow-up questions or used probes to ensure that the participants elaborated on some information and/or provided more details.

Probing comes in many forms and the researcher used a neutral probe that did not influence the content of the participant's response. To keep the participants talking, the researcher often prompted with '*Mhmm…'; 'yes';* or *'okay*'. The researcher also would often request the participant to "*please elaborate on what you are saying*".

Interviews were recorded by means of an audio recorder. Before the audio recorder was switched on, the participants were made aware (by means of informed consent) that they would be recorded. The researcher took field notes to remind her on how the interview unfolded.

The researcher applied communication skills such as listening attentively, probing, paraphrasing and sometimes using a longer pause intended to communicate to the participant to continue with the narrative. The researcher made sure she maintained eye contact to assure the participant felt she or he was listening and hearing what the participant was sharing.

The researcher collected the demographic data before starting with the interview.

Section A of the interview schedule gathered the demographic data of the TOP providers in question form and the following questions were asked:

- How long have you been a TOP provider?
- How many TOPs do you perform on average in a week?
- How many hours do you work per day?
- Do you work in the clinic/hospital over weekends? And
- How many TOP providers work in a shift per day?

These questions were asked to enable the researcher to understand any complexities related to TOP provision.

Section B of the interview schedule (Annexure 3) aimed at establishing the factors that the participants believe impact on the successful implementation of the TOP policy by professional nurses and midwives providing TOP in Gauteng. The main questions asked were:

- *What are the challenges you are faced with in your line of duty in relation to providing TOP services?*
- Are there any other challenges you face in trying to implement the policy?

A similar process was followed to contact the nurse managers and doctors and to recruit them for the study. The main questions put to them were the same as for the TOP providers.

2.4.2.4. Data analysis

The researcher transcribed the recordings *verbatim.* After the transcribing the data, it was analysed according to Braun and Clarke's six steps of data analysis. In this study the intention was to explore and describe the perceptions of the TOP providers on factors impacting on the implementation of the TOP policy in the GDoH. A co-coder was used to assist with data analysis.

The researcher read transcripts and familiarised herself with the data. This was done by revisiting the problem statement, re-reading the transcripts and determining what was commonly narrated by the participants that was relevant to the problem in question. Each transcript was reviewed, and statements extracted. The researcher integrated the results into full description of the phenomenon that was investigated and after that data cleaning was done.

Data was collected until data saturation was reached (Burns &Grove 2009). Data saturation is described as the point in a research process where enough data has been collected to draw necessary conclusions, and any further data collection will not produce value-added insights (Polit & Beck, 2021). Data saturation was reached, when the tenth (10^{th}) participant was interviewed. At this stage the researcher became aware that participants were not saying anything new.

The results of the data analysis are described in detail in chapter 4.

2.4.3. Phase 3: Audit / record review

The objective for this phase was: To audit the demand for, and the resources available in the GDoH for the provision of TOP.

2.4.2.1. Population

The population of this study was all the health facilities that offer TOP in Gauteng Department of Health.

2.4.2.2. Sampling

The records of women who had requested termination between the months of November 2023 and January 2024 were selected. These three months were selected because it traditionally provides a range between high and lower demand for TOP services.

2.4.2.3. Data collection methods

Structured checklists were developed to audit the demand for TOP services. The following aspects for the clinics were audited as this informant is required according to the guidelines for TOP.

- The age of the client
- The marital status of the client
- The race of the client
- The occupation of the client
- Whether the client had booked at the clinic within the first trimester
- Whether contraception was offered post-abortion
- Whether there had been a need to affect an emergency transfer to a provincial hospital
- Whether medical or surgical abortion had been requested
- The number of staff on duty at the time of request

The following aspects for the hospitals were audited:

- The age of the client
- The marital status of the client

- The race of the client
- The occupation of the client
- Whether the client had booked at the clinic within the second trimester
- The drugs used for abortion
- The instruments used for abortion
- The number of staff on duty at the time of request (including medical practitioners)
- Health problems of the client

The original intention was to audit the files of the patients to obtain this information, but the filing system was so poor that the researcher had to rely on the patient registers to obtain the information. The photograph is an illustrated example of the poor state of the filing system found in all the CHCs'.



FIGURE 2. 5.: FIGURE 2.5 AN EXAMPLE OF THE FILING ROOM IN THE HEALTH ESTABLISHMENTS

The researcher requested permission to audit the files / registers by calling the CEOs of the six (6) hospitals and Chief Directors of the five (5) district health after which the researcher was granted permission to access the facilities. The researcher accessed the facilities during weekends and captured the results on an Excel spreadsheet for later analysis. In the hospitals, the registers were available in the area where patients request abortion.

The second part of the audit involved auditing the resources and facilities available for TOP in the health establishment.

The audit tool (see Annexure 2A) for this part was also based on the requirements set out in the Guidelines for National Clinical Guideline for implementation of the Choice on Termination of Pregnancy Act (2019).

The following aspects were audited:

- access to medical and nursing staff
- access to an operating theatre
- availability of surgical equipment
- Supplies of drugs for intravenous and intramuscular injection
- Availability of emergency resuscitation equipment and access to an emergency referral centre or facility
- Availability of access to appropriate transport should he need arise for emergency transfer
- Availability of facilities and equipment for clinical observation and access to in-patient facilities
- appropriate infection control measures
- access to safe water disposal infrastructure
- Availability of telephonic means of communication
- Approval by the member of the Executive Council by notice in the Gazette

For auditing the facilities, the researcher did a walk-about and checked whether the facilities complied with the requirements as listed in the guideline and the CTOPA (Act no 1 of 2008). The researcher checked the emergency trolley to check all items that are supposed to be in the trolley were there. The researcher used a tool to tick what is available or not available at the facilities (see Annexure 2B). The staff on duty were also asked some questions where clarity was needed.

2.4.2.4. Analysis of data from the audits

The data from each of the health establishments was entered into a separate Excel spreadsheet. Descriptive statistics were used to calculate the number of TOP requests per health care establishment, the average number of clients seen per hour, the ages of clients requesting TOP, the number of previous pregnancies prior to request for TOP and the gestational age of pregnancies at the time of request for TOP. The hospital data and the clinics (CHC) data were recorded and analysed separately as the former dealt only with first trimester TOPs and the latter mainly second trimester TOP's some of which had been referred from the clinics. As it was not possible to identify which clients had been referred from the clinics, there was an inevitably double count of some clients.

Walkabouts of the health establishments using the checklist based on the requirements for a facility to offer TOPs revealed that all had all the required equipment. The only exception at some of the clinics was the lack of a dedicated telephone or cell phone and lists of facilities to which clients could be transferred. The data was therefore not analysed as such, but the information has been captured in chapter 5.

2.4.3. Triangulation of data from previous phases

Bans-Akutey and Tiimuk (2021) define triangulation as a process that helps to increase the validity and credibility of a research study. In this study both data triangulation and methodological triangulation were used to improve the validity of the study. This was for the findings to be robust as the recommendations based on the findings of this research study need to provide contextual and credible advice to the GDoH on how to better align their services with the TOP guidelines of the Gauteng province in accordance with the CTOP (Act of 1996) as amended by the CTOPA 2008.

During the process of triangulation, the researcher makes use of multiple approaches to extract the required information and, in the process, critically analyse the findings.

Methodical triangulation uses more than one research methodology to approach the same topic, in this study a scoping review, semi-structured interviews and an audit of facilities and records provided rich data for the process of triangulation. This proved useful as the perceptions of TOP providers, and even their managers differed from

what appeared to be the reality of the context in which they work which was uncovered by the audit. The scoping review, on the other hand, provided a broad perspective to the topic and enabled the researcher to be more objective in her analysis of the findings.

Data triangulation, on the other hand makes use of several sources of data – in this study the international literature, the TOP providers, the managers and the audit data meant that data from different times, spaces and people could be included and enabled objective analysis and prevented researcher bias in research results (QDAcity. N.d.)

By using walt and Gilson's framework to organise the data during the process of triangulation, the researcher was able to identify important aspects of policy implementation in in order to develop the recommendations for the study.

The first step in the triangulation of the data was the development of a table of "lessons learned" from the various phases of the study. Once this was done the research was able, though an iterative process guided by her supervisors, conduct a deeper analysis of the collective data. The details of this process are explained in chapter 6.

2.5. Reliability and Validity / trustworthiness

Trustworthiness is the degree of confidence qualitative researchers have in their data. Trustworthiness is assessed by using the criteria of credibility, dependability, confirmability, and transferability (Polit and Beck,2021). Trustworthiness is how one can establish confidence in research studies. Scientific rigor in qualitative studies is measured by its trustworthiness or the extent to which the findings are true to the data and the research context.

- Reliability

Reliability indicates that the research approach is consistent and well documented such that should another researcher follow the same approach they would get similar results. Reliability is defined as the extent to which an instrument consistently measures a concept or the degree of consistence or dependability with which an instrument measures an attribute (Burns & Grove, 2015). Reliability focuses on level of similarity of results obtained when measurement is repeated even on the same subject or group.

Attempts were made to ensure reliability in this study by using a standardised format of the data capture sheets, verifying and cleaning the data.

- Validity

Validity refers to the degree to which items of the instrument measure the construct that they are intended to measure (Polit & Beck, 2021). Validity ensures that the items of the instrument are sufficiently good to measure the concerned construct.

In a true quantitative study, the instruments used for data collection need to be shown to be reliable. In the researcher's study, the instruments were checklists and data sheets on which the data from the records was entered. Attempts were however made to ensure accuracy and consistency when entering the data and input errors were checked and corrected prior to analysis of the data.

- Credibility

Credibility refers to confidence in the truth of the data and its interpretation; thus, it is about making sure that the study results are a true reflection of the phenomenon under study (Polit and Beck, 2021). Confidence and truth were established through the following: prolonged engagement, persistent observation, triangulation, and peer debriefing.

- Prolonged engagement

Prolonged engagement affords the researcher sufficient time to collect data and gain enough time to understand the phenomenon. The researcher took one month to collect the qualitative data. As the researcher remained in the filed during data collection, it was possible to do some members checking. When the researcher stays longer in the field, trust and rapport between the researcher and the participants is built (Brink, et al., 2012). Lincoln and Guba (1985) state if an investigator produces field notes and makes predictable interpretations from the original formulation, then the investigator did not spend enough time on the site. In this study, the researcher spent 30 to 60 minutes with each of the participants and kept field notes to maintain persistent observation. For the credibility of the study to be ensured, the researcher communicated with the participants to make an appointment to visit them after the data had been collected.

The participants were allowed to verbalize their feelings without being hurried or interrupted. The interviews were conducted until data saturation was reached. During

data analysis, the researcher listened to the tape recordings over and over, wrote and re-wrote the transcripts, and then read and re-read them to fully comprehend the data.

- Peer debriefing

Peer debriefing entails holding sessions with peers to objectively review and explore various aspects of the inquiry (Polit and Beck, 2021). The researcher interviewed the participants and transcribed the transcripts verbatim before sending them to the co-coder for analysis. The researcher and the co-coder discussed the transcribed data until they reached consensus on the final categories and sub-categories.

- Triangulation

Triangulation is a strategy for enhancing the quality of the research, particularly its credibility. There are four types of triangulations, namely: (i) triangulation of the data method, (ii) triangulation of the data sources, (iii) theoretical triangulation, and (iv) triangulation of investigators (Polit and Beck, 2021). For this study purpose, only triangulation of the data method and triangulation of the data sources were applicable. Various data sources such as literature relevant to the topic were used to validate the conclusion. The researcher gathered data through the participants' observations and in-depth face to face interviews with TOP providers, managers, and doctors who provided TOP services in the five (5) district health services in Gauteng province. A triangulated approach using multiple sources of data enabled a broad range of issues to be cross-checked. The researcher collected data on different dates using the same questions to ensure consistency. The strategies of data collection used by the researcher included face to face individual interviews, using an audio recorder, and writing field notes. The researcher further made use of the services of a co-coder to analyse the data.

- Dependability

Dependability refers to the "stability of data over time and conditions (Polit & Beck , 2021)". According to Polit and Beck (2021), dependability in qualitative research can be equated to reliability in quantitative studies. The researcher transcribed exactly what every participant had said, studied the field notes made during and after every interview, and formed categories and sub-categories only after she felt that she had considered and understood all the new data in its entirety. In this way, the researcher arrived at consistent, accurate information. Brink, et al. (2012) state dependability

requires an audit. In this study, the auditor was the researcher's supervisor who followed the process and procedures used by the researcher in the study and determined whether they were acceptable or not.

- Confirmability

Confirmability refers to the objectivity and neutrality of the data. This means that the findings of the study were the actual results of the study and not assumptions made the researcher (Polit and Beck, 2021). These authors further state confirmability is "to be objective about the data's accuracy, relevance or meaning" (Polit and Beck, 2021). The researcher made use of an experienced, independent co-coder to verify that she interpreted the gathered data accurately and correctly. Thus, they reached consensus on identified categories and sub-categories. In the written discussion, the researcher used verbatim quotes and literature control. The researcher also made an appointment with each of the participants and shared her verbatim transcription of their own interview with them.

- Transferability

Transferability is the extent to which qualitative findings can be transferred to other settings or groups; it is one of several models of generalisation (Polit and Beck, 2021). The researcher provided sufficient descriptive data and description of findings which, according to Polit and Beck (2021) is a "thick description" enabling the readers of the study to evaluate the applicability of the data. Brink, et al. (2012) state a qualitative researcher not only wants to generalise findings but rather define observations in a specific context. Thick description therefore means that the researcher collected and provided sufficient detailed data within the given context and the reporting thereof after data collection. The researcher visited the participants in their respective clinics and clarified any misunderstandings that the participants might have had. The findings of this study cannot be generalized as it was conducted in public institutions in one province, although the descriptions and results could assist researchers to consider transfer as a possibility. A rich description of results with supporting quotations from the participants was given.

- Authenticity

Authenticity refers to “the extent to which the researcher fairly and faithfully shows a range of realities” (Polit and Beck, 2021: 778). The researcher demonstrated fairness and faithfulness by quoting the participants’ interviews verbatim. The transcripts were then shared with the co-coder for her to verify the accuracy of the interpreted data.

2.6. Ethical considerations

To protect the participants from harm or risk, the researcher adhered to the following ethical principles throughout this study: beneficence, respect for human dignity, and justice (Polit and Beck, 2021).

- Beneficence

The researcher has a moral duty to ensure the well-being of the participants and to minimise harm and maximise benefits in a research study (Polit and Beck, 2021: 778). The research study should bring benefits, excluding financial gain. The study may benefit the TOP providers and help to assist the GDoH to put in place mechanisms to roll out medical abortion services so that termination of pregnancy will be easily accessible, should the recommendations of this study be implemented. In this study, the researcher made sure that harm was minimised, and participants were informed that they have a right to withdraw from the study at any time.

- Right to freedom from harm and discomfort

Researchers are obligated to “avoid, prevent or decrease harm in studies with humans” (Polit and Beck, 2021: 133). Physical injury, emotional stress, the loss of social support, and loss of wages are regarded as harm and discomfort in research on humans. The researcher made sure that the participants were not exposed to any danger or discomfort. None of the participants reported being exposed to any harm or discomfort. The distress protocol was given to the participants to read before interviewing them.

- Respect for human dignity

This principle includes the right to self-determination and the right to full disclosure. The principle was applied by not divulging the names of the participants and by also making sure that confidentiality was not broken. The participants were not forced or coerced to participate but did it of their own free will.

- Justice

This principle includes the participant's right to fair treatment and privacy (Polit and Beck, 2021:). Brink, et al. (2012) state there must be fair selection of the participants. The authors emphasise that the researcher must be on time, terminate the interview on the agreed time, and treat the participants with respect. The right to privacy of the participants was ensured by interviewing them in a private setting where they felt safe and secured. The researcher informed the participants that the information given would not be made available to anybody except the co-coder and the university under which this study was conducted. The researcher further assured the participants that they would remain anonymous, and the information given by each of them would be marked with a code to guarantee anonymity.

- Anonymity and confidentiality

It was crucial to protect the identities of the participants. To ensure that the participants were not identifiable, codes were used. The principle of ensuring confidentiality maintains that participants must be protected, and stay protected, at all times. The audio recordings are saved on a password protected device where they inaccessible to any other except the researcher. The transcripts of the interviews are saved of a separate password protected electronic device – also only accessible to the researcher. The researcher made sure the collected, analysed, and all other data sources were accessible only to her and her supervisors.

2.7. Conclusion

This chapter described the research methodology. The research approach, design, and methodology including the setting, population, sampling, data collection and analysis were fully detailed. The measures of trustworthiness were presented, and ethical issues addressed. In the next chapter the focus will be on the scoping review.

CHAPTER 3: SCOPING REVIEW

3.1. Introduction

This chapter presents the process and results derived from the scoping review. The results from the review contributed to the researcher finding articles that could answer the research question, including the study's objectives.

3.2. Framework and study selection

The scoping review followed the PRISMA extension for scoping reviews and the five-stage framework by Arksey and O'Malley (Arksey & O'Malley, 2005; Levac et al., 2010; Munn et al., 2018) as described in Chapter Two of this study. This framework ensured a thorough and replicable strategy for scoping review results (Peters et al., 2021; Arksey & O'Malley, 2005). Scoping reviews serve to describe research findings, both quantitative and qualitative, pinpoint gaps in knowledge, set research priorities and decision-making implications, and offer guidelines for reporting scoping review investigations (Peters et al., 2021; Munn et al., 2018). See Figure 3.1 below for the overview of the five-stage framework of Arksey and O'Malley (2005) that guided the scoping review.

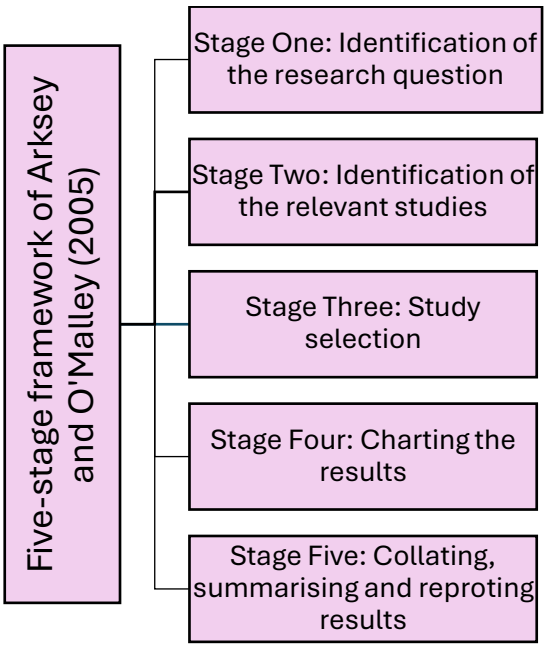


FIGURE 3. 1.: OVERVIEW OF THE FIVE-STAGE FRAMEWORK OF ARKSEY AND O'MALLEY (2005)

3.2.1. Stage One: Identification of the Research Question

What is currently known about the TOP policy? What needs to be done to provide TOP successfully?

3.2.2. Stage Two: Identifying Relevant Studies

The researcher used the three search strategy steps as recommended by the JBI (Peters et al., 2015).

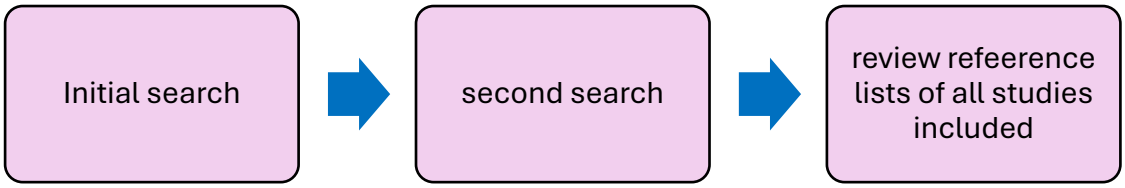


FIGURE 3. 2.: THREE-STEP SEARCH STRATEGY ACCORDING TO THE JBI (PETERS ET AL., 2015)

As the first step, the following databases were searched: PubMed, ProQuest and CINAHL. The retrieved articles' titles, abstracts, and index terms were analysed in relation to possible search terms. The second step included searching the databases: PubMed, ProQuest, PsycINFO, MEDLINE, Cochrane Library, Google Scholar and CINAHL. The researcher scanned the hits and applied identified keywords and index terms across all published and unpublished databases/sources. After scanning the databases, the researcher used PubMed, ProQuest and CIHANL. The researcher chose these databases because they were relevant to the profession and represented the multidisciplinary nature of the phenomenon under study. They were available from the University of the Witwatersrand Health Sciences Library.

TABLE 3. 1.: DATABASES SEARCHED, SEARCH STRINGS AND RESULTS

Database	Keywords	Number of results
PubMed	Factors impacting abortion, termination of pregnancy, induced abortion and unsafe abortion	28 119
	Policy, healthcare policy, national health policy and health policy	311 339
	Health personnel and healthcare provider	180 930
CINAHL Complete	Factors impacting abortion, termination of pregnancy, induced abortion and unsafe abortion	23 822
	Policy, healthcare policy, national health policy and health policy	149 689
	Health personnel and healthcare provider	23 834
ProQuest	Factors impacting abortion, termination of pregnancy, induced abortion and unsafe abortion	115 241
	Policy, healthcare policy, national health policy and health policy	1 029 726
	Health personnel and healthcare provider	633 376

To search, the researcher used Boolean terms, such as “AND”, “OR”, and “NOT”, to separate and combine the keywords. Truncations were also used to separate or combine the keywords. A librarian assisted with the search after the keywords were selected. Studies/ literature relevant to the scoping review were identified by searching the following electronic databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL hosted within EBSCO host), PubMed, and ProQuest from 1 January 2012 to 31 December 2022.

The following keywords/strings were used: factors+ impacting +termination+abortion and unsafe abortion. The second search words/strings were: health policy, healthcare policy and national health policy. The last search words/ strings were health care provider+health personnel. The studies that were selected had to be written in English

because it was the language mainly used by the researcher, supervisor, and reviewers. The scoping review only focused on the studies that investigated the factors impacting the implementation of termination of pregnancy. The search strategy was done using a combination of mesh and keywords. For CINAHL (EBSCO host), 120 455 studies were found and filtered further using subject-significant headings.

CINAHL studies selected from 120 455 were filtered until they were 472. A ProQuest database search yielded 115 438, and the filter was conducted, which resulted in 223. The final filter resulted in 58 studies. PubMed search yielded 16 077 results and, after filtering, ended up with 1655. of the 2185 selected records, 289 were removed because they were duplicates. After removing the duplicates, 1896 records were screened, of which 1809 were excluded based on their title, leaving 87 records. The titles of the publications were reviewed, followed by the assessment of the abstracts where the titles of the studies were unclear – the titles and abstracts were initially screened only for eligibility. Thereafter, abstracts and full texts were screened; 66 were discarded for not meeting the criteria, and only 16 met the inclusion criteria. All publications found during the search strategy were reviewed to exclude those not meeting the inclusion criteria. The following were considered when searching: the author's name, publication date, country of origin, research design, population and findings. Two reviewers conducted and verified the search results. The list of publications acquired from the databases searched was saved. Thereafter, the references were saved in the Endnote citation manager.

In this stage's third and last step, the researcher's reference lists of the included studies were investigated to check for other potential studies to be added. The search was limited to the reference lists of the studies included in the scoping review.

Table 3.2 illustrates the Population, Concept and Context (PCC) framework recommended by JBI (Peters et al., 2015), aligning the selected studies with the research question.

TABLE 3. 2: PCC FRAMEWORK BASED ON RECOMMENDATIONS BY JBI (PETERS ET AL., 2017)

PCC element	Definition
P- Population	TOP providers, managers and doctors working in TOP units in Gauteng healthcare facilities
C- Concept	The factors impacting the provision of TOP in GDoH facilities
C- context	The hospitals, CHCs and PHCs providing TOP in GDoH

Stage 2 inclusion and exclusion criteria: The studies included in the scoping review were articles that reported on the termination of pregnancy, including policies and laws governing the provision of safe TOP. Furthermore, the studies that have been included were articles that reported on complications related to unsafe abortion because of a shortage of healthcare providers willing to provide TOP, conscientious objectors and denial of TOP due to lack of facilities offering TOP. The studies included are written in English because it is the language that the researcher and supervisors mainly use. In addition, grey literature, abstracts, newspapers and debates were excluded. In addition, the inclusion and exclusion criteria are listed in Table 3.3 below.

TABLE 3. 3.: INCLUSION AND EXCLUSION CRITERIA

Category	Inclusion criteria	Exclusion criteria
Population	Women aged 15-49 years old	Women above 49 years old and below 15 years old
Language	English	Any other language which is not English

Type of article	Full texts	Gray literature Abstracts Newspapers Debates
Study focus	Studies focusing on termination of pregnancy, safe and unsafe	Other studies incompletely address the inclusion criteria for the PCC combination.
Timeframe	01 January 2012 – 31 December 2022	Articles published before 2012. Literature not published in a journal.
Study Design	Qualitative and quantitative Cross-sectional survey, survey, propensity score weighted difference to difference, retrospective review of computerized records and scoping review	N/A

3.2.3. Stage Three: Study Selection

The articles identified were stored in the Endnote citation manager and reviewed by the researcher. The studies selected were also reviewed by another researcher, the researcher's supervisor. The two reviewers agreed on which articles met the inclusion criteria. The second co-supervisor reviewer also reviewed the articles, and there were no disagreements about the articles to be included. The articles in full text were saved in the Endnote citation manager.

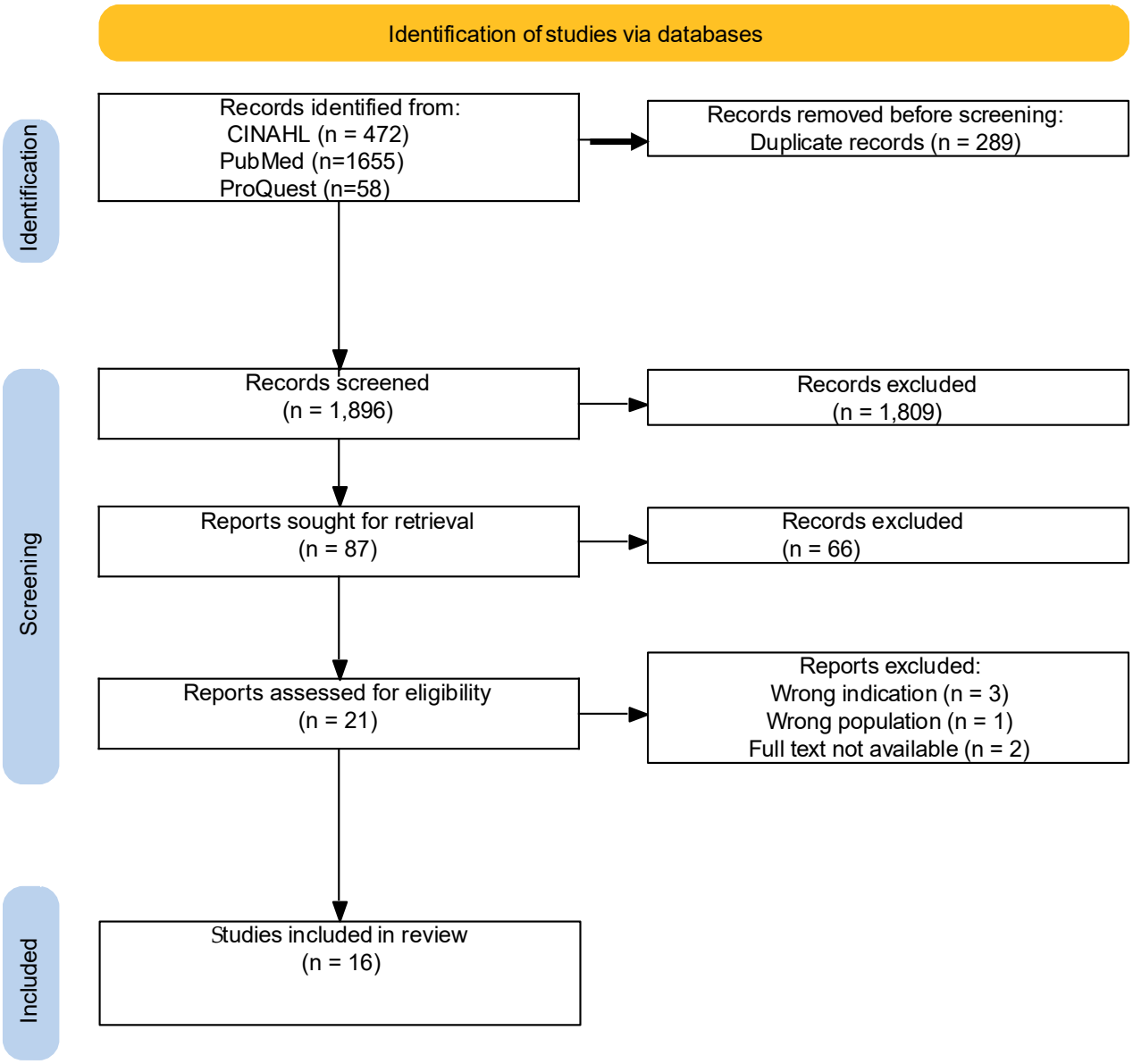


FIGURE 3. 3.: PRISMA-SCR 2020 FLOW CHART (PAGE ET AL.,2021)

3.2.4. Stage Four: Charting the data

Key information from the selected articles' abstracts will be collected and organised. Standard data items will be extracted and reported. These items will include bibliographical information (author, year of publication, title, journal), the paper's purpose, study design, sampling and sample, data collection and analysis and major findings of the studies. **Table 3.4** displays the characteristics of the included articles.

TABLE 3. 4.: CHARACTERISTICS OF THE INCLUDED ARTICLES (N=16)

Author (country)	Name of Journal	Purpose of the study	Study design	Sampling and sample	Data collection and analysis	Major Findings and conclusions
Atakro et al. (2019) Ghana	BMC Women's Health	To explore factors contributing to high incidence of unsafe abortion practices among women of reproductive age in the Ashanti region of Ghana	Qualitative descriptive study design.	Purposive sampling Sample: 111 (n=111) participants (patients, religious leaders and midwives).	Interviews and FGDs Data saturation was reached after 46 (n=46) Interviews 65 (n=65) focus groups	• Lack of knowledge of safe abortion services. • Socio-economic conditions influencing unsafe practices • Cultural and religious taboos regarding safe abortion • Stigma of unplanned pregnancies • Desire to bear children after marriage • Avoidance of parental or guardian disappointment • Desire to pursue education • Conclusions: Numerous factors contribute to unsafe abortion practices
Bain et al. (2019)	BMC Women's Health	To address high rates of maternal mortality and	Retrospective analysis	Reference findings from	Utilized qualitative interviews and	• Maternal mortality rates as high as 596 per 100,000 live births

Cameroon		complications related to unsafe abortions in Cameroon,	(qualitative and quantitative)	previous studies Women attending ANC services seeking abortion	quantitative surveys	• Over 13% of maternal abortions are linked to unsafe abortions • Clandestine abortions are common, especially among lower socio-economic women • Restrictive legal framework poses significant barriers to safe abortion access • Conclusions: A restrictive legal environment contributes to maternal morbidity from unsafe abortions.
Berglas et al. (2020) United States	BMC Public Health	To describe abortion-related activities in state and local health departments from the perspective of MHC and family planning professionals. To	Qualitative	Purposeful sampling 29 (n=29) professionals from 22 (n=22) hospital departments	Key informant interviews Not specified number	• Range of activities: engagement in activities like data collection and creating informational materials • Approaches to work: identified three methods: legally mandated informed by public health principles, and

		understand approaches to programmatic work on abortion and examine barriers and facilitators				department initiatives based on needs • Political climate influence: barriers include political climate, funding constraints and departmental leadership attitudes. • Conclusions: Public health professionals can incorporate evidence-based practices into abortion practices despite legal mandates and political pressures.
Bell et al. (2020) Cote d'Ivoire	Plos One	To assess one-year incidence of induced abortion in Cote d'Ivoire; assess safety of repeated abortions; identify socio-demographic	A national population-based survey conducted in 2018	2,738 women aged 15 to 49 Stratified cluster design with 73 enumeration areas	Face-to-face interviews using smartphones Structured questionnaire covering abortion frequency,	• One-year incidence: 27.9 per 1,000 women; confidence incidence: 40.7 per 1,000 • Unsafe abortions: 62.4% (respondents), 78.5% (confidantes) • Vulnerable groups: adolescents, less educated, and impoverished women at

		factors associated with recent or unsafe abortions			methods and sources	higher risk for unsafe abortions • Conclusions: High rates of unsafe abortion contribute to maternal mortality.
Blystad et. al. (2019) Zambia Ethiopia Tanzania	International Journal of Equity Health.	To explore the relationship between abortion laws, policy and women's access to safe abortion services in Ethiopia, Tanzania and Zambia	Qualitative exploratory design with cross-country comparison	79 (n=79) participants from ministries, NGOs, religious organizations, health professionals	Semi-structured interviews with key stakeholders	• Paradoxical relationship between legal classifications and actual access to services • Ambiguities in law texts create barriers to accessing safe abortion services. • Zambia's liberal law hindered multi-signature requirements. • Ethiopia's policy is poorly implemented despite being theoretically accessible. • Tanzania's restrictive law saw informal access avenues develop, indicating pragmatism. • Conclusion: Legal frameworks are critical but

						not sufficient alone; there is a need for contextualized studies to understand real access to safe abortion practices
Brown et al. (2020) United States of America	JAMA OPEN	To assess the association between highly restrictive state abortion policies and abortion rates and to evaluate the role of distance to abortion facilities.	Cohort study using propensity score – weighted, linear regression difference in difference analysis	1,178 (n=1,178) countries across 18 states covering data from 2000 to 2014	Data from state vital statistics offices, legislative records on abortion restrictions, and facility locations were linked.	• Restrictive legislative climate associated with a decrease of 0.48 abortions per 1,000 women (17% reduction) • Adjusted analysis indicated 0.44 fewer abortions per 1,000 women in restrictive climates. • Each additional mile to a facility related to a decrease of 0.02 abortions per 1,000 women • Conclusion: Highly restrictive state policies correlate with lower abortion rates, indicating these policies act as barriers to access.

Burstscher et al. (2020) Democratic Republic of Congo (DRC)	Sexual and Reproductive Health Matters	To examine the vulnerabilities of women and girls regarding unwanted pregnancy and abortion in the Democratic Republic of Congo (DRC)	Qualitative study	251 (n=251) participants Purposive sampling	In-depth individual interviews (n=122), group interviews (n=34) and focus group discussions (n=4)	• Contributing factors: sexual violence and transactional sex linked to unwanted pregnancies • Stigma and shame: major influence on women's decision-making regarding abortion • Perception: Variability in attitudes towards abortion across study areas • Healthcare barriers: legal constraints and societal attitudes inhibit safe abortion care. • Conclusion: there is a critical need for safe abortion care services in the DRC; women prefer the risk of death from unsafe abortions over societal stigma.

Cameron et al. (2016) Edinburg United Kingdom	Journal of Family Planning Reproductive Health Care	To compare the safety and patient satisfaction of outpatient early medical abortion (EMA) services in community sexual and reproductive health (SRH) settings versus hospital departments.	Retrospective review of medical records and anonymous surveys	1,342 (n=1,342) women outpatient department EMA <9 weeks; 601 (n=601) women hospital settings; 741(n=741) SRH settings	Review computerized records for re-attendance rates. Anonymous surveys assessing satisfaction with information received	• No significant difference in re-attendance rates due to complications (2.7% overall) • Higher telephonic contact rate at SRH (18.8%) versus hospital (10.8%; p=0.033) • High satisfaction scores for information received: Hospital (9.2), SRH 9.6) • Conclusion: Outpatient EMA is as safe in community settings as in hospitals, with similar patient satisfaction levels.
Chowdhary et al. (2022) Southern United	Maternal and Child Health Journal	To evaluate the factors affecting workforce recruitment and retention of abortion providers in the South United States	Qualitative design using grounded theory methodology	12 (n=12) abortion providers Purposive sampling Across various	In-depth semi-structured interviews	• Challenges include restrictive legislation, lack of training opportunities, safety concerns, sigma and isolation. • Motivations for practice: desire to impact high-need

States of America				southern states		areas, combat health access disparities • Recommended strategies: increase networking opportunities, enhance training initiatives, foster better organizational support • Conclusion: There is an urgent need for collaboration among organizations to support abortion providers, address barriers, and ensure continued access to safe abortion services.
De Londras et al.(2022) United Kingdom	BMC Public Health	To address knowledge gaps on health and non-health outcomes of mandatory waiting periods (MWP) for	Systematic review	34 (n-34) studies from 2010 to 2021 in the united states Filtered 10,063	2 reviewers: extracted data discrepancies resolved collectively. Organized findings based	• Health and non-health harm: MWPs cause delays in accessing abortion and increase opportunity costs • Workload implications: increased operational costs and workloads for healthcare providers

		abortion. To integrate human rights considerations into the analysis.		citations based on relevance to MWP-related outcomes.	on predefined outcomes (e.g. delayed abortion, opportunity costs)	• Disproportionate impact: more significant effects on marginalized groups (adolescents, racial minorities) • Conclusion: MWPs act as barriers to timely reproductive healthcare, undermining women's autonomy.
Dawson et. al.(2016) Australia	BMC Health Services Research	To improve access to comprehensive medical and early surgical abortion services in Australia.	Systematic review	29 papers, included primarily from the UK (n=14), and USA (n=7), focused on qualitative and quantitative studies from 2005 to 2015	Literature searches, screening for relevance, appraisal using critical tools, and extraction of data based on various research characteristics	• Flexible service delivery and telemedicine improve access • Shortage of healthcare providers impacts availability, especially in rural areas • Integration of abortion services within family planning is essential • Conclusion: There is a need for national standards, increased choices for women, improved provider education, telemedicine

						expansion, and decriminalization of abortion in Australia.
DePineres et al. (2017) Colombia	Reproductive Health	To understand why women in Colombia are denied legal abortion services and to explore factors influencing their subsequent pregnancy termination choices.	Qualitative	21 (n=21) denied abortion services Aged 19-24, some younger, most with prior pregnancy experiences	Individual interviews in the clinic Follow-up interviews conducted by phone two months later	• Barriers: lack of knowledge about service availability, delayed pregnancy recognition • Support: some women received partner support and referrals, but many-faced poor care and stigma • Mindset: contemplation of illegal abortion methods due to misinformation • Conclusion: There is a need for enhanced awareness of legal services, effective counselling upon denial and improved provider training in compassionate care.

Fiol et al. (2016) Uruguay	International Journal of Gynecology and Obstetrics	To examine the implementation of the law liberalizing voluntary termination of pregnancy (VTP) in Uruguay and the role of medical abortion within this framework.	Observational retrospective analysis of national data VTP	15,996 (n=15,996) voluntary terminations of pregnancy reported nationwide Additional data from 481 (n-481) women	Monthly reports from health providers detailing the number of terminations, methods used, and complications, including maternal deaths and hospital admissions	• 98.8% of abortions were medical, with only 3.4% requiring hospitalization • 46.2% of procedures occurred before 19 weeks of gestation, and 53.8% at 10 to 12 weeks. • Zero maternal deaths were reported for legal abortions; one death was linked to an illegal procedure. • Conclusion: Medical abortion greatly supported the successful implementation of VTP services in Uruguay, providing a model for other countries considering similar legislative changes
Gerdts et al. (2014)	Journal Family Planning,	To assess socio-demographic characteristics and reasons for	A comparative study focused on women's	Total 701(n-701)	Surveys were administered at clinics to gather	• South Africa: 45% denial, reasons included gestational age limits and staffing issues

Colombia, Nepal, South Africa and Tunisia	Reproductive Health Care	abortion denial among women seeking legal abortion in Colombia, Nepal, South Africa and Tunisia	experience seeking legal abortion services.	225 (n=225) Columbia 311 (n=331) Nepal 60 (n=60) South Africa 85 (n=85) Tunisia	information on abortion experiences and reasons for denial.	• Tunisia/Nepal: 26% denial, reasons included gestational age restrictions and unnecessary clinic requirements • Colombia: 2% denial, all due to gestational age limits • Conclusion: Denial of abortion services impacts women's health and well-being significantly.
Kabiru et al. (2016) Kenya	BMC Pregnancy and Childbirth	To assess the prevalence and correlates of previous induced abortions among young women (ages 12 – 24) seeking abortion-related care in Kenya	Cross-sectional analysis using data from a nationwide survey	1,378 (n=1,378) young women presenting for abortion care at 246 health facilities selected via stratified random sampling	Conducted over 12 months using abortion case capture form covering socio-demographic and reproductive information	• 9% reported a previous induced abortion • Higher reporting rates among urban dwellers, unemployed/other occupations, and lower education levels • Most women reporting prior abortions indicated their current pregnancies were unintended.

						• Conclusion: There is a need for comprehensive post-abortion care services targeting young women, emphasizing contraceptive counselling to prevent unintended pregnancies
Makleff et al. (2019) Uruguay	BMC Women's Health	To assess women's experiences seeking abortion services in Uruguay post-2012 legal changes focusing on knowledge, attitudes and stigma.	Mixed method approaches combining quantitative surveys and qualitative data	207 (n=207) women aged 18 and older seeking services at high-volume public hospitals Recruited via convenience sampling	In-person or telephonic surveys, including socio-demographic information and the Individual Level Abortion Stigma (ILAS) scale	• 94% of women agreed with the abortion law; 72% found access difficult • 70% deemed the 5-day waiting period unnecessary • Younger women reported higher self-judgement and worries about judgement • Conclusion: Stigma and barriers persist despite legal recognition of abortion as a right; efforts are needed for nonjudgemental care and enhancing social acceptability.

3.2.5. Stage 5: Collating, Summarising and Reporting the Results

In Step 5 of the scoping review, the results were collated, synthesized, and presented following Braun and Clarke's thematic analysis. An inductive approach was used, allowing themes to emerge directly from the data rather than being predefined. The included studies were summarized in terms of key characteristics such as study design, population, and geographic distribution, which were presented in a table for clarity (Table 3.4). A thematic analysis was conducted through an iterative coding process, identifying patterns and grouping findings into themes. The main themes were then presented with descriptive explanations, supported by study examples where applicable. Tables and figures were used to summarize thematic findings and illustrate their frequency across the included studies. A narrative synthesis was provided to connect themes, highlight patterns, and discuss variations, contradictions, or gaps in the literature. Where relevant, findings were compared to existing theoretical perspectives or frameworks. The section concluded with a summary of key findings, emphasizing critical insights and areas requiring further research or policy considerations.

3.3. Results

3.3.1. General Characteristics of the Articles

Seven of the studies 44% (n = 7) originated from Africa, three from North America (19%; n=3), three from South America (19%; n = 3), two from Europe (12%; n=2) and one from Australia (6%; n=1). The publications were distributed according to the author, the year and journal of the publication, the purpose of the study, study design and sample, data collection and analysis and major findings of the study. The publications were from up to and including 31 December 2022.

3.3.2. Distribution of Publications by Year of Publication

In 2015 and 2017, one (1) article was published, and in 2018, 2020 and 2022, two (2) were published in each of these three years. Three (3) were published in 2019, and three (3) in 2016. The articles dealt with termination of pregnancy access, denials, and complications related to termination of pregnancy. Some of the articles explored the role

of medical abortion and the expansion of safe abortion care, which included family planning.

3.3.3. Author Collaboration in Publications

Author collaboration implies more than one author collaborated on it. In this study, the literature sources reviewed were all written by more than one author.

3.3.4. Approach used in Reviewed Studies

Most articles (44% (n = 7) were qualitative studies, while 19% (n = 3) were reviews. The quantitative studies comprised 6% (n = 1) and 13% (n = 2) were surveyed. Further, six per cent (6%; n = 1) was cross-sectional descriptive qualitative and quantitative studies, 6%; n=1) was a retrospective review of computerised records, and 6% (n=1) used a propensity-score weighted difference-in-difference design. The articles included in the scoping review were selected according to the names of the author/s, year of publication, name of journal, purpose of the study, study design and sampling and sample, data collection and analysis and major findings of the study, The table below illustrates the countries of origin of the studies selected for the scoping review, the years of publication and the journal of the publications.

TABLE 3. 5.: COUNTRIES OF ORIGIN, YEARS AND JOURNAL OF PUBLICATION

Country of origin	Years	Journal of publication
Colombia Nepal South Africa Tunisia	2015	BMJ
Uruguay	2016	International Journal of Gynecology and Obstetrics
Kenya	2016	BMC Pregnancy and Childbirth
UK (Birmingham)	2016	BMJ Evidence-Bad=sed Medicine
Australia	2016	BMC Health Services
Colombia	2017	Reproductive Health
Cameroon	2018	BMJ Evidence-based Medicine
Uruguay	2019	BMC Women's Health
Ghana	2019	BMC Women's Health
US	2020	JAMA network open
Democratic Republic of Congo	2020	SRHM (Sexual Reproductive health Matters
Cote d'Ivoire	2020	PLOS one
San Francisco	2020	BMC Public Health
UK (Birmingham)	2022	BMC Public Health

USA Dar es Salaam Zambia	2022	Maternal and Child Journal
USA	2022	BMC Public Health

3.3.5. Focus of the Study

The studies included the barriers met by women wanting to access abortion services and the complications that arise from abortion care, especially from unsafe abortion. Some of the studies focused on the laws and policies regulating abortion. In other studies, the restrictive laws of abortion were outlined. The experiences of the women seeking abortion and termination of pregnancy providers were discussed in various studies. In the content of the scoping review, five themes were identified, as presented in Table 3.6 below.

TABLE 3. 6.: THEMES AND SUB-THEMES ARISING FROM STUDIES INCLUDED IN THE REVIEW

Theme	Sub-theme
3.3.6 Access to safe abortion services	3.3.8.1 Geographic and financial barriers
	3.3.8.2 Post abortion care
3.3.7 Knowledge and attitude toward abortion	.3.3.7.1 Women's awareness and decision-making
	3.3.7.2 Healthcare providers' attitudes
3.3.8 Cultural and societal influences on abortion practices	3.3.8.1 Stigma and social Judgement
	3.3.8.2 Family and Community Influence
3.3.9 Ethical considerations in abortion care	3.3.9.1 Conscientious objection and provider ethics
	3.3.9.2 Informed consent and counselling
3.3.10 Policy and legal frameworks impacting abortion services	3.3.10.1 Legislative climate 3.3.10.2 Need for comprehensive and inclusion policies.

3.3.6. Theme 1: Access to Safe Abortions

Despite advances, accessing safe abortion services remains a challenge due to a range of barriers, including geographical disparities, financial obstacles and limited post-abortion care services. Six studies (Atakaro et al., 2019; Bain et al., 2020; Blystad et al., 2019; Burtscher et al., 2020; Dawson et al., 2018; Gerdts et al., 2014) identified shared barriers to access to safe abortion services in multiple contexts.

3.3.6.1. Geographical and financial barriers

Geographical variations in access also compound barriers for women living in remote or underserved communities, potentially entrenching inequities in access to safe abortion services. Bain et al., (2019) and Dawson et al. (2018) indicated in Cameroon and Australia, rural women face significant obstacles due to the uneven placement of healthcare facilities providing abortion services. Bain et al. (2019) also noted that abortion services in Cameroon are mainly located in urban centres, and the onus is on women from rural areas to travel long distances, which maintains the costs and challenges. Similarly, Dawson et al., (2018) identified that in Australia, the restricted availability of abortion service providers in rural environments leads to delays in accessing care and greater reliance on unsafe methods. These authors suggested that incorporating telemedicine into abortion care services may be one tool that can help address these geographic disparities by offering remote access to consultation and prescription services.

In addition, financial issues are also posing additional challenges towards abortion access, especially in low-income settings. Gerdts et al., (2014), in a cross-country study across Colombia, Nepal, South Africa, and Tunisia, found that financial barriers, including direct costs such as service fees, transportation, and medical expenses, place a significant burden on women seeking abortion services. These economic restrictions could result in later care-seeking and a higher likelihood of unsafe procedures. Similarly, De Pineres et al., (2017) investigated the financial costs linked to the denial of access to legal abortion services in Colombia. In this situation, women turn to expensive and dangerous alternatives when their legal rights are not upheld. The study emphasised financial constraints' ongoing socio-economic and health

consequences while calling for policy measures to improve affordability and accessibility.

3.3.6.2. Post abortion care

Increasing access to post-abortion care is vital in seeing a positive health impact of abortion for women. Chowdhary et al., (2022) highlighted that comprehensive post-abortion care prevents complications and facilitates women's physical and emotional recovery. However, the study found that stigma and restrictive laws prevent women from seeking the follow-up care they need, which puts them at greater risk for complications following an abortion. The authors also noted ethical concerns, including the quality and consistency of post-abortion care services, as healthcare systems in some regions lack the adequate resources to provide the necessary support.

Blystad et al., (2019) reported that post-abortion care availability is highly variable worldwide, owing to the legal and healthcare landscape in each region. In such narrow-minded environments, post-abortion services are often severely limited, further complicating recovery and increasing the risk of complications. The study emphasised the critical need to strengthen post-abortion care services and elevate their standards in restrictive legal settings to reduce adverse health.

3.3.7. Theme 2: Knowledge and Attitudes

There is a social determinant of a lack of understanding of safe abortion options and attitudes toward abortion (Atakro et al., 2019; Chowdhary et al., 2022; Blystad et al., 2020). Women's awareness and autonomic decision-making, along with the attitudes of healthcare providers, impact accessibility to safe abortion services.

3.3.7.1. Women's awareness and decision Making

However, awareness of safe abortion services and access to an informed choice is heterogeneous across regions. Atakro et al., (2019) found that many women in the Ashanti Region of Ghana are unaware of legal and safe abortion services. While legal frameworks are in place supporting access to abortion, the lack of awareness around

these provisions sends women in search of unsafe alternatives, often based on misguided knowledge.based on misguided knowledge.

Makleff et al., (2019) conducted a study in Uruguay and found 58% of women supported abortion rights but faced substantial barriers to their awareness of service access. Participants expressed that a greater understanding of legal changes and available healthcare options might empower them to navigate the system more effectively. It highlights the need for targeted educational interventions to improve awareness and improve access to safe abortion services.

Knowledge and external influences also play a role in decision-making about abortion. Gerdts et al., (2014) showed through a comparative study that women well-informed about safe abortion options showed more confidence and autonomy in reproductive health decision-making. In contrast, individuals with limited knowledge reported uncertainty, anxiety, and external pressure that restricted their decision-making process.

Similarly, Chowdhary et al., (2022) explore how restrictive legislation and societal stigma affect women in the Southern United States' ability to exercise autonomy in decisions surrounding abortion. The study found that pressure, often from family members and societal expectations, complicated decision-making for many women, sometimes leading to choices that did not align with their health needs.

3.3.7.2. Healthcare provider's attitudes

Healthcare provider attitudes are key in shaping women's experiences and access to abortion. Bain et al., (2019) explain that restrictive legal frameworks further foster negative provider attitudes, as evidenced by the judgmental behaviour and reluctance to provide abortion care exhibited by some health professionals. These attitudes make it an inhospitable space for women providing here, which discourages them from seeking care and may push them towards unsafe practices.

Blystad et al., (2019) observed the counterintuitive dynamics between abortion laws and healthcare provider perspectives; even in areas with permissive abortion laws,

providers can retain restrictive views that constrain their ability to deliver services. The study found that the lack of transparent laws means that providers in some places can impose their personal beliefs on patients, limiting access to safe services. These must be accompanied by standardised training and sensitisation efforts for healthcare professionals so that legal provisions can be translated into equitable and supportive access to abortion services for women.

3.3.8. Theme 3: Cultural and Societal Influences on Abortion Practices

Five studies (Atakro et al., 2019; Blystad et al., 2020; Burtscher et al., 2020; Bell et al., 2020) pointed to cultural and societal influences shaping abortion practices. Stigma, community norms and family expectations shape barriers to safe abortion access and affect women's decision-making behaviours.

3.3.8.1. Stigma and society judgement

Social stigma attached to abortion is still a significant obstacle to access to safe services. Atakro et al., (2019) women seeking abortions in Ghana's Ashanti Region experience stigmatising judgement from people in their lives, which is rooted in cultural and religious ideologies that frame abortion as a moral failure. Women are afraid of being shunned from their communities and families and will choose dangerous procedures rather than face public shaming.

The compounded vulnerability of women was further examined by Burtscher et al., (2020) in the Democratic Republic of Congo (DRC), where abortion stigma itself is interspersed with cultural expectations around womanhood and the necessity of being life-bearers. The study showed women's perceived utility is frequently attached to their capacity for childbearing, creating enormous pressure to see pregnancies to term, even in instances where abortion may be a safer or more feasible alternative.

Similarly, Chowdhary et al., (2022) explored how restrictive legislation and societal stigma affect women in the Southern United States' ability to exercise autonomy in decisions surrounding abortion. The study found that pressure, often from family

members and societal expectations, complicated decision-making for many women, sometimes leading to choices that did not align with their health needs.

3.3.8.2. Family and community influence

Family and community dynamics also shape women's reproductive choices. Blystad et al., (2020) illustrated how family expectations in Ethiopia, Tanzania, and Zambia dictate abortion decisions, with many women feeling pressured to conform to cultural norms around childbearing. In these contexts, reproductive autonomy is often constrained by familial obligations, where a woman's decision is not solely her own but influenced by broader social structures.

Burtscher et al., (2020) similarly found that in the DRC, family members, particularly male partners and elder relatives, play a crucial role in determining whether a woman can access abortion services. The study revealed that many women undergo unsafe procedures to avoid familial shame, underscoring the tension between personal health choices and collective cultural expectations.

Atakro et al., (2019) also highlighted the emotional burden of disappointing parents or guardians, which prevents many women from openly discussing reproductive health options. This lack of open dialogue perpetuates misinformation and reinforces cycles of stigma and restricted access to safe abortion services.

3.3.9. Theme 4: Ethical Considerations Abortion Care

These three studies (Chowdhary et al., 2022; Blystad et al., 2020; Gerdts et al., 2014) identified key ethical dilemmas in abortion care, specifically conscientious objection among healthcare providers and informed consent and the provision of non-directive counselling.

3.3.9.1. Conscientious objection and provider's ethics

Ethical issues arise when the personal beliefs of healthcare providers clash with the ethical obligation they have as healthcare professionals to provide abortion services.

Chowdhary et al., (2022) addressed this difficulty. They noted that, although conscientious objection is legally protected in numerous areas, it could result in substantial obstacles for women accessing care. Where abortion is already limited, provider refusal compounds healthcare access inequities; it reduces the availability of legal services.

Blystad et al., (2019) took the analysis a step further, exploring conscientious objection in the context of liberal abortion laws. Even where legal, some providers enforce a personal moral or religious belief on patients that leads to a delay in or an outright refusal of abortion care, the study found. These results generate ethical questions about balancing provider autonomy and patient access to comprehensive reproductive healthcare.

3.3.9.2. Informed consent and counselling

Informed consent is a core ethical obligation intrinsic to abortion care. Gerdts et al., (2014) highlighted the need for women to be fully informed about the risks, benefits and alternatives before the procedure. Yet there are obstacles stemming from lack of counselling, misinformation and coercion that can result in uninformed choices and jeopardise the ethical standards of care.

Bain et al., (2019); legal restrictions in relation to abortion further complicate the ability to have an informed consent process. Healthcare providers face competing responsibilities to abide by restrictive laws and ethical principles of autonomy and patient-centred care. The study was envisaged as a delineator, calling for explicit directions to assist ethical decision-making in legally constrained environments.

Chowdhary et al., (2022) also noted the importance of non-directive counselling (ensuring that women are informed about their choices without pressure to follow one path). Ethical abortion care requires providers who will support women without pressure, allowing them to consider their choices freely. However, Blystad et al., (2019) study showed persistently unreported stigma and community pressures, prompting a need for systemic conditions that allow women to step forward for counselling in safe and healthy healthcare environments.

3.3.10. Theme 5: Policy and Legislative Climate

Four studies (Bain et al., 2019; Blystad et al., 2020; Dawson et al., 2018; Gerdts et al., 2014) explored the role of policy and legislative frameworks in shaping abortion access in restrictive legal contexts.

3.3.10.1. Restrictive legal frameworks and impacts

Restrictive policies around abortion are linked to high maternal mortality rates and push women into unsafe procedures. Bain et al., (2019) explored the legal framework within the jurisprudence of Cameroon, revealing that adopting restrictive policies had led to over 13% of maternal deaths being traced to unsafe abortions. At the same time, the study recommended policy reforms in India to meet global reproductive health standards, stressing the need to reform existing laws that did not place women's health and autonomy as the highest priority of laws governing reproductive healthcare.

When Brown et al., (2020) analysed the strict abortion legislation in the Southern US, they noted that while restrictive laws led to fewer abortion procedures, they also led to more individuals undertaking unsafe self-managed procedures. The authors called for evidence-based policies that acknowledge the socio-economic differences influencing women's reproductive choices.

3.3.10.2. Need for comprehensive and inclusive policies

Blystad et al., (2019), for instance, explore comparative differences in Ethiopia, Tanzania and Zambia, demonstrating how legal arrangements shape abortion access. The study found that even though Zambia's abortion laws are relatively liberal, bureaucratic obstacles and multi-signature requirements still restrict access. Conversely, the restrictive policies of Tanzania have resulted in the rise of informal abortion services, demonstrating the unintended consequences of legal restrictions. The authors advocated a more pragmatic approach to policymaking, ensuring that legal language drives genuine healthcare realities.

Berglas et al., (2020) examined the relationship between public health and legislative frameworks, arguing that although legal requirements create baseline standards, they often fail to reflect the complexities of reproductive healthcare. The study recommends the inclusion of evidence-based practices that integrate abortion services into broader reproductive health agendas, thereby reducing barriers to access and increasing availability to a wider population.

3.4. Discussion

This scoping review has identified several salient and controversial issues regarding termination of pregnancy (TOP). These comprise maternal death, denial of TOP services, stigma and judgment, legislative and policy barriers, and cultural beliefs and taboos. Similar social stigmas, coupled with fear of rejected access to safe procedures, lead women to seek underground services. Although some countries have relatively liberal abortion legislation, many, if not most, countries lack access to safe abortion services.

Gerts et al. (2015), for instance, stated that 2% of women requesting an abortion in Colombia and 45% of women in South Africa were being denied days of access to a legal, safe abortion. It calls attention to the persistent barriers to accessing safe abortion, a leading cause of maternal mortality and morbidity resulting from unsafe procedures. Coen et al. (2022) and further (2022) point out that when women cannot access safe abortion services, they seek unsafe dies. Referring to the reversal of Roe versus. Wade, Coen et al. (2022) observe that the withdrawal of a woman's constitutional right to abortion in several U.S. states is a denial of reproductive autonomy.' In the United States, women denied abortions can go to another state where it is legal. However, this option is commonly unavailable to low-income women, especially in resource-limited settings, where both transportation costs and stigma constitute significant barriers.

DePineres et al. (2017) identified several barriers that prevent women from obtaining safe abortion services in a timely and confidential manner, often pushing them to unsafe alternatives. Restrictive laws continue to be a major driver of maternal mortality and morbidity. A further theme highlighted in this review was the effect of

abortion-related knowledge and attitudes. Many women do not know that safe abortion services are available or if abortion is legal, which results in delays in seeking care or resorting to unsafe methods. Gerdts et al. (2020) highlighted how misinformation about the safety of abortion leads to reliance on informal provision, and Bell et al. (2020) are concerned with how misinformation impacts decision-making around abortion. Additionally, Atakro et al. (2019) identified that women who reported a preference for bearing children within marriage strengthened decisions on abortion-seeking behaviours.

How abortion is practised is shaped profoundly by cultural and societal forces. Women are often afraid of stigma from their communities and even judgment from health-care providers when seeking abortion services. Wubetu et al. The authors highlight how health-care providers' knowledge about safe abortion care did not override their biases toward supporting abortion in cases of rape or incest (2024). This contemptuous attitude prevents women from using even formal health-care services, allowing them to get treated by untrained providers. Hanschmidt et al. (2016) also emphasised how cultural norms and expectations can reinforce abortion stigma, resulting in secrecy and risk-taking from women seeking abortion services.

Ethical considerations in abortion care further complicate access to services. Some health-care providers exercise conscientious objection in performing abortion for reasons of religious or moral beliefs, perceiving the foetus as a human being (Harries et al., 2014). Although conscientious objection is legally protected in numerous contexts, it might hinder access to abortion care if there are no substitute providers. However, health-care providers who refuse to perform abortions are still obligated to treat women who encounter complications from abortions, like excessive bleeding. Belgas et al. (2020) noted that state health departments are primarily concerned with abortion law enforcement and assessing service availability, while local health departments work to connect women to services.

Forty per cent of the literature examined identified restrictive laws and policies as a barrier to abortion access. Compared to 13% noted the stigma against women who had abortions and the stigma experienced by providers of TOP. 13% of studies examined denial of abortion, one of which (Gerts et al., 2015) reported only 2% of women seeking an abortion were denied it, with a much higher incidence of denial

found in South Africa and Colombia, where 45% of women were denied care. Moreover, 13% of the literature reported complications in women after abortion. 7% found no significant differences in outcomes among women undergoing early medical abortions (EMA). By comparison, a further 7% said abortion rates did not decline as a result of not having access to contraception. Another 7% addressed the role of telemedicine in expanding access to abortion, enabling women to obtain care without crossing state or national borders.

Similarities and differences between our findings and those from previous reviews on the factors influencing the implementation of the TOP policy were identified within this review. Common themes included refusal of abortion care, stigma, abortion-related complications, and conscientious objection. Abortion care, globally, is still a controversial issue. Although abortion is legally entitled as a women's health right, many hurdles remain. As recently summarised elsewhere, one of the important differences highlighted in this review is that, while in South Africa, abortion is legal, access primarily suffers from the scarcity of private and public health-care facilities providing second-trimester abortion services. Although significant research and policy efforts have taken place, access remains limited to safe abortion.

Most of the research reviewed concluded that women's right to abortion was still being denied to them. Gerdts et al. (2014) called for policies and programs to improve access to safe abortion services as well as harm reduction strategies for women who cannot legally obtain an abortion. Restrictive laws continue to be a major hurdle in most nations. Still, even where abortion is legal under liberal terms, access can be difficult, especially for second-trimester services. In South Africa, 20% of abortions occur in the second trimester. However, services are limited to a few facilities (Harries et al., 2014). Legalisation does not guarantee that abortions will be provided entirely safely, but a legal context for abortion provision is an important step to reduce maternal mortality and morbidity (Mutua et al., 2018). Ghana, South Africa and Ethiopia, where abortion is legal, have shown reductions in maternal deaths from unsafe abortion.

Recommendations

This scoping review urges further study on the reasons for conscientious objection to TOP, as it remains a primary barrier to implementation. The conscientious objectors

are health-care workers and civil society groups involved in creating stigma around abortion care. Abortion was legalised in South Africa with the passing of Choice on Termination of Pregnancy (CTOP) Act No. 92 of 1996 (amended by CTOPA Act No. 1 of 2008). Yet even this liberal frame leaves room for contentious politics and demands policy action to shape the practice of abortion. Allies to streamline implementation: It is necessary to implement punitive measures to prevent individuals from obstructing women's access to TOP services.

Moreover, to mobilise abortion policies that effectively achieve the goals set forth, policymakers should engage all stakeholders and adopt a multi-actor implementation approach. Health system performance can only be understood considering the challenges of policy implementation (Campos & Reich, 2019). While governments formulate policies, their execution tends to remain troublesome. This study necessitated the lack of successful implementation of TOP policies within the Gauteng Department of Health (GDoH).

3.5 STRENGTHS AND LIMITATIONS

Despite conducting this review using robust methods, some relevant literature may have been unintentionally excluded by limiting it to only English. Only English language articles were considered, which could have affected results. Public bias may have also affected how the results were interpreted. Furthermore, this review followed the JBI model despite these limitations, enabling comparison to other work.

These findings highlight the need for policy changes to improve abortion access and lower maternal mortality and morbidity. Research on TOP policies in transitional countries is scarce, particularly with a focus on the implementation of policies and barriers to good practice (e.g. stigma, conscientious objection and access to second-trimester abortion services).

3.6 CONCLUSION

This chapter reports the results of a scoping review following the methodology described by Arksey and O'Malley (2005) and based on a fixed set of research questions. This review sought to assess the effect of abortion law availability on

women accessing abortion care. A multi-method approach was applied, including a scoping review with other studies comparing the results and the current study's findings. The approach used was explorative and descriptive to identify the factors influencing the implementation of the Termination of Pregnancy (TOP) policy in the Gauteng Department of Health (GDoH).

The scoping review found that restrictive abortion laws contribute to women seeking unsafe abortions. These laws did not deter women from seeking abortion services but instead drove women to turn to unscrupulous providers for unsafe abortions. Four common factors affecting the GDoH TOP policy implementation were found to be shared across the included studies. These reasons were stigma around abortion, denial of abortion services, conscientious objection from health-care providers, and complications due to unsafe abortion.

These study results suggest an unmet need for policy reform. Abortion laws are liberal in South Africa (where this study took place), and the law states that those who obstruct access to abortion services could be fined or imprisoned. However, there exists a gap between the law in theory and the law in practice and implementation, and this gap needs better bridging, along with more action and enforcement of the provisions of the Choice on Termination of Pregnancy Act (CTOPA).

Stigma, conscientious objection and denied access to abortion care are manifestations that threatened the effective implementation of the TOP policy. We need a multisectoral approach to strengthen our efforts for clearing the barriers towards ensuring access to safe abortion services as well as proper implementation of the TOP policy. Future research should further identify and elaborate on these factors influencing the implementation of the TOP policy. Abortion access in South Africa also needs policy reform.

This chapter presented the scoping review results, including findings and answers to the review questions. The following chapter will report the data collected from the semi-structured interviews with TOP providers, managers and doctors.

CHAPTER 4 FINDINGS FROM SEMI-STRUCTURED INTERVIEWS

4.1. Introduction

This chapter describes the findings of the semi-structured interviews where open-ended questions were put to the TOP providers, mangers and the doctors. Latent content analysis was conducted to identify themes and sub-themes that emerged from the participants' answers to questions that were asked.

The TOP providers were asked the following questions: "What factors do you believe impact on the successful implementation of the TOP policy by professional nurses and midwives providing TOP in Gauteng?" and "Are there any other challenges you face in trying to implement the policy?

The managers and the doctors were asked about challenges they experience, resources that they require and/or need and support received/required. While the questions differed from those put to the TOP providers, their responses were sufficiently similar to be categorised according to the categories and sub-categories developed for the TOP providers. The categories and subcategories of the TOP providers were therefore used to conduct a template analysis of the doctors and managers' responses. The findings of their interviews will be reported after those of the TOP providers.

The codes in this chapter refer to individual participants, for example, participant TP indicates TOP providers, MN represents managers and DP indicates doctors.

4.2 FINDINGS FROM THE TOP PROVIDERS' INTERVIEWS

Two categories with six sub-categories each were identified during analysis, as illustrated in the Table 4.1 below.

TABLE 4. 1.: CATEGORIES AND SUBCATEGORIES DERIVED FROM TOP PROVIDER'S INTERVIEWS

Categories	Sub-categories
Challenges providing TOP services	• Staffing issues • Equipment and supplies • Management support • Work environment • Stigma • Emotional stress
Factors impacting on policy implementation	• Access to second trimester abortion • Backstreet abortion • Opposition to TOP

4.2.1. Challenges providing TOP services

This category describes the range of problems providers of termination of pregnancy services face that significantly impact their ability to offer care effectively. These challenges often stem from resource constraints, lack of adequate support, and the emotionally taxing nature of the work. Additionally, the societal stigma surrounding these services can lead to a hostile work environment, further complicating the delivery of care. Together, these factors create a demanding and often unsustainable environment for providers, making it difficult to maintain high-quality service provision.

4.2.1.1. Staffing issues

Staffing emerged as a critical challenge in providing TOP (Termination of Pregnancy) services, with significant implications for the quality of care. Participants emphasized that a shortage of staff severely limited their ability to provide adequate TOP services. The combination of staff shortages and work overload made it difficult to ensure quality patient care. As one participant explained:

"When I'm not on duty, maybe I'm sick. On that day, my patients are not attended in the clinic, so it's better if maybe there are two providers so that if the other one is not

on duty, the service is continuing, but if you are alone working alone, then there's no one who's going to see the patient when the other one is not in." (TP 01)

The participants uniformly expressed the need for additional staff members to assist with the duties required to run a TOP unit effectively. They described feeling overwhelmed by the high demand for TOP services. One participant articulated this clearly:

"We are short-staffed, like we're seeing that now as you see me, I'm the only one who's providing this." (TP 12)

In the facilities where data was captured, this was a common theme with participants consistently expressing a desire for additional nursing staff to reduce their workload. Most of the TOP providers reported working alone, without assistance from enrolled nurses, nursing assistants, or clerks, despite managing over fifty (50) patients per week.

"It's only me who is trained here." (TP 01)
"My challenge is here one, I'm the only provider - we have only one to person provide TOP." (TP 12)

The overwhelming number of clients further exacerbated the situation, as highlighted by another participant:

"With regards to clients, we are overwhelmed because clients will be coming in numbers, and the most challenging problem is when we cannot offer the service that they are requesting." (TP 12)

As one participant explained:

"On estimation, walk-ins are so many, many, many, many. We can see, we can find them that 10 (ten), sometimes 80 (eighty) depending." (TP 12)

Another said, "It's the overloading, there's... a lot of people that are coming here, that is why we end up... cutting the number in a day." (TP 19)

TP 19 indicated an additional problem of patients coming to the clinic from other areas. She said, "We are having here is... a lot of people coming... to XXXX (name of the

CHC redacted) clinic for CT for choice on termination of pregnancy, procedures... coming from all walks of the country, and even from outside... the borders." (TP 19)

In addition to providing TOP services, these providers perform a range of nursing procedures, including taking vital signs, conducting ultrasound scans, and performing MVAs (Manual Vacuum Aspirations) and medical abortions. They were also responsible for washing and packaging instruments for sterilization. Furthermore, they manage additional services such as family planning and voluntary counselling and testing (VCT).

As two participants noted:

"I don't have any... admin to help with... the admin work, counselling, because we would like to also... screen all our clients for HIV. I don't send anyone to do that; I do it myself or we used in the clinic staff, it takes time." (TP 07)

"We are (also) doing family planning, and we are only two (2) professionals; we don't have the person who's gonna do the family planning. We also have to do the family planning, and to do family planning, it also takes time, so patients most of the time, the time waiting is too much because when we do the counselling, you must, the counselling took plus minus two hours and the patient is here from 4 o'clock, so the waiting time we are failing also on it." (TP 19)

TP 06 explained how the shortage of staff and work overload impacted on her personally. *"I'm not happy honestly, I am not happy at all because I'm a human being. I have to go for lunch. I have to eat. I have to make sure that my things as a nurse to provide good nursing care I have to provide a good nursing care are okay. … You know when you come up the stairs, you are seeing 21 to 26 patients alone sometimes you think, what if I can go to your doctor and put off for the whole week so that I can see what will happen?" (TP 6).*

4.2.1.2. Equipment and supplies

The provision of TOP (Termination of Pregnancy) services is heavily reliant on resources such as equipment, materials, and adequate space within health facilities.

Participants reported shortages of essential equipment such as MVA (Manual Vacuum Aspiration) packs, cannulas, and vaginal speculums, as well as supplies like linen savers, linens, and sanitary towels, all of which, they indicated, are vital for the safe and effective provision of TOP services.

This concern was illustrated by the following quotes:

"But they'll tell you that the cannulas are expensive. So really and truly, how are you going to perform if you don't have enough aspirators? Enough cannulas, and unfortunately, that's the challenge that I'm facing." (TP 06)

"OK, the equipment like the sonar machine, OK. We do need a sonar machine because some of the patients you cannot palpate." (TP 01)

Medication shortages were another significant issue, as described by one participant:

"Medication does run out, and you will find out that we are running around from different clinics because, uhm... I think we are the highest in doing TOP in terms of statistics, so we will be going up and down looking for medication." (TP 20)

Another participant highlighted a specific problem with mifepristone saying:

"Sometimes we don't have the mifepristone for the medical abortion, and then we must do the surgical for all the clients. And another thing that we do not have are the cannulas, yah, the cannulas." (TP 21)

The inadequacy of equipment and supplies severely hindered the participants' ability to provide safe and high-quality care. In some cases, the lack of proper sterilization agents further compromised patient safety. Two participants (TP21; TP 02) mentioned that they were using Biocide-D instead of Cidex, which is not recommended for the sterilization of equipment, thereby increasing the risk of infection.

"And the other thing we don't have is the sterilizing agent... [long silence]... The Cidex—we don't have the Cidex at all, at all, at all. We've been ordering from the pharmacy, we use uhm, Biocide. We clean with Biocide only." (TP 21)

"But lately I had a problem with the solution for... for... for equipment, for... to... to wash the equipment because the ideal clinic discourages us from using the Biocide." (TP 02).

4.2.1.3. Management support

Management support emerged as a significant challenge in the provision of TOP (Termination of Pregnancy) services. The support from management is crucial, given the high volumes of women seeking TOP services and the emotional strain experienced by the providers. However, the participants consistently reported a lack of support from their managers and supervisors, which left them feeling overwhelmed and neglected.

Participants expressed their dissatisfaction with the infrequent and insufficient support from management. As one participant noted:

"Maybe they come once a month." (TP 01)

When asked about the support received from her managers, another participant responded with a resigned tone:

"(A very big sigh) ... not at all. (giggles) Yeah, not at all." (TP 10)

Several participants emphasized that their interactions with management were limited to instances when there were complaints or when statistics were needed, rather than regular check-ins or support. One participant articulated this frustration:

"No, I don't—they don't support us; they just complain. We see them only if there is a complaint from any other patient. They don't even come and ask, 'Are you coping? What's the challenge?' They don't do that. We just see them when there is a problem only." (TP 16)

Another participant echoed similar sentiments:

"Personally, from our supervisors here, our managers here, I don't think we are getting any support at all. We are on our own, working. If we have problems, we tackle them on our own or maybe have to call other people outside of the clinic." (TP 18)

The sense of being disconnected from management was a common theme, as one participant remarked:

"It seems as if our management doesn't even know what we are doing, actually…." (TP 19)

This lack of engagement and support was further illustrated by another participant who expressed frustration:

"(A long silence then hitting the table) … and then our managers—they don't come and visit us, they DON'T (emphasizing). They just (inaudible) here, they just want the stats. They don't come to the facility, to the department, they don't." (TP 21)

In addition to the general lack of support, some participants felt that management was unsupportive due to an underlying bias against TOP services. One participant noted:

"TOP, it's... it's... uh..., it's legal, but some of our managements are anti-TOP." (TP 19)

The emotional toll of providing TOP services was significant, and participants expressed a strong need for emotional support from their managers. As one participant articulated:

"They must even support me emotionally. Just come to work and go home, come to work and go home, produce the stats... even to the district, there's no one who will say, 'Yoh! Why so many people?' And when you are alone and you are short of this and this and this, no one... at least emotionally, then." (TP 14)

The lack of managerial support was a common grievance among the participants, with only two reporting that they were satisfied with the support they received from their managers.

4.2.1.4. Work environment

Participants consistently reported significant challenges related to the working environment, particularly the lack of space and overcrowding in TOP units, which compromises patient privacy. A single room was often used for multiple purposes—pre- and post-procedure counselling, ultrasound scans, and the TOP procedure itself. This lack of dedicated space was a recurring concern among the participants.

TP 01 spoke of the lack of space in relation to compromised privacy for the patient:

"And the space…. also, the space is not enough for my patient. Like, for instance, if I'm having when I'm doing the group counselling, we don't have enough space here" (TP 01).

TP 07 conveyed a similar sentiment: "The space for one, the challenge here is just one room." (TP 07).

Some participants were of the opinion that the lack of space allocated for TOP was an indication that no one cared about the TOP service.

"We are still having a problem with building structure where I have been working. The building walls are falling and all the stuff they told us they gonna renovate till today it's almost three to five years now" (TP 13).

"*Right now, my challenge is space, of which is the structural problem. I have been in this mkhukhu (shack) for more than 15 (fifteen) years there are no improvement" (TP 14).*

"Really and truly it's uhm, the structure itself where we are doing the termination of pregnancy procedures. I feel that it's not well maintained. The broken furniture the doors without handles, you know, people can get injured while they are in our unit" (TP 20).

4.2.1.5. Stigma

The TOP felt stigmatised for the work they were doing indicating that others held negative and often unfair beliefs about them. The participants were judged by their fellow colleagues*:*

"Some people sometimes judge us like they think that you we are killers, that thing is not nice, to hear from your staff or from your managers (TP: 16).

*An*other participant confirmed the stigmatization they experience during their course of duty*: "they are stigmatizing me that I'm doing this evil work because of the er..,"(TP 13).*

The judgement and stigma related to performing TOP was taking its toll on the participant who was labelled a killer and a mortuary as attested by this quote: *"they usually call me and say how this today obalaile babakae (how many have you killed today? They even call me AVBOB (TP:9)".* Another participant shared the same sentiments, *"maybe, because they label this place, they do label this place a lot" (TP 21).*

“They also label us as killers, so they don’t, some they don’t they are anti-TOP through religious beliefs”). (TP19).

They indicated that the same stigma affected their patients which affected the service because some of the women would not come to them for safe TOP but would rather go to the unscrupulous providers where they were not going to be judged.

“The client here are stigmatized. They have been called names, so that's why now we try to integrate a CTOP into family planning into women's department where you are going, you will not be noticed whether you are going to be seen a CTOP a patient” (TP 02).

The stigmatisation affects TOP extends outside the workplace as illustrated by TP 09:

*“*It *affects me a lot. Now, most of the times you won’t find me outside the hospital even I don’t even go to the shop I’m always in the ward, because once I meet with them in the streets, they will start saying those names” (TP 0*9).

4.2.1.6. Emotional stress

The participants’ responses indicated a high level of emotional stress and burnout resulting from their work as TOPs. The emotional stress was caused not only by the nature of the work but also the lack of support already referred to in a previous category.

With regard to emotional stress caused by the nature of the work, TP 02 said:

“Eish, sometimes when you talk to the patient, it's so stressing like, for instance, if you come across with a rape case, it's so affecting me as individual, you know, how can this thing happen to, to this woman)” (TP 1).

“Because this thing that we are working with it’s a stressful thing and it affects us psychologically, and emotionally” (TP 16).

“*Hay, watsakeng? (you know what) I, I, don’t know I. Maybe I'm … But I what can I say? kana mona (here) we have burnout syndrome so I can’t think well sometimes it is as if I can work from 7 o’clock to 1 o’clock then this one of 7 o’clock to 16:00 every day sometimes I get exhausted”. “I don’t cope with my burnout, I think if ,if, it can be*

time what can we do? kana nne reetsa eng (by the way what were we doing?" (TP 09).

The stress and burnout were exacerbated by lack of debriefing sessions for the TOP providers. The participants mentioned that no debriefing sessions were done due to the financial constraints in the Gauteng Department of Health (GDoH). The participants emphasised that they were in extreme need of debriefing sessions as they were dealing with an emotionally draining service.

TP 09 illustrated this point saying:

"I think …debriefing sessions if they be at least quarterly or se,, wa bona ntho e,(do you see this thing") (TP 09)

TP 03 indicated that debriefing sessions for the Gauteng Department of Health were conducted by one NGO (IPAS SA) in collaboration with the GDoH but since the COVID -19 era this has changed.

"What is most lacking is the debriefing. Since COVID, we never had debriefing and I understand at some stage there was a there is a social worker in the hospital who was sent to us for all those things to discuss about. Debriefing, but it is debriefing ever works. So, the most thing that is lacking is the debriefing more than anything.". (TP 03).

4.2.2. Factors impacting on policy implementation

The implementation of termination of pregnancy (TOP) policies is often hindered by a range of complex and interrelated factors. These challenges can limit access to safe and legal abortion services, create disparities in healthcare delivery, and drive individuals toward unsafe alternatives. Additionally, societal, cultural, and political opposition can undermine the effectiveness of these policies, leading to inconsistencies in their application. As a result, the intended outcomes of TOP policies are frequently compromised, highlighting the need for a comprehensive approach to address the barriers that impact their successful implementation.

4.2.2.1. Access to Second trimester TOP

The Choice on Termination of Pregnancy Act No. 92 of 1996 gives all women the right to a free abortion (termination of pregnancy) at a government hospital or clinic during the first 12 weeks of pregnancy. Medical abortions can be done between four and nine (4 – 9) weeks gestation and surgical abortion up to twelve (1) weeks gestation. First trimester abortions are clearly preferable to the more invasive and potentially complicated second trimester abortions, but participants indicated that although the policy allows for first trimester abortions, the many delays, bureaucratic and provisioning challenges made the implementation of this aspect of the policy impossible.

As a result, the patients were only eligible for a second trimester abortion once they were granted access to termination of pregnancy but in Gauteng only six out of 26 hospitals with maternity offer second trimester abortion. Essentially this meant they were denied the right to a termination of pregnancy.

TP 12 said, *"The most challenging thing is that when most of the hospital are not commencing second trimesters So once most of the hospital can commence second trimesters, I think our client will be assisted". (TP 12).*

TP 18 and TP 03 agreed saying,

"I think obviously by us having to have more doctors coming in that would attend, facilities being opened second trimester" (TP 18)

Uh, the challenges that I'm facing, number one is second trimester, because I'm working at xxxxx (name of the hospital redacted). So, it's only xxxxx hospital (name of the hospital redacted) that is offering second trimester services, of which all the other hospitals eh performing TOP. They are referring to xxxx (name of the hospital redacted). (TP 03).

Even in those hospitals that do offer second trimester TOP, there is limited bed capacity. Of the six (6) hospitals only one has four (4) beds, one has two beds, and the rest have one bed each. This status quo frustrates the TOP providers illustrated this point saying:

"Another challenge, we have a challenge of referral system as we don't have a referral system, those who are above 13 weeks we are referring them nowhere, we must see to it we don't refer to them so that's what is the problem we are having. And we see that we are failing the patients," (TP 19).

4.2.2.2. Backstreet abortions

One of the consequences of the above change is that patients then seek what are colloquially referred to as "back street abortions" or illegal and usually dangerous operations to end a pregnancy done by someone who is not medically trained. Five of the participants expressed concern about this situation:

"*Okay, it's a challenge because you will find out that they are desperately willing to do these abortions, and once we cannot assist them as they go to backstreet abortion, the challenge is they go to bogus doctors they are so desperate that they can go to anyone. Regards to clients we are overwhelmed because clients will be coming in numbers and the most challenging problem is when we cannot offer the service that they are requesting definitely they are going to they are requiring the service but you will find that due to Mhmm.., policies or protocols like we do up to twelve weeks, but we cannot assist them so once she is here and you cannot assist you can see that no, we put them in in, the dilemma because once she leaves this institution definitely they will go to backstreet abortions".(TP 12).*

"Will get those clients, ten of them of which if ten of them and per week we're doing six OK some of them they end up not qualifying. Going to Back Street because they can't wait". (TP 03).

"*Abortion backstreet and there are those doctors outside there who are killing the women" (TP 02).*

"If they don't return, obviously they will go into a backstreet abortion because they will come now being incomplete abortion, some with sepsis, then they end up going to theatre. With, with their wombs removed, so for health reasons, it's not right," (TP 04).

"They are going backstreet it is obvious, and they come here with ICA" (TP 19).

Participants also referred to the many patients who suffer complications as a result of these illegal or backstreet abortions.

“I can say they are because when they come back, they go to casualty, but the rate of the MVA's that are done by the doctors for whatever the incomplete miscarriages, you can see that it's because of this” (TP 03).

“That's why some of them will end up with having total abdominal hysterotomy done to them because they end up going to those ladies. I don't know those sell Cytotec at the street” (TP 04).

“We are trying to minimize the maternal deaths because last year there were er..., maternal deaths where the numbers were increasing the number were increasing last year uh...,” (TP 09).

4.2.2.3. Opposition to TOP

While only one participant in the TOP group spoke of conscientious objection as such, others raised issues that impacted on the implementation of the policy that were related to values, beliefs and attitudes that hinder the efforts of the TOP to implement TOP.

One TOP provider expressed her frustration as she was left alone due to the other providers refusing to perform TOP as they were conscientious objectors.

She said, *“We were two that were trained one has just signed conscientious objection she says she doesn’t want it anymore so... so …I am left alone we have already trained one and that person resigned” (TP13).*

Religious beliefs of the staff in the workplace emerged as one of the factors that impacted on the successful implementation of the TOP policy. The participants expressed that:

“Some of them they don't want to come and work with me as a healthcare provider because they are of others, they say their religion that doesn't allow them to do the practice.” (TP 01).

“Eish they are personal things like religious things or cultural things and so we cannot er.., judge them if they are not for TOP then we can’t say anything.”(TP 14)

“What I would start with is uhm., the belief system that I think that impacts the policy of termination because what people believe in the society the norms and values what

they value, for example, I will give a example of er.., Christianity because I'm a Christian myself"(TP17).

"Uhm…, I don't think it's, it's something that could be resolved easily because it all start from our beliefs and (silence…) maybe what maybe what we believe in TOP is still something that other people still take as taboo so.., and religion, what yah what other people you can't force or change them to believe in what you believe in, though we all know kuthi(that) it has got nothing to do once you come in here our beliefs and uhm.., issues we should leave behind but I feel like it's still difficult for some people to be able to that to be able to cut the line between their religion and work". (*TP 18).*

4.3. Findings from the managers' and doctors' interviews

4.3.1. Challenges providing TOP services

The challenges remarked upon by the doctors and managers were remarkably similar to those mentioned by the nurses, indicating consensus about the issues.

4.3.1.1. Staffing issues

Doctors agreed that not only was there a shortage of nurses but of administrators, counsellors and doctors who, he believed, were necessary to provide a quality TOP service.

DP 1 said, "There *is only one professional nurse that's rendering the service. I don't have any … Admin (staff) to help with the admin work (or the) counselling, because we would like to also … screen all our clients for") (DP 1). "*

DP 2 supported DP1's contention that there was a shortage of doctors and further that he had informed management of this fact.

DP 4 went to some length to explain the problems relating to recruitment of staff for the TOP service. *" And it was it's a very good initiative then lets go - let's look for posts that are available (but) we can't even hire them. … When someone leaves (they) could convert the post (into a TOP post) but we are told … we are already short staffed as*

we are, so I can't just strain a service to accommodate a new service (referring to the TOP service)"

The shortage of doctors to perform TOP is exacerbated by some doctors refusing to conduct TOP's putting a strain on those who are willing to do so. This was explained by DP 4 who said, "*among us doctors there are doctors that they don't do TOP, they don't do TOP at all. When they arrive they will call you wherever you are meant to come because I accept and I like to do to save life wherever I am I would come to admit those patients." (DP 4).*

4.3.1.2. Equipment and supplies

The shortage of equipment and supplies mentioned by the doctors included medicines, stationery and clinical equipment.

DP 3 specifically mentioned the shortage of mifepristone indicating that patients were "complicating" due to the shortage of this medication. DP1 bemoaned the fact that due to a shortage of stationery, he was obliged to make his own photocopies. This doctor also referred to the shortage of clinical equipment, "*"We need equipment, because for the procedure to be done smoothly we need to have availability of aspirators, cannulas all the equipment that you need to use for the procedure" (DP 1).*

DP2 explained that the shortage of equipment and supplies was generalised resulting in the TOP staff having to "*fight for very limited resources".*

4.3.1.3. Management support

The two managers who referred to management support indicated they were aware they were not providing support. MN 1 had only recently become aware of this and referred to being shocked when she read the exit interview transcript of a nurse who was leaving the service to discover that it was due to a lack of support. She said, "*one of our staff members is resigning she's going to join the, the same clinic (TOP) at our local clinic so she is, she mentioned on her exit interview that there is lack of managerial support in terms of debriefing that's when I realized when I was checking her forms."*

The other manager (MN 2 was more up front about the issue saying, when asked if she gave the TOP providers support, said: ***(laughing)*** *"At the moment we don't. I don't. I don't want to lie (MN 2).*

4.3.1.4. Work environment

The lack of space for providing an adequate TOP service was mentioned by the managers and doctors, as it has been by nurses, but the doctors explained the impact of the space constraints in some detail.

"Many patients are coming but we do not have space, in the facility. We don't send them away we give them dates according and we have a limit, we don't do above 20 weeks and when someone comes she's let's say 16 weeks the book is already up to when we book her, we can't even book her because by the time we book her she will be 22 weeks 24 weeks we can't do that…the problem is that we have many patients, but we have less beds like in my hospital they give me only two beds. So, I am doing six per week when in my book I have 50, many patients so that disturbs me a little bit I am worried about it but there is nothing I can do the space is too small." (DP 4).

While DP 4 was working in a hospital, the same problem exists in the clinics. DP 2 who referred to the problems of aftercare said, "*…currently because we are running a T 1 service and it is at the clinic level I am not sure because there are 5, 6 beds there but the way they work is on a frequency based because those women are just lying there … we just keep we (theoretically) keep them for recovery but I don't know whether they are kept … because there is high turnover"(DP 2).*

A third doctor said, *""Specifically in our unit, we do not have enough space. To assist women daily. We have one room that's used as a waiting area for procedures, counselling of patients and post procedure management of patients". (DP 1).*

The managers expressed similar problems related to a lack of space. MN1 stated that the resources were available but there was a lack of space, and MN 2 explained that, "*At the moment we're having four (beds), but we end up with six (patients) sometimes" (MN 2).*

MN1 who worked at a tertiary hospital said that they too had problems related to a lack of space.

4.3.1.5. Stigma and emotional distress

The doctors involved in TOP services, as had the nurses, expressed similar problems related to feeling stigmatised for providing such a service, indicting this had a negative impact on their mental health.

"And another thing … we never take into account the people running the service, in terms of their mental health as well and us helping them - we don't want to be known as a someone who … is … killing babies. That stereotype must go because it also impacts the quality of running this service efficiently" (DP 2).

The issue of a lack of debriefing was raised by the doctors as it had been by the nurses. *"In the past Ipas SA (an external service provider) used to play an active role to support them with debriefing and all these things, but due to what I have heard from the office of the Director of Mother and Child (services) IPAS is gone. Currently what we do we give them I would say informal counselling; we take them out, from time to time when we got team building" (DP 2).*

The same doctor raised a concern that the patients themselves were not being offered counselling. He said, "*the very patients we are offering TOP for, they never are offered psychological counselling that is a big problem I was not aware of. Some of them this we might take it like as if they wanted the service … but it is grieving, and they go through that because of psychological harm. So, it's something that we will reconsider and look at it from the patients' side and also for the nurses. Currently it is voluntary to go to employment wellness on a regular basis, … but I want to change it to not be voluntary it must be mandatory because other people see mental health as a sign of weakness, but we must change this thing, and to reduce the stigma by saying it is mandatory". (DP 2)*

4.3.2. Factors impacting on policy implementation

While the doctors and managers, like the nurses spoke about the same factors that impact on policy implementation as did the nurses, not all spoke about the factors as impacting on policy implementation but rather on the consequences resulting from an inability to provide sufficient services.

4.3.2.1. Access to second trimester abortion

The doctors concurred with the nurses' views that lack of access to second trimester TOP was hugely problematic.

"But that in its own we found that the demand for first trimester (TOP) has actually doubled over the other year so, it comes like – it kills the implementation of the second trimester because now we found that we are so working backwards - not backwards but we are swimming against the tide because we are trying. Let's outsource but the numbers are so high that we can't even start anew easily because the demand is actually high, and the population has grown very significantly" (DP 2).

The issue of the population growth was raised by DP 1 who explained that "*In Gauteng especially for second trimester we do get clients who (come) from other areas of the province even cross border to access the service in our hospital" (DP 1).*

4.3.2.2. Backstreet abortion

Doctors and managers referred to patients going for so called "backstreet" abortions or unsafe abortions and the tragic consequences thereof, sometimes due to the fact that the provincial services were inadequate to cater for the number of people requesting TOP.

DP 2 said, "*They exercise their right to go to GPs (and) they go to backstreet, and this is seen by the high number of emergency hysterectomies we do for sepsis that is when we see that it is a challenge." I think we have three or four maternal deaths a month that were cases of the complications of sepsis or illegal terminations – they contribute to a lot of mortality. Last year (there were) five of the twenty maternal deaths. (DP 2).*

A nurse manager (MN 3) referred to a specific patient who died. She said, "*'we had one - she … turned out to be the maternal death She was a defaulter of ARVs, and I am sure it was (because she was) a defaulter - she came here with a low Hb so we didn't work on the Hb timeously. We started the procedure so the bleeding that occurred threw her out and there was that delay" (MN 3).*

Another nurse manager (MN 1) said, *"If they don't return, obviously they will go into a backstreet abortion because they will come now being incomplete abortion, some with sepsis, then they end up going to theatre. With, with their wombs removed, so for health reasons, it's not right," (MN 1).*

4.3.2.3. Opposition to TOP

Doctors mentioned that some of their colleagues were conscientious objectors, and they could even call the doctor who is dedicated in TOP provision to come and attend to the woman seeking abortion care. This doctor was quoted under the previous category of staffing but referred specifically to conscientious objection:

‘*'Among us doctors there are doctors that they don't do TOP; they don't do TOP at all". (DP 4)*

4.4. Conclusion

In this chapter the findings from the interviews with staff members have been described. In the following chapter the results from the audit of facilities will be described.

CHAPTER 5: FINDINGS FROM THE AUDIT OF THE DEMAND FOR AND THE RESOURCES AVAILABLE FOR THE PROVISION OF TERMINATION OF PREGNANCIES

5.1. Introduction

This chapter describes the findings of the document review of the demand for termination of pregnancy at each of the health establishment included in the sample for this study as well as the findings of the audit of the resources available in those facilities for the purposes of providing terminations of pregnancy.

The methods used to collect the data for this phase of the study were described in chapter two where it was explained that data was collected from a total of 20 health care establishments, namely 13 community health centres, 1 primary health clinic and six hospitals.

A structured checklist was used to collect the data from the registers at each clinic but due to the poor quality of record keeping in some of the health establishments some of the data was missing. Some aspects such as whether contraception was offered post-abortion were not noted in the registers and while they may have been noted in the patient files, it was not possible to access the files due to the sheer number of requests and the poor state of the patient file storage. All the data provided in this chapter was retrieved from the patient registers.

The objective for this phase was: To audit the demand for, and the resources available in the GDoH for the provision of TOP.

5.2. The hospital data

5.2.1. Number of TOP requests

The requests for termination of pregnancy at six hospitals providing second trimester terminations of pregnancy over a period of three months from November 2023 to January 2024 were audited.

A total of two thousand three hundred and eighty-three (2383) TOPs were requested over the three-month period. The number varied considerably between health

establishments and from one month to another as seen in table 5.1 and figure 5.1. below.

TABLE 5. 1.: NUMBER OF TOP REQUESTS PER HOSPITAL

	H 1	H 2	H 3	H 4	H 5	H 6	Total
November	286	144	200	219	26	71	946
December	215	106	99	192	40	18	670
January	209	104	121	229	22	40	725
Total	710	354	420	640	88	129	2341

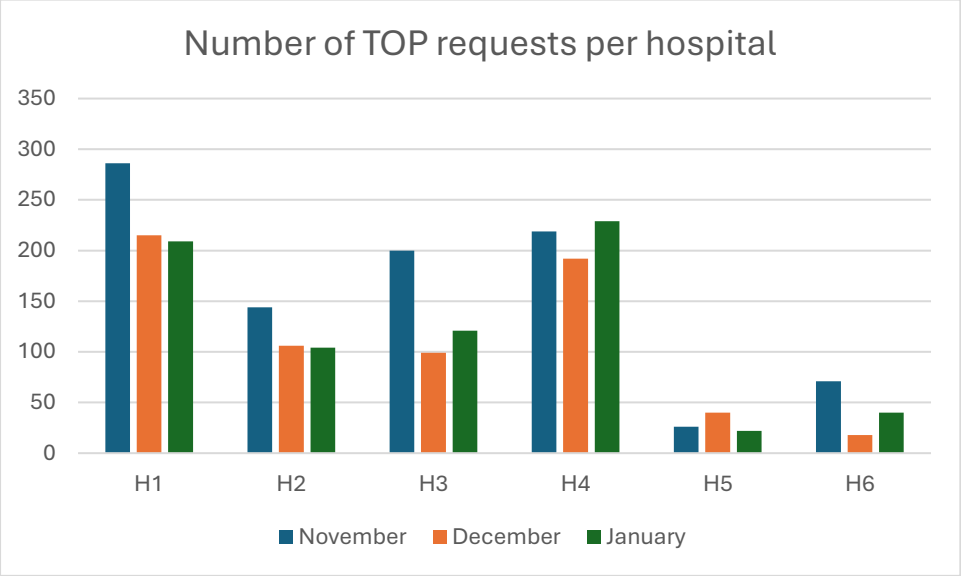


FIGURE 5. 1.: NUMBER OF TOP REQUESTS PER HOSPITAL

5.2.2. Staffing availability

The number of requests for termination that can be managed depends on the staff available. The following table indicates the number of requests for termination for each of the three months in relation to the number of nursing staff available for those periods. At the hospitals, the TOP services are offered for 7 hours Mondays to Fridays and 5 hours on a Friday. The calculations in the table below are based on the number of working hours that were available per month and indicate how many requests for termination were managed per hour per nurse.

The calculation is as follows:

Clients per hour = Total clients / Total hours

TABLE 5. 2.: AVERAGE NUMBER OF CLIENTS SEEN PER HOUR

		H 1	H 2	H 3	H 4	H 5	H 6
November	Number of requests	286	144	200	219	26	71
	No available nurses	1	1	1	3	1	1
18 Full 4 Fri	Number of working hours in the month	146	146	146	438	146	146
	Average no. clients seen per nurse per hour	2,0	1,0	1,4	0,5	0,2	0,5
December	Number of requests	215	106	99	192	40	18
	No. available nurses	1	1	1	3	1	1
14 full 5 Fri	Number of working hours in the month	123	123	123	123	123	123
	Average no. clients seen per nurse per hour	1,8	0,9	0,8	1,6	0,3	0,2
January	Number of requests	209	104	121	229	22	40
	No. available nurses	1	1	1	3	1	1
18 Full 4 Fri	Number of working hours in the month	146	146	146	146	146	146
	Average no. clients seen per nurse per hour	1,23	0,7	1,6	1,6	0,2	0,3

Note: At **H1, H5 and H6** where surgical TOPs are done, the nurse assists one doctor at each of the sites.

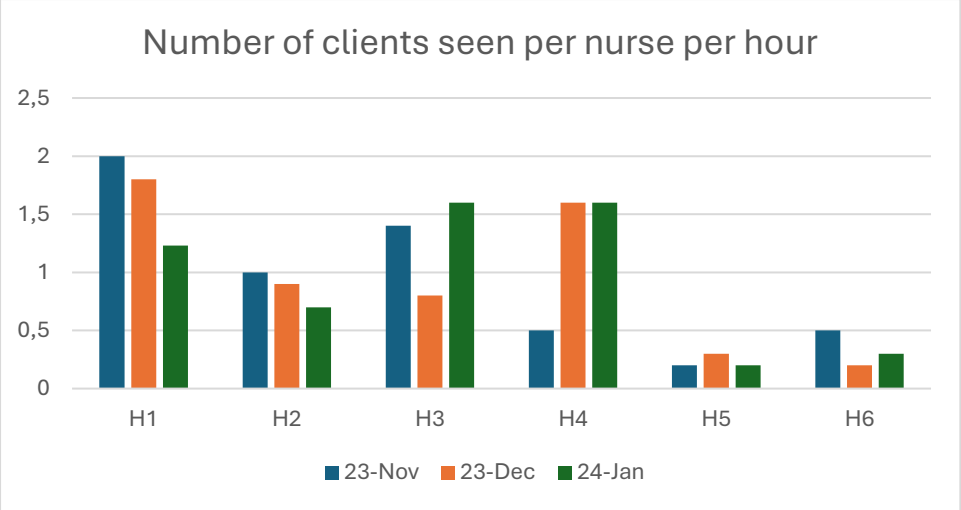


FIGURE 5. 2.: NUMBER OF CLIENTS SEEN PER NURSE PER HOUR

5.2.3. Ages of clients requesting TOP

The health establishments are required to record the age of the patient seeking TOP. Hospital H5 did not record this data. The table below (Table 5.2) shows the average age of the patients seeking TOP as well as the age range of patients seeking TOP in the hospitals where this data was recorded. The youngest patient of all the hospital patients was 10 years of age and the oldest 46 years of age. The average age of patients differed little between hospitals.

TABLE 5. 3.: AGE RANGE OF PATIENTS SEEKING TOP AT HOSPITALS

	H 1	H 2	H 3	H 4	H 5	H 6
Average age	27,4	25,5	27,4	27,7	Not recorded	26,2
Maximum age	46	43	45	45	Not recorded	45
Minimum age	10	12	15	14	Not recorded	14
Age 40-49 (%)	11.8	2.5	3.6	2.2	Not recorded	3.1
Age 30-39 (%)	22.7	26.3	35	31.3	Not recorded	25.6

Age 20-29 (%)	48.9	50.0	47.4	51.8	Not recorded	41.1
Age 10-19 (%)	16.6	21.2	14.0	14.7	Not recorded	30.2

5.2.4. Marital status of, and reasons for, clients requesting TOP

Another requirement in terms of the CTOP guidelines is that the marital status of the client be recorded. Hospital H1 recorded all clients as single. Hospital H2 recorded three (3) clients as divorced, and the rest single. Hospital H3 recorded ten (10) patients as married and the rest single. Hospital H4 recorded four (4) as married and the rest single. The marital status of the clients was not recorded at two of the hospitals viz. H5 and H6.

The reasons for requesting TOP were either left blank in the register or were completed as "social."

5.2.5. Race and occupation of clients seeking TOP

A further two requirements of the CTOP guidelines is that the race of the client and their occupation be recorded. This was not done at any of the hospitals.

5.2.6. Number of previous pregnancies prior to request for TOP

The data regarding the number of previous pregnancies prior to request for TOP was not well recorded and was missing in several clients' entries in the register. The one hospital (H5) did not enter this data for any of its clients. Of the hospitals that did record previous pregnancies, the data in the following table (5.3.) indicates the percentages of entries that were not completed for this aspect of the register.

TABLE 5. 4.: PERCENTAGES OF MISSING DATA REGARDING PREVIOUS PREGNANCIES

	H 1	H 2	H 3	H 4	H 5	H 6
Percentages of missing data re. gestational age	18,2	0	3.6	1,7	100	6,2

The following data was recorded at each of the hospitals that did record the gestational age of pregnancies of clients.

TABLE 5. 5.: NUMBER OF PREVIOUS PREGNANCIES PRIOR TO REQUEST FOR TOP EXPRESSED AS PERCENTAGES

Gravida	H 1	H 2	H 3	H 4	H 5	H 6
0	17,2	37	21,2	26,2	Not recorded	46,3
1	16,5	28,6	23	25,3	Not recorded	25,6
2	18,2	19,8	31,1	29,2	Not recorded	17,4
3	18,5	9,3	16,8	12,2	Not recorded	3,3
4	14,6	4,5	5,4	5,6	Not recorded	5,8
5	9,0	0,8	2,5	0,5	Not recorded	0,8
6	3,1	0	0	0,2	Not recorded	0,8
7	2,1	0	0	0,8	Not recorded	0
8	0,5	0	0	0	Not recorded	0
9	0,3	0	0	0	Not recorded	0

This same data is expressed as a graph in Figure 5.3. below.

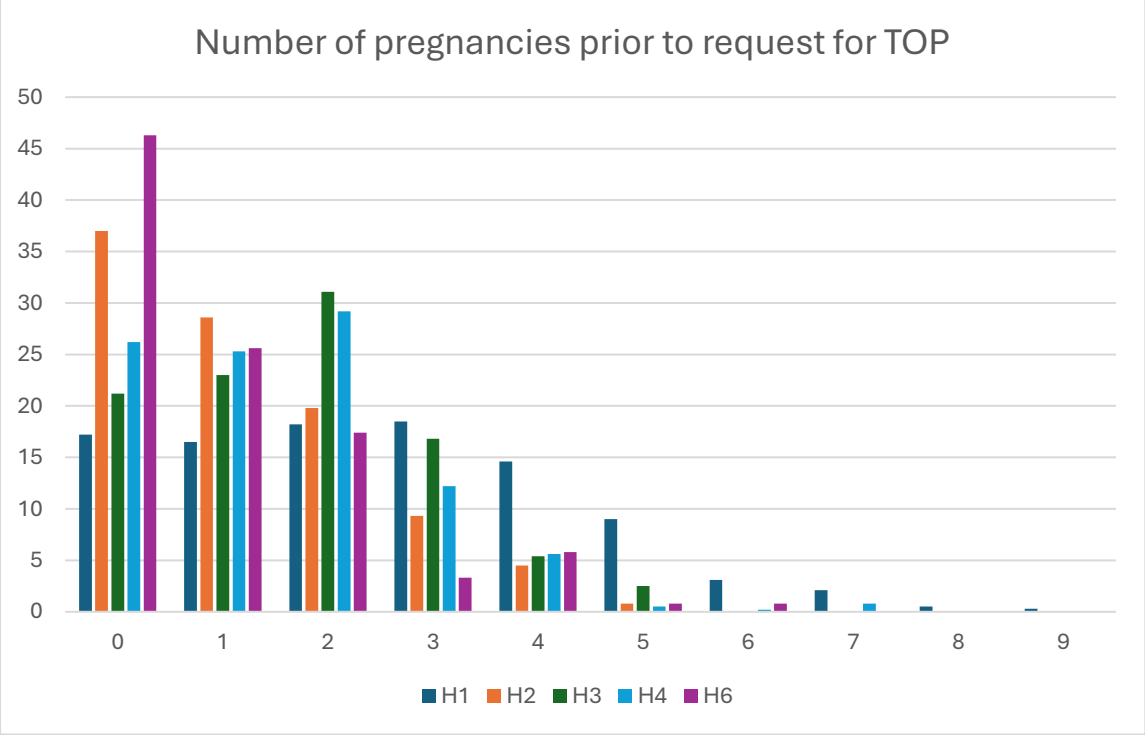


FIGURE 5. 3.: NUMBER OF PREGNANCIES PRIOR TO REQUEST FOR TOP

Nulliparous women accounted for the highest number of women seeking abortion as illustrated in table 5.5 above. Nulliparous women comprised 33% of women seeking abortion at Ghana and Nigeria (Chae et al. 2017). Hospital H5 did not record the data.

5.2.7. Gestational age of pregnancies at the time of request for TOP

The data regarding the gestational age of the foetuses of clients seeking TOP was recorded at the health establishments although many individual records did not have this information recorded. The percentages of the gestational ages of foetuses of clients who sought TOP at the six (6) hospitals that were recorded can be seen in table 5.6 below.

TABLE 5. 6.:THE PERCENTAGES OF THE GESTATIONAL AGE OF THE FOETUSES OF CLIENTS WHO SOUGHT TOP AT THE SIX HOSPITALS

	H1	H2	H3	H4	H5	H6
Not pregnant	1,5	1,4	0,0	0,0	0,0	0,0
≤ 6 weeks	12,5	11,3	20,2	16,4	0,0	0,8
7-12 weeks	45,6	68,4	79,8	81,4	1,1	20,2
13-18 weeks	18,3	8,2	0,0	0,0	89,8	65,1
19-24 weeks	3,0	5,4	0,0	0,0	9,1	7,0
25&26 weeks	0,1	0,0	0,0	0,0	0,0	0,0
>26 weeks	0,7	0,6	0,0	0,0	0,0	0,0
Not recorded	18,2	4,8	0,0	2,2	0,0	7,0

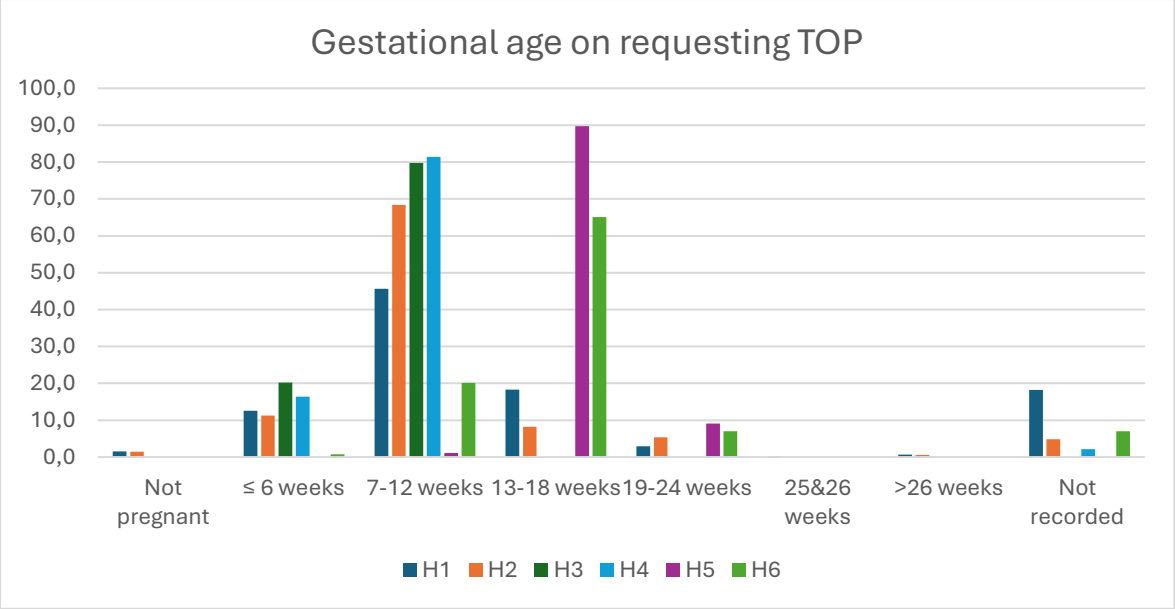


FIGURE 5. 4.: PERCENTAGES OF GESTATIONAL AGE OF CLIENTS SEEKING TOP

5.2.8. Audit of resources available for TOP at hospitals

An audit of the resources available at the hospitals was conducted using the audit tool in Annexure 2B which is based on the requirements in the guidelines of the CTOP. The hospitals were well equipped with the only exception being equipment for dilation and evacuation which has been replaced by MVA so the former procedure is not practised, and commonly hospitals did not have a list of facilities to which patients could be referred. The latter was unnecessary at hospitals 1 ,5 and 6 as they are referral units. Hospitals did not have recovery rooms for post procedure care. Instead, patients are “recovered” in their admission beds.

5.3. The clinic data

5.3.1. Number of TOP requests

The requests for termination of pregnancy at eight (8) clinics providing first trimester terminations of pregnancy over a period of three months from November 2023 to January 2024 were audited.

A total of two thousand eight hundred and twenty-three (2823) TOPs were requested over the three-month period. The number varied considerably between health

establishments and from one month to another as seen in table 5.7 and figure 5.5. below.

TABLE 5. 7.: NUMBER OF TOP REQUESTS PER CLINIC

	C1	C2	C3	C4	C5	C6	C7	C8	Total
November	165	52	0	113	17	330	48	142	867
December	122	47	0	51	98	276	57	121	772
January	0	63	95	84	128	383	71	360	1184
Total	287	162	95	248	243	989	176	623	2823

This same data is expressed as a graph in Figure 5.5. below.

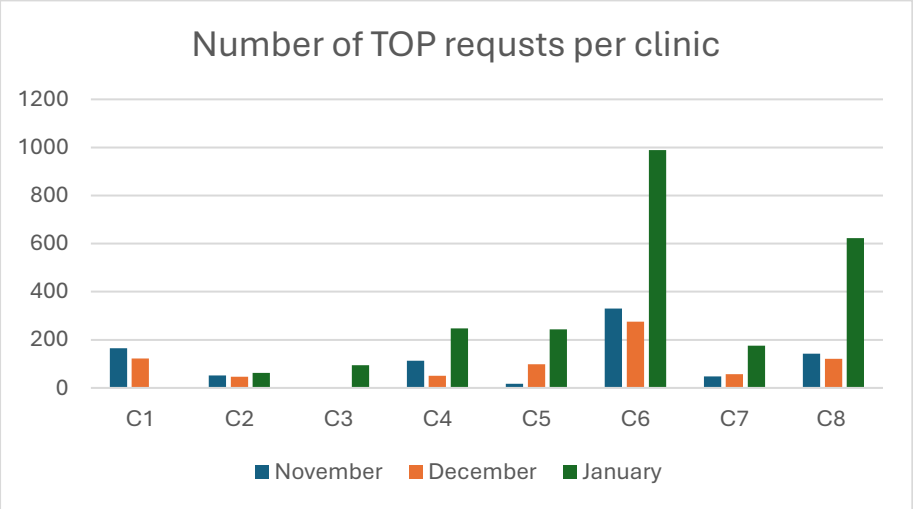


FIGURE 5. 5.: NUMBER OF TOP REQUESTS PER CLINIC

The highest number of TOP requests were at clinic C6, followed by and clinic C8. The geographic location of Clinic C6 is in the city.

Where no requests were recorded, the TOP provider had been on leave or only available some of the time. Table 5.7. gives further details regarding the availability of TOP providers.

5.3.2. Staffing availability

As in the hospitals, the number of requests for termination that can be managed depends on the staff available. Calculations of the ratio of staff compared to the number of TOP requests was more difficult in the clinics as in some cases, when the TOP provider was on leave there was a relief, but on other occasions no relief was available. The following data was calculated per week rather than per month and while the number of hours the TOP providers were available is fairly accurate, there are some discrepancies as not every month has 4 weeks. Thus, in C5 the table indicates 17 TOPs were requested in November, but these were managed in the week that "overlapped" from the previous month when the TOP provider was still available. The ratio for this month has therefore not been calculated. As for the hospitals, the TOP services are, at least in theory, offered for 7 hours Mondays to Fridays and 5 hours on a Friday.

TABLE 5. 8.: AVERAGE NUMBER OF CLIENTS SEEN PER HOUR

		C 1	C 2	C 3	C 4	C 5	C 6	C7	C8
Novembe r	Number of requests	165	52	0	113	17	330	48	142
	No available nurses	1	1 for 3/52	0	1	0	2	1	2
18 Full 4 Fri	Number of working hours in the month	146	110	0	146	0	292	146	292
	Average no. clients seen per nurse per hour	1,1	0,47	0	0,77	NC	1,1	0,33	0,49
Decembe r	Number of requests	122	47	0	51	98	276	57	121
	No. available nurses	1	1 for 3/52	0	1 for 2/52	1	2	1	2
14 full 5 Fri	Number of working hours in the month	123	110	0	61	123	246	123	246

	Average no. clients seen per nurse per hour	1,0	0,42	0	0,84	0,80	1,12	0,46	0,49
January	Number of requests	0	63	95	84	128	383	71	360
	No. available nurses	0	1 for 2/52	1	1	1	2	1	2
18 Full 4 Fri	Number of working hours in the month	0	73	146	146	146	292	146	292
	Average no. clients seen per nurse per hour	0	0,86	0,65	0,58	0,88	1,31	0,49	1,23

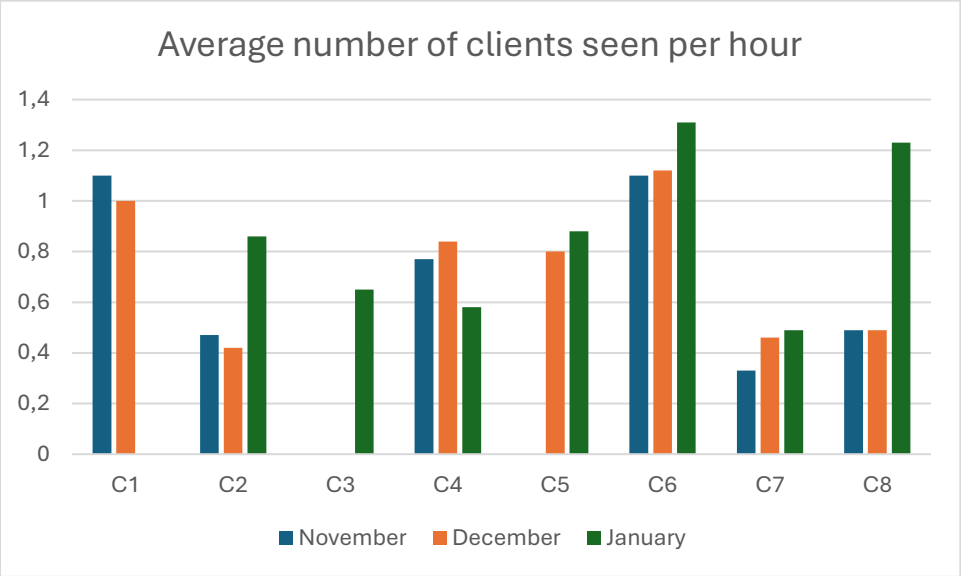


FIGURE 5. 6.: AVERAGE NUMBER OF CLIENTS SEEN PER HOUR

5.3.3 Ages of clients requesting TOP

Despite it being a requirement to record the age of clients seeking TOP, on seven (7) out of eight (8) clinics recorded their ages. The table below (Table 5.8) shows the average age of the patients seeking TOP as well as the age range of patients seeking TOP in the clinics. The youngest patient of all the clinics was 12 years of age and the

oldest 48 years of age. The average age of patients differed little between clinics. Clinic C2 and C5 had some missing data and Clinic C8 did not record this data at all.

TABLE 5. 9 AGE RANGE OF PATIENTS SEEKING TOP AT THE CLINICS

	C1	C2	C3	C4	C5	C6	C7	C8
Average	26,30	27,25	27,12	28,32	25,51	27,57	25,45	Not recorded
Minimum	15	16	15	15	14	14	12	Not recorded
Maximum	45	48	46	46	43	47	43	Not recorded
Age 10-19 (%)	18,5	14,2	22,1	11,7	24,3	11,0	22,3	Not recorded
Age 20-29 (%)	50,5	48,7	38,9	50,4	45,3	49,6	49,1	Not recorded
Age 30-39 (%)	28,6	30,9	32,7	31,0	21,7	36,1	26,3	Not recorded
Age 40-49 (%)	2,4	3,7	6,3	6,9	7,8	3,3	2,3	Not recorded
Not recorded (%)	0	2,5	0	0	0,9	0	0	Not recorded

5.3.3. Marital status of, and reasons for, clients requesting TOP

Three (3) of the eight (8) clinics in the study recorded the marital status of the women requesting TOP. Clinic C1 recorded all clients as single. Clinic C4 recorded seventeen (17) of the ninety-five (95) clients as married (17,9%) and the rest single. Clinic C5 recorded two clients as married (0,82%) and the rest single.

The section for the reasons for requesting TOP was either left blank (as was the case for the hospital data) or the reason was recorded as “social”.

5.3.4. Race and occupation of clients seeking TOP

A further two requirements of the CTOP guidelines are that the race of the client and their occupation be recorded. As with the hospitals, this was not done at any of the clinics.

5.3.5. Number of previous pregnancies prior to request for TOP

There were several instances where the clinics had not recorded the number of previous pregnancies of the clients requesting TOP. Two of the clinics, namely C2 and C8 did not record this data for any of their clients.

The table below shows the number of previous pregnancies prior to the request for TOP i.e. the data does not include the current pregnancy. The data for the two clinics that failed to record this data has been omitted from the table and the following figure.

TABLE 5. 9.: NUMBER OF PREVIOUS PREGNANCIES PRIOR TO REQUEST FOR TOP EXPRESSED AS PERCENTAGES

Prev Preg	C1	C3	C4	C5	C6	C7
0	28,91	28,42	20,97	39,32	26,9	31,25
1	28,57	25,26	24,6	28,63	30,23	35,8
2	22,3	23,16	29,44	17,95	27,1	21,6
3	12,55	9,47	13,3	5,98	11,02	8,52
4	6,27	2,11	7,26	3,42	3,34	1,14
5	0,7	0	1,21	0,86	0,91	0,56
6	0,35	1,05	0	0,43	0,1	0
7	0	0	0,4	0	0	0
NR	0,35	10,53	2,82	3,41	0,4	1,13

This same data is expressed as a graph in Figure 5.7. below.

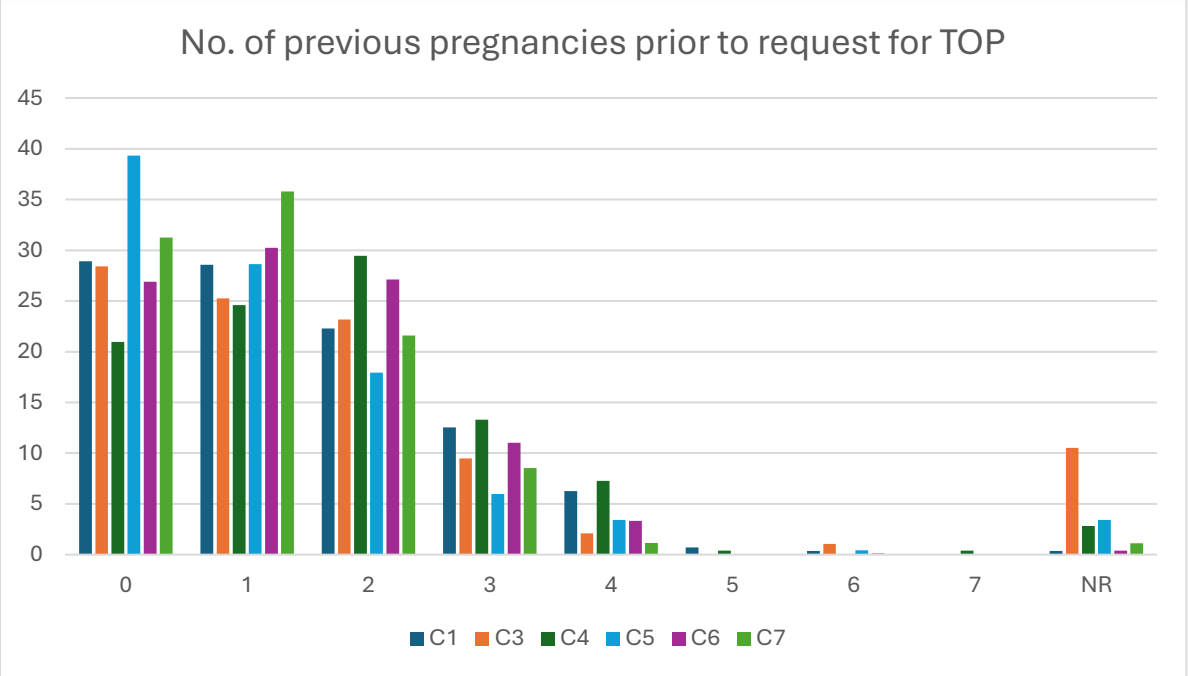


FIGURE 5. 7.: NUMBER OF PREVIOUS PREGNANCIES PRIOR TO REQUEST FOR TOP EXPRESSED IN PERCENTAGES

Nulliparous clients and those who had had one previous pregnancy accounted for 29,3% and 28,8% of the requests respectively with those who had had two previous pregnancies accounting for nearly as many i.e. 23,6%.

5.3.6. Gestational age

The data regarding the gestational age of the foetuses of clients seeking TOP was recorded at the health establishments. The percentages of the gestational ages of foetuses of clients who sought TOP at the eight (8) clinics that were recorded can be seen in table 5.12 below.

Three clients presented at the clinics with pregnancies that were already close to viability namely one at C1 with a 26 weeks pregnancy and two at C6 with 26 weeks pregnancies.

There were discrepancies in the records relating to the gestational age of the foetus as the age was first calculated according to dates and then the client was examined, and the findings did not always match the dates. Where possible the data collected used the results from examination of the client.

TABLE 5. 10.: THE PERCENTAGES OF THE GESTATIONAL AGE OF THE FOETUSES OF CLIENTS WHO SOUGHT TOP AT THE EIGHT CLINICS

	C1	C2	C3	C4	C5	C6	C7	C8
Not pregnant	0,3	1,9	1,0	0,4	1,7	5,1	2,3	2,1
≤ 6 weeks	0,3	2,5	9,5	14,1	21,7	21,8	13,7	7,6
7-12 weeks	68,3	40,7	64,2	51,2	51,3	35,9	22,3	34,2
13-18 weeks	11,1	11,1	10,5	20,7	6,1	24,8	13,7	8,9
19-24 weeks	4,1	2,5	6,3	4,0	1,7	4,6	3,4	1,1
25 & 26 weeks	0,3	0	2,1	0,4	0	0,7	1,7	0,3
>26 weeks	0	0	0	0	0	0,5	0,6	0,5
Not recorded	3,0	41.3	4.2	2.0	13.0	5,7	18.9	39.8
Inconclusive	12.5	0	2.1	7.2	4.3	1.0	23.4	5.4

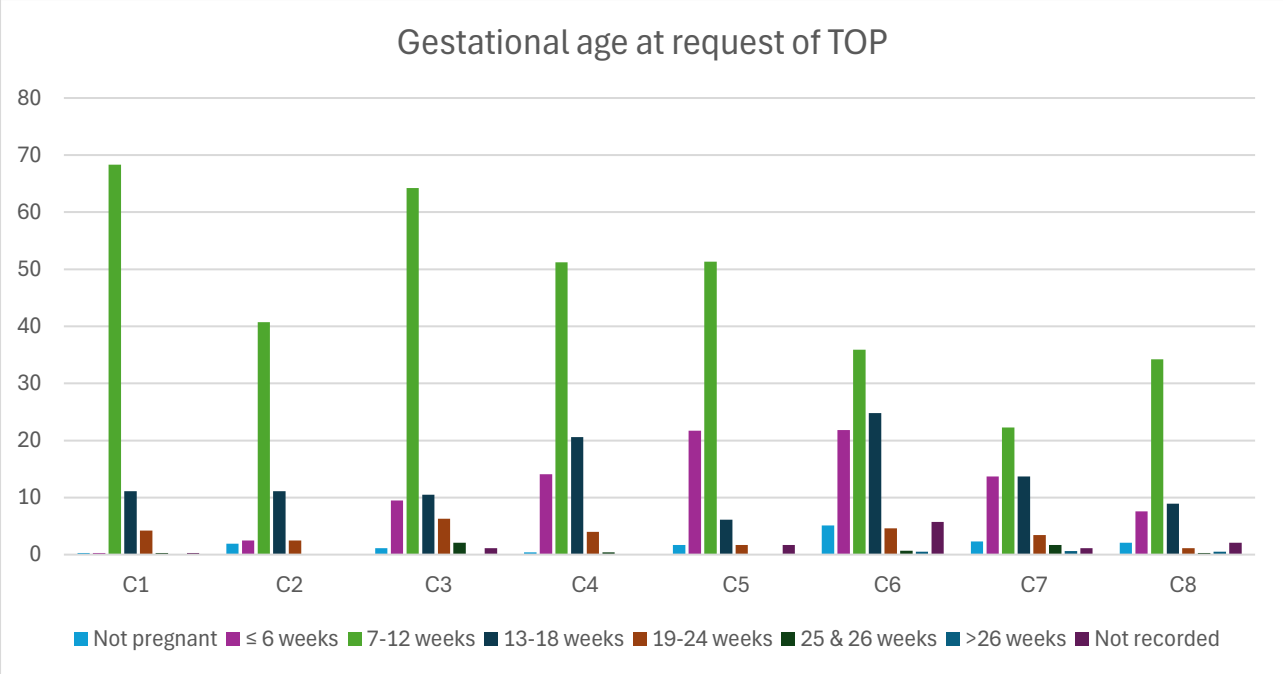


FIGURE 5. 8.: THE PERCENTAGES OF THE GESTATIONAL AGE OF THE FOETUSES OF CLIENTS WHO SOUGHT TOP AT THE EIGHT CLINICS

The following table shows the percentages of clients' gestational age when presenting at the clinics.

TABLE 5. 11.: PERCENTAGE OF CLIENTS PRESENTING ACCORDING TO GESTATIONAL AGE

	Percentage
Not pregnant	1,85
≤ 6 weeks	11,41
7-12 weeks	46
13-18 weeks	13,36
19-24 weeks	3,46
25 & 26 weeks	0,69
>26 weeks	0,2
Not recorded	16
Inconclusive	7

The vast majority of clients presenting at the clinics do so between 7- and 12-weeks gestational age. The registers indicate that many of the clients who did present in the first trimester were rebooked to come back two weeks later when some of their pregnancies would already be in the second trimester. Many however present after twelve weeks despite the clinics only conducting first trimester TOPs'.

5.3.7. Audit of resources available for TOP at the clinics

An audit of the resources available at the clinics was conducted using the audit tool in Annexure 2B which is based on the requirements in the guidelines of the CTOP.

The clinics were well equipped with the one exception being equipment for dilation and evacuation which has been replaced by MVA, as the former procedure is no longer practised. Commonly clinics did not have a telephone. Facility managers of those clinics that do not have a landline have a departmental cell phone and one provider mentioned that she uses her own cellphone for work related matters. The clinics did not have a list of facilities to which patients could be referred but they all refer to their nearest hospital that offer TOP.

5.4. Discussion of the findings of the audit of requests for TOP

Verifying the validity of the data collected was difficult due to the incompleteness of many of the records and the fact that no uniform register is used for recording patient information. All the hospitals and the clinics had a form of register, but the information recorded differed from one health establishment to the next and none complied fully with the requirements of the guidelines in terms of what needs to be recorded for patients.

The age of the patient and the gestational age were the two most recorded aspects data for all the hospitals. In the clinics, the age of the patient was record in most instances but there was much missing data relating to gestational age. Contraceptive used post- abortion was also not recorded at any of the health establishments.

When examining the total number of requests for TOP for the six hospitals, it shows that the largest number of requests occurred in November, the least in December and then another increase in January. In the clinics however, the number of requests for TOP are more or less the same in November and December but there is a marked increase in January.

In searching for an explanation for the larger number in the hospitals November, the researcher considered that students and scholars may wish to go home to their parents over the festive period and fear of judgement from the authoritarian parents. However, as the demographic data did not include the clients' occupational status or educational status, this remains unproven. Ndwambi & Govender (2015) did however find a statistically significant relationship in their study between the women's age and two reasons which they gave for choosing to terminate the current pregnancy, namely the need to focus on their studies and the conviction that their family was already complete. Given that in the researcher's study, the largest grouping of clients was in their twenties, it is possible that a wish to focus on their studies is a possible factor in their decision to request termination of pregnancy. The reasons for seeking termination of pregnancy are likely to be multi-factorial.

Kheswa and Takatshana, (2017) argue that female students tend to abort the pregnancy when they have been impregnated by married men. The authors further state that university students opt for abortion in order for their studies not to be affected. Masanabo, Govender and Bongongo, (2020) affirmed that women cited the

reason of focussing on completing their studies before giving birth to secure good financial position to be able to care for the child. Additionally, the authors alluded that the parents who have strong religious or cultural beliefs were the ones who coerced their children to abort the pregnancy for fearing stigma from society of their children giving birth out of wedlock.

The relatively small number of terminations requested in December in hospitals may be due to young people leaving the Gauteng during this period and the reduced number of working days the health establishments were open for non-emergencies during this period. The relatively small number of requests for TOP in clinics in November and December is most likely linked to the availability of the clinic TOP providers as there were several clinics with TOP providers on leave in November and December.

Harries and Constant (2019) reported a shortage of trained and willing TOP providers in South Africa. The shortages appear to be deeply felt in the clinics where there is usually only one TOP provider and no relief available when he/she is on leave or not present for any reason. This situation is likely to deteriorate with time as a compounding factor is the general shortage of professional nurses in the health system. Those willing to be trained will therefore decease proportionally.

With regard to the ages of client seeking TOP, the majority (41,1%) seeking TOP in the both the hospitals and the clinics were between the ages of 20 and 29. A similar findings was made by Ndwambi & Govender (2015) who found that, in their study in Tshwane, 45,2% fell into this age category. Bearing in mind that the hospitals perform where second trimester TOPs, this is surprising in the light of the findings of Azimirad (2023), that teenagers requested TOP late in their pregnancy. However, in the same study the authors suggested that it is most common for the teenagers to seek prenatal care late in pregnancy or no prenatal care at all. In the researcher's study, it also became clear that as a result of late requests, this grouping of clients was referred to antenatal clinic as it was too late for a TOP. A common myth is that teenagers choose to keep their baby in order to get a childcare grant in South Africa. However, no evidence could be found to support this notion. The relatively few teenagers requesting TOP in the first trimester at the clinics may indicate they choose to keep their babies rather than seek TOP or, alternatively there may be fewer teenagers having unwanted

pregnancies compared to those in their twenties and thirties. No evidence could be found to support either possibility.

While this study did not establish reasons for requesting termination of pregnancy due to the lack of recording of this aspect, or entries that simply stated “social” other studies on the reasons given by women in Gauteng for requesting termination provide some insight into this issue. Ndwambi and Govender’s study (2015) conducted in Tshwane, indicate these reasons include conflict with partner, financial difficulties, and lack of a committed relationship with the partner, all of which can be considered as social reasons.

Steyn et al (2018) conducted in Soshanguve, also in Tshwane, also found financial difficulties and problems with partners as reasons, and added the need to complete formal education, contraceptive failures, wrong timing and reasons relating to existing family to the list of reasons for requesting termination.

An even more recent study, this time conducted in Soweto by Mabetha et al (2022) categorised the reasons for requesting termination on two levels – individual and interpersonal. The individual level reasons also included financial insecurity and added lack of readiness for a pregnancy, the impact on employment, and pregnancy related physical and mental conditions. The interpersonal reasons also included lack of support or stability with a partner, lack of family support and the threat of adverse impact on the existing family dynamics.

When considering the reasons given, it is clear that the women did not choose to be pregnant for a variety of mostly social reasons, but this does raise the question of why they did not use contraception or, if they did, why contraception failed.

Coleman et al (2021) determined that reasons included discordance between the woman and her partners relating to contraceptive use, inconsistent or unsuccessful contraceptive usage, concerns about side effects, logistical barriers to accessing contraception and concerns about community stigma, including nurses, around sexual activity. Several participants in their study indicated that they did not believe it (pregnancy) would happen to them.

This would indicate a failure on the part of the health to educate women and provide accessible contraceptive services. Mushwana et al (2023) indicate possible reasons include poor access to health clinics, awkward operating hours and bad attitudes of

nurses. They also suggested that the failure of the school nursing programme may have resulted in teenagers not receiving health education on sexual health and prevention of pregnancy.

An area of concern revealed in the researcher's study is that 65 (2.3%) teenagers between the ages of 10-19 years request TOP in their second trimester and three (3) requested TOP at 26 third trimester 26 weeks and 28 weeks respectively resulting in them not accessing TOP but being referred to Antenatal care. The reason for this is unknown but may be due to reluctance to accept they are pregnant or reveal that they are to their parents.

Azimirad (2023) confirms that adolescent pregnancy is a major is a big public health challenge. This author suggests that the number decreases in the presence of improved better public health efforts but remain a serious problem in many parts of the world – both rich and poor. While stating that the reasons vary in each community, teenage pregnancies tend to be higher in communities with lower education levels or unstable economies.

The findings in this study indicated that the majority (46,3%) of women requesting termination of pregnancy at the hospitals were nulliparous (Para 0), followed by those having had one previous pregnancy (25,6%) and 17,4% with two previous pregnancies. In the clinics, the numbers of clients requesting TOP was evenly spread between nulliparous women and those who had had one of two previous pregnancies (25,1%, 24,9% and 20,5% respectively) A study by Jones et al, (2014) conducted in the United States of America that showed that the majority (60,2%) of women requesting terminations of pregnancy had two or more previous pregnancies and 28,5% had no previous pregnancy. An Australian study (Edvardsson et al, 2024) showed similar findings in that only 10% of women requesting termination of pregnancy were nulliparous. Other studies look at the relationship between previous requests for termination and the current request for termination, but this information is not required in the South African regulations although it may be more useful than knowing how many previous pregnancies the woman has had. It is difficult to compare the findings of the studies by Jones et al (2014) and Edvardsson et al (2024) with the findings of the researcher's study as the socio-economic conditions of women are likely to influence when they fall pregnant and whether they choose to terminate the pregnancy or not. The fact that the majority of women in the researcher's study seeking

second trimester TOP being nulliparous may relate to age and life stage, lack of experience and concomitant anxiety about having a baby, as well as socio economic factors and access to information and family planning services. It is however interesting that it is not the youngest grouping of women (below the age of 20 in the researcher's study) that requested termination of pregnancy but rather those in their twenties who presumably had longer opportunity to fall pregnant.

The gestational age at the time of termination has profound influences on the individual client as well as the health services. According to the CTOP Guidelines, medical termination can be conducted on request of the client for pregnancies of twelve weeks or less. According to the guidelines, "A combined regimen of mifepristone with misoprostol is the preferred regimen for medical TOP. It is more effective and safer, with success rates of over 95%, continuing pregnancy rates of less than 2% and complication rates of 3% up to 13 weeks + 0 days gestation.)On the other hand) the misoprostol-only regimen, … has a lower success rate at 85%, with continuing pregnancy rates of 3-10% and complication rates of 4% up to 13 weeks + 0 days gestation. The combined regimen of mifepristone and misoprostol also results in faster completion of TOP and is associated with fewer side effects than misoprostol only."

Home-use of misoprostol (up to 10 weeks + 0 days gestation) following provision of mifepristone at a health care facility may be offered as this "can improve the privacy, convenience, and acceptability of services, and has been shown to be safe and effective".

The guidelines further state that "after 10 weeks + 0 days of gestation, medical TOP should be undertaken in a health facility only and that clients should remain in-facility until the expulsion of pregnancy is complete. These services are offered at primary health care clinics.

Vacuum aspiration is the recommended technique of surgical TOP for pregnancies of up to 14 weeks + 0 days of gestation. Manual vacuum aspiration (MVA) uses a hand-held aspirator to generate a vacuum. The aspirator is attached to cannula ranging from 4 to 14 mm in diameter and can be used in multiple settings, including those without electricity. This service is only provided at hospitals.

It is clear, just from reading the guidelines that the earlier the client requests the termination the better as there it is quicker, less traumatic and more cost effective for the health care services.

The data for the hospitals, which deal mainly with second trimester TOP indicate an average of 49,4% of women requesting TOP at 7 to 12 weeks and 30,2% at 13 to 18 weeks. Add data of the clinics The data for the clinics which deal with first trimester TOP indicate an average of 46% requesting TOP at 7 to 12 weeks and 13,36% at 13 to 18 weeks. Those requesting TOP at less than six weeks was 11,41%. All the reasons put forward by Mothiba et al (2020) for women requesting termination of pregnancy impact on how early in the pregnancy they choose to seek a TOP. These include views related to rection and response of family members the health care professionals, and their personal circumstances. Chances are that if a woman has support for her decision to terminate and she trusts the health professionals, she is more likely to seek TOP earlier rather than delaying it for as long as she can.

In the current study, some women requesting TOP early were booked to come back later because the TOP providers had a quota for the maximum number of women they could assist in any one day. Anecdotal evidence showed that some of the women did not return, and the records were then recorded (particularly in the H6 data) that they were defaulters. By delaying the time of the TOP some of the women were no longer eligible for a medical termination of pregnancy thus increasing the social and health care risks.

5.5. Conclusion

Despite some health establishments where the study was conducted keeping incomplete records it was possible to develop a demographic profile of the clients requesting TOP. The profile is not dissimilar from studies in other South African studies. It would appear that both the clinics and the hospitals have sufficient material and human resources to manage the number of requests for pregnancy at their respective health establishments. The difficulty at the clinics is that while one TOP provider would seem to be sufficient to manage the number of requests, there are other factors at play including the absence of a relief system. The qualitative phase of the study identified other issues that are impacting on the efficient and compassionate

process of managing TOP's. The following chapter will present the findings from the triangulation of the data which is where these tensions and issues become evident.

CHAPTER 6 TRIANGULATION OF THE DATA FROM SCOPING REVIEW, THE AUDIT OF THE DEMAND FOR, AND RESOURCES AVAILABLE, FOR TOP, THE INTERVIEWS OF PROVIDERS AND MANAGERS

6.1. Introduction

In this chapter the data from the four phases of the study will be triangulated in order to answer the research question which was: How can TOP policy be better implemented in the services in the GDoH to align the implementation of the Gauteng province TOP guideline with the CTOP (Act of 1996) as amended by the CTOPA 2008?

Walt and Gilson's Policy Triangle (1994) was used to guide the process of triangulation. As shown in the figure 6.1.below, the data collected was used to explain the context, the process, the content and the actors involved in the implementation of the CTOP policy. Through this process the strengths and weaknesses of the policy and its implementation were explored, lessons learned were derived and recommendations made to better implement the policy and align the implementation of the CTOP policy with the guidelines.

6.2. Objectives of the phases of the study

There were four objectives of the study which were:

- To review international literature on factors affecting implementation of TOP policy. Phase 1
- To explore and describe the TOP providers, managers and doctors' perceptions of factors impacting on the successful provision of TOP services in Gauteng Phase 2.1
- To explore and describe the managers and doctors' perceptions of factors impacting successful provision of TOP services in Gauteng Phase 2.2
- To audit the demand for, and the resources available in the GDoH for the provision of TOP Phase 3

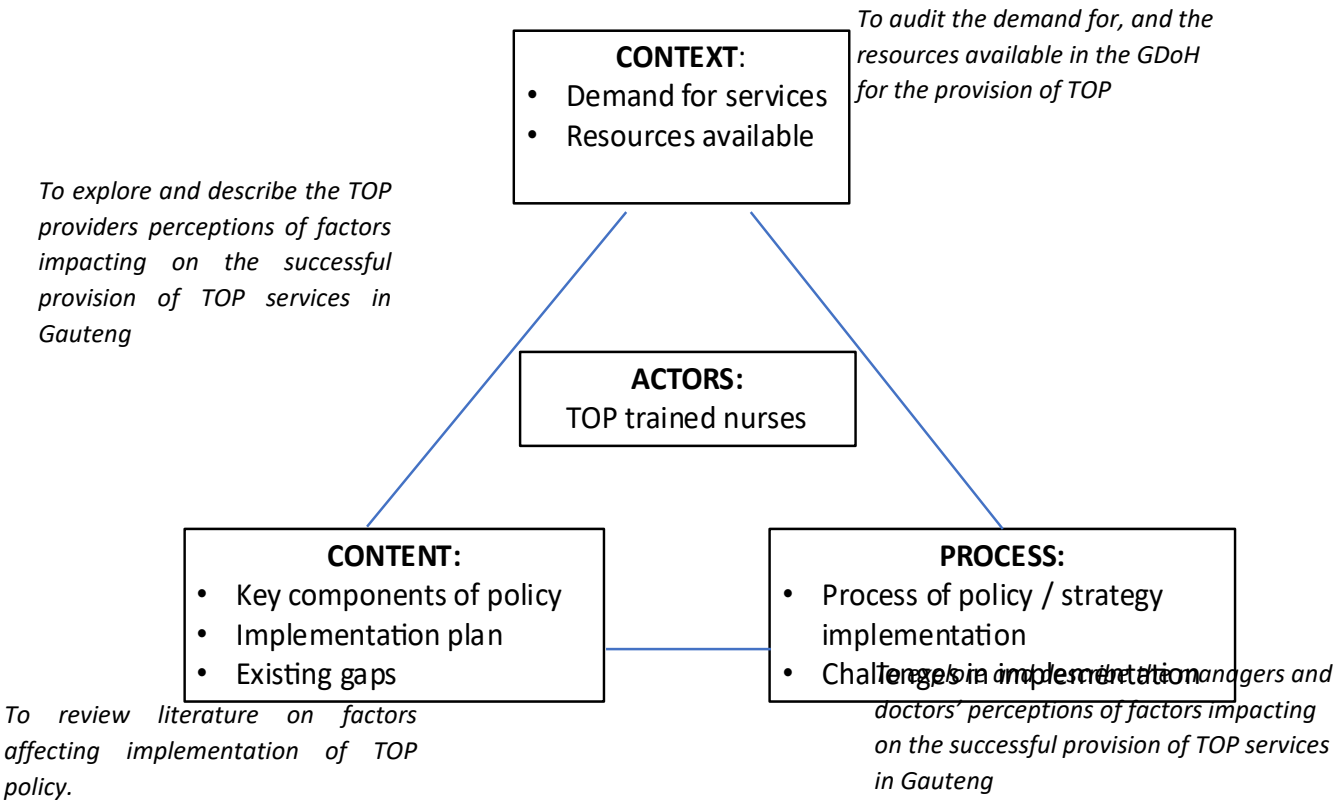


FIGURE 6. 1.: ADAPTED POLICY IMPLEMENTATION TRIANGLE (WALT AND GILSON, 1994)

6.3. Lessons learned from the phases of the study

As explained in chapter 2; by using Walt and Gilson's framework to organise the data during the process of triangulation, the researcher was able to identify important aspects of policy implementation in order to develop the recommendations for the study. The first step in the triangulation of the data was the development of a table of "lessons learned" from the various phases of the study. Once this was done the researcher was able, through an iterative process guided by her supervisors, to conduct a deeper analysis of the collective data.

The table summarising the lessons learned can be found in table 6.1. below.

TABLE 6. 1.: LESSONS LEARNED FROM THE PREVIOUS PHASES OF THE STUDY

Phase	Aspect covered	Objective	Lessons learned
1	CONTENT	To review international literature on factors affecting implementation of TOP policy.	• Access to TOP services should be facilitated by removing legal barriers, providing services closer to clients and removing any financial constraints. • Ensuring accessibility to TOP services requires a multi-pronged approach by policy makers. • Accessibility should be given not only to TOP services but to contraception services. • Failure to facilitate access to safe abortion services results in an increase in illegal abortions and subsequent health consequences. • Informed consent is very important for the women accessing abortion, they need to be aware of what the procedure entails. • Health care providers have an ethical obligation to inform women about their options related to TOP. • Awareness campaigns about safe abortion to be conducted. • Negative attitudes of health providers and community members create a barrier to women seeking TOP. • Cultural and societal influences such as judgement, stigma and family pressure make it more difficult for women to seek TOP. • Health providers exercise their right to conscientious objection which limits the number of providers willing to be trained and to provide a TOP service.

			• Further studies that address factors which prevent the implementation of TOP in specific communities should be conducted. • Penalties should be applied to people preventing women from accessing a TOP facility.
2	CONTEXT	To audit the demand for, and the resources available in the GDoH for the provision of TOP	• Facilities and supplies are largely available in the GDoH TOP services for the provision of TOP services although this is disputed by participants in SSI. • There are few private comfortable areas for clients to wait and/or to receive counselling and treatment. • There is no standardized record keeping of the women seeking TOP • Records are often incomplete • Patient files are inaccessible due to poor storage and retrieval system which causes delays to providing a service.
3	ACTORS	To explore and describe the TOP providers' perceptions of factors impacting on the successful provision of TOP services in Gauteng	• TOP providers believe they are short-staffed, despite only seeing an average of one patient an hour. • TOP providers, particularly in the clinics, work alone, resulting in a feeling of isolation. • Management support plays a crucial role in boosting the morale of the TOP providers but is sometimes lacking. • TOP providers feel a need to be supported psychologically and to be debriefed. • Stigma related to abortion continues to exist in the community and amongst health workers which creates a negative working environment for TOP providers. • Providers' negative attitude towards women seeking abortion causes them to access unsafe abortion or use clandestine methods for fear of being judged.

			• Renumeration of the TOP providers may assist in recruiting other nurses to want to offer the service.
4	PROCESS	To explore and describe the managers and doctors' perceptions of factors impacting on the successful provision of TOP services in Gauteng	• Conscientious objection is used as a reason for refusing to participate in TOP. • Values clarification workshops may be useful in addressing conscientious objection issues. • Quality TOP cannot be performed in an environment where space and bed capacity is limited. • Women still obtain illegal abortions and experience complications due to scarcity of available legalized services and/or other problems related to access. • Implementation of post abortion care by strengthening contraception services, particularly the long-acting reversible contraceptives (LARC) aimed at reducing the number of maternal deaths and the number of subsequent abortions. • Recruitment of additional doctors to perform abortion is required for second trimester TOP. • Reduction of maternal mortality and morbidity is crucial which can be achieved by accessibility of safe abortion. • There is a need for increased access to second trimester abortion • The practice of postponing TOP by requiring clients to return at a later date needs to end. • Women between the ages of 20 and 40 account for the majority of requests for TOP.

6.4. Discussion

6.4.1. Content of policy

In the paper by Walt and Gilson (1994) where they first suggested the policy framework used for the purposes of analysing the data in the researcher's study, the authors argue that, when reviewing a policy, emphasis is often put on the content of a policy and neglects the people (or actors) that are involved in policy reform, when much health policy wrongly focuses attention on the content of reform, and neglects the actors involved in policy reform as well as the context in which the policy is to be implemented and the processes followed to implement the policy. They point out that policy is "not simply about prescription or description, and nor does it develop in a social vacuum; it is the outcome of complex social, political and economic interactions". While policy can include some of these aspects in the actual content, many dimensions are often neglected.

The Choice on Termination of Pregnancy (CTOP) Act of 1996 South Africa is entrenched in the philosophy of reproductive rights and provides a framework for safe, legal abortions under certain conditions. It was one of the first pieces of legislation drafted and adopted by the new democratic government in South Africa and was a response to the historical context of apartheid, where women's rights, including reproductive rights were not recognised. While health professionals and women's organisations were involved in its development the organisations were those that represented a pro-choice stance and nurses did not play a significant role in the consultation process. This despite nurses being the health professionals who were "expected" to perform the majority of the TOP. Guttmacher et al (1996) stated in an article published soon after the promulgation of the Act that many were opposed to the legislation on religious grounds and there were rank and file members of the African National Congress (ANC) government who, although proponents of gender equality, were opposed to the CTOP Act as they were "devout Christians and Muslims. " The authors speculate that while the legislation was passed 209 to 87, with five abstentions and 99 absentees, "had the ANC allowed an open vote, the 1996 Act might not have passed by such a wide margin". There is little reason to believe that such divisions do not still exist in society today.

The Guidelines for implementation (2020) used in this study provide further detail as to how the Act should be implemented. It is not the content of these policies that needs revision, but it is the factors affecting implementation of the TOP policy that need attention. Kaswa & Yogeswaran (2004) remarked that “two decades since our landmark legislation was enacted, …women are still demanding the reproductive health rights that the law provides for them”. The scoping review in the researcher’s study identified challenges to implementation that are well known and yet the problems relating to access persist. Cultural and societal influences including social stigma remain a substantial barrier, often discouraging women from seeking the services they are entitled to, leading some to resort to unsafe procedures.

According to (Markleff et al. (2019 ; and Burtscher et al (2020), societal values and norms perceive women as child bearers and those seeking abortion were seen to be rejecting the identity of motherhood. Given this perception, no policy will be able to provide access to women for TOP unless such values and norms change.

It became clear from phases 2 and 3 of the study that specific aspects of the content of the Act and the guidelines are being ignored by many health professionals. An example of this is, despite it being mandatory for healthcare workers to conduct counselling regarding contraception to reduce maternal mortality and morbidity (Bain et al., 2018; Kabiru et al., 2016), there was no evidence that this is being done given the fact that this was not documented in the registers.

The Act provides a conscientious objection clause which is essential to protect the rights of health providers. The difficulty that arises is the clash between the rights of the women to request and obtain TOP within the criteria laid down in the Act, and the rights of the health workers to refuse to provide TOP. The content of the Act makes it clear that while health workers have this right, they cannot refuse to treat a woman who has already had a TOP and, as stated above they have an obligation to provide them with information about TOP. The issue is not what is written in the law but the implementation of the policy when health workers refuse, as is their right (set out in the same Act) to perform TOP. Should all health workers exercise their right to conscientious objection, no TOP service would exist and there is little doubt from interviewing the TOP providers that the service is already compromised due to the number of health workers exercising this right. The

scoping review suggested incentives to encourage more health workers to participate but this goes against the whole principle of conscientious objection.

It is clear that education of both the public and the health professionals that supports women's right to autonomy is necessary, but the question is whether or not education will change deeply ingrained prejudices and the seeming reluctance to comply fully with the content of the Act and the Guidelines.

Another problem that relates back to the content of the policy is the assumption that the district health care system, within which the CTOP Act must be delivered is functional. A study by Bresick et al (2019) demonstrated that the weakest aspects of the system are access, informational and relational continuity and awareness of services available to patients as well as the implementation of community orientated primary health care – all aspects needed to have adequate implementation of the CTOP Act and he guidelines. This too points to Walt and Gilson's (1994) mentioned earlier that the focus of any policy implementation study should not be on the content but on the actors, the processes and the context.

6.4.2. The context

In their policy framework (1994), Walt and Gilson say that context refers not only to a focus on the state (where policy is made) but it is also concerned with culture and the extent to which cultural factors impact on the implementation of policy.

In the researcher's study, the context includes the working environment of those actors who are involved with TOP. The audit which was carried out to obtain objective information resulted in differences to the perceptions of actors derived from the interviews held with them.

Edem et al (2017) indicate that the working environment includes physical factors, social factors, environmental factors and organisational factors and that these factors significantly affect health professionals' ability to perform their duties, influencing their motivation, productivity, and overall well-being.

The audit which was conducted using the requirements for offering TOP as a guide indicated that the resources were generally available as required. One common problem in the clinics related to communication with other facilities as they did not have a dedicated cell phone or landline. The only other common lack was that of referral lists but the staff knew where to refer patients and did not need such a list.

Presumably new staff members will be told about this, but this is a lack that should be remedied as it is an easy thing to correct. What was evident was the lack of space dedicated to TOP which made it difficult for TOP providers to offer a confidential service to their clients. The lack or, or uncomfortable seating was a further problem. The space problem is a difficult one to deal with given that the clinics are providing comprehensive primary health care and facilities are needed for all the facets of the broader service. Many of the buildings are old and some not purpose built compounding the difficulty of seeking solutions for the lack of space and privacy.

Judging by the responses of the participants in the researcher's study, it would appear that the GDoH is not budgeting for TOP services but rather using funds for competing priorities. One of the participants mentioned that she was performing the TOPs in *a mkhukhu (shack).* In two clinics the TOP unit is located at the same place as the antenatal care clinics which compromises the privacy of the women seeking abortion and must be distressing for the client seeking TOP. One of the academic hospitals had only four (4) dedicated beds for TOP and these are located in the gynaecological ward. The same can be said about a regional hospital that has the TOP service in a gynae ward. There was no recovery bed used for the patients after abortion, and they are taken straight to their admission bed. Teffo and Rispel (2017) who conducted their study in 2017 and mentioned the lack of space for provision of TOP and yet, to date, the status quo remains.

In the interviews, some participants mentioned that they sometimes do not have stock of mifepristone which is a cornerstone of the provision of TOP. The irregular supply of the medication has an impact on the provision of the service as clients' TOPs may have to be postponed pushing them over the limit for a TOP and resulting in an unwanted infant or an illegal abortion.

Zuma (2022) found that medicine stockouts are not uncommon in the public health sector which varied in the different provinces in terms of stock-out occurrence, duration and impact. Any systems problem relating to medicine management in the public health establishments impacts as much on the TOP service as it does on other health services. Zuma also found that there is a correlation between a higher stock-out occurrence and the absence of a pharmacy assistant in a facility. Based

on this finding, it would be important that pharmacy assistants are appointed in facilities offering TOP if this service is to be implemented effectively.

One of the participants, a doctor, stated that the absence of supplies results in what he referred to as a “fight for limited resources” which impacts on the quality of the working environment.

6.4.3. The actors

In the Walt and Gilson (1994) policy framework, the term “actors” refers to groups, organisations and individuals who play an important role in developing and/or implementing policy. As actors have their own interests and agendas they can, even unwillingly, affect how policies are formulated and implemented (O’Brien et al, 2020). Understanding these actors is essential for effective stakeholder analysis in health policy development.

In this study, the only actors studied were the TOP providers, the managers and the doctors involved with TOP. The problems identified by the managers and doctors was remarkably similar to those issues raised by the TOP providers in their respective interviews. Most of these issues related to the context in which they are working which is discussed in section 6.4.2.but the issues related to actors and context are intertwined as the actors cannot be seen separately from their working environment.

It was very evident from interviewing TOP providers, managers and doctors that the staff involved, both directly and indirectly, with the provision of TOP are stressed and demoralised. Whether this condition pertains specifically for those involved in the TOP services or whether it applies too to other health professionals in the GDoH was not something this study could demonstrate.

TOP providers believe strongly that they are understaffed and overworked. All the TOP providers stated that they needed extra staff members to assist with some duties and activities required for a TOP unit to run smoothly. Out of the eight (8) clinics where interviews were conducted, only two (2) of the clinics had two (2) TOP providers - the rest were operating with only one provider. The effect of having one (1) provider performing TOP, is felt when the provider goes on leave of any kind because the service cease to operate.

In this study, it was apparent the participants also believed that a TOP service could not function optimally without adequate provision of staff. There were duties that could be performed by clerks or nurse assistants, which would give the TOP providers more time to focus on their own work.

It was interesting to review the data from the audit in phase 3 in the light of these claims as they showed that, on average, TOP providers were only seeing one client an hour which does not appear to be excessive, especially for first trimester TOPs. It however became evidence from anecdotal evidence that while TOP providers were employed full time and therefore employed to work 40 hours per week, in reality they only see TOP clients in the mornings. Other evidence from the interviews was that they are also often required to provide family planning services, Voluntary Counselling and Testing for HIV (VCT), doing sonars, washing instruments and packaging them for sterilisation.

Other studies have also reported staff shortages as an impediment to TOP provision. A study by Teffo and Rispel (2017) conducted in the North West and Gauteng Provinces reported that participants suggested that the staff shortages were as a result of resignation and staff attrition, where those staff members were not replaced, and other staff were allocated in other programs other than TOP unit. The authors further attested that TOP was not seen as a priority hence the allocation of other staff members to programs such as primary health care (PHC). Additionally, Monanyane, Serapelwane and Manyedi (2024) affirmed that staff shortage was still a problem including in high-income countries which have shortages of providers in regional and remote areas.

The participants were unified in their wish for other category of nurses to be employed in their unit to reduce their workload. It was not clear from the data gathered what role the participants thought that these other categories of nurse would fulfil. There may be support functions that would be appropriate but whether enrolled nurses and/or enrolled nursing assistants should counsel and medicate clients wishing to have a TOP is a moot point. In a study that was conducted at a tertiary hospital in Bareilly, India, on unsafe abortions, Srivasta et al (2013) conclude that safe legal abortion will not be fulfilled without skilled providers and accessible and adequate facilities. Whether lower categories of nurses could or

should be upskilled in this regard should certainly be considered but any such decision would have to be taken with extreme care and in-depth training.

6.4.4. Process

In Walt and Gilson's (1994) policy framework, they refer to the process of policy making. O'Brien (2022) suggest that process refers not only to the way in which policies are initiated, developed or formulated, negotiated, and communicated, but also how they are implemented and evaluated. Consultation with stakeholders to ensure smooth implementation is essential. This consultation needs to continue after the policy is initially implemented as the repercussions of its implementation and the challenges experienced in ongoing implementation need to be addressed.

In the researcher's study, an attempt was made during the semi-structured interviews with managers and doctors to determine the challenges regarding implementation of the policy. They in fact came up with similar ideas to the TOP providers, who were also asked to answer this question, in this regard.

It was evident from the audit of the requests for TOP that there is a month-by-month variation of the demand which makes it difficult to cater for as human and physical resources have to be available for a high demand in case this exists, but TOP providers may not be fully occupied in weeks when the demand is less. This data however needs to be seen in context as the demand in certain months related to the availability of a TOP provider at a clinic rather than the other way around.

Managers and TOP providers agreed that there is a lack of management support for providers in implementing the CTOP policy. This is seemingly not because managers lack empathy but because they also feel unable to cope with the context they find themselves in. Skogsberg et al (2022) suggests that managers with limited resources and unclear roles find it difficult to support their staff members adequately. Other factors may be their own workload and stress, limited competence, decisions being beyond the manager's control, and policy changes. While the CTOP Act has been in place for some time, the guidelines were implemented in 2020, shortly before data collection for this study began. There may well have been uncertainty in this regard. Other policy changes, seemingly unrelated to the CTOP policy, such as changes in human resource policies and the management of non-communicable disease may have caused uncertainty

amongst the managers as they manage the entire health establishment and not only the TOP service.

Tayfur and Arslan (2012) mentioned that supervisory support is crucial among people in need of help. In termination of pregnancy services, the TOP providers are the people in need of help from management and fellow TOP providers. Nurses who have made a choice to work with women who choose to terminate a pregnancy have to learn to care more for each other and give more support to one another. Tayfur and Arslan. (2012) state that stress and exhaustion can be reduced if there is supervisory support. The authors concluded that supervisory support improves the employees' well-being resulting in alleviation of stress. was like a debriefing session.

The participants especially the TOP providers mentioned that they were stressed emotionally and that they had not been offered debriefing since 2020. They felt alone and not valued. Reason for lack of debriefing sessions was attributed to lack of funds from GDoH. Dempsey et al (2024) suggest that managers should undergo values clarification training to equip them to support the TOP providers in providing the service.

One of the most concerning findings in this study was the number of clients who seek TOP in the first trimester who are asked to return at a later date when often they are no longer eligible for a first trimester TOP. As mentioned earlier in this thesis, this causes anxiety to the clients but also has a major impact on the second trimester service at hospitals as increases demand on the hospitals providing second trimester TOP. The reasons for this practice need further investigation to determine whether there is a genuine need to postpone the TOP due to lack of capacity or whether this is a vindictive and unnecessary practice.

There would appear to be genuine problems regarding the process of referring clients for second trimester TOP. All participants in this current study mentioned that they had trouble in referring the women in their second trimester to the hospitals. The participants further argued that the limited bed capacity at the referral hospitals was the main cause of women in the second trimester seeking illegal and unsafe abortions. Harries, Gerdts, Momberg and Greene-Foster (2015) agree that there is a problem with the referral system. The participants stated they

were frustrated because of the difficulty in getting a bed for the women in second trimester.

According to Kaswa et al., 2020 and Harries et al (2012) between 20% and 25% of TOPs in South Africa (SA) are performed during the second trimester." It has been revealed that second trimester facilities in South Africa are very scarce. Amnesty international reported that out of three thousand eight hundred and eighty (3880) facilities, only two hundred and sixty-four (264) offer second trimester services in the public service of South Africa. In Gauteng, only six (6) out of 26 hospitals that have a maternity unit offer second trimester abortion.

Another reason put forward by Harries et al (2012) for managers and providers being reluctant to perform second trimester TOP is because they feared dealing with body parts of a foetus in the second trimester compared to what they called a "blood clot" in the first trimester. A doctor in the researcher's study said he found it difficult to get staff to assist him in the second trimester TOP procedure.

The issues related to conscientious objection were discussed under the content section but impact on the process of implementing the CTOP Act to a marked degree. The issue of stigma mentioned in the section on actors also impacts on the process of providing an effective TOP service.

de Londras et al (2023) state that, in some cases, such objection is based on health workers' religious or ethical objections to abortion and in many settings conscientious objection is accommodated within health systems in response to a perceived need to preserve individual health workers' moral and ethical integrity. Harries and Constant (2019) however found that some health care practitioners misunderstood conscientious object.

The TOP providers were stigmatized by their co-workers. An example cited by one participant was having received phone calls from her colleagues asking her that o *bolaile baba kae (how many have you killed*). This utterance made her to be afraid to go to the canteen. Not only TOP providers were stigmatized, but patients are also subjected to stigma. In their study, Teffo and Rispel (2017) stated that their participants mentioned that they were called names and were often mocked by their colleagues. Additionally, Dempsey, Callaghan and Higgins (2024) argue that name calling such as abortionist, butcher, assassin, and murders were commonly said to the providers in Africa, Europe and North and South America. This name

calling caused providers to feel uncomfortable. Providers across many countries in Africa, Australia, Europe, is stigma in the workplace of the providers. Dempsey et al (2024) indicated that providers in conservative countries such as Ghana, Ethiopia, and South Africa experienced stigma at the highest level. This in a country which has one of the most liberal abortion laws in the world. Anton , et al (2018) partially explain this anomaly as they state that although abortion was decriminalized in Uruguay in 2012, stigma still prevails many years later.

Several studies have been conducted on TOP of “teenage girls” but the researcher’s study showed that the majority of clients seeking TOP are between the ages of 20 and 40. This must be seen in context in that the data was not expressed as a ratio of the numbers of clients seeking TOP according to the number of women within that age group, but it does point to the fact that women during their reproductive life need easy access to contraception just as much, if not more than teenagers which is sometimes the topic of such discussions. This raises the possibility of making contraception available in pharmacies where women who work, and even those who do not if the contraceptive methods are provided as a free service can go out of hours. With the advent of telemedicine this may be a viable proposition. Shin et al (2022) state that contraceptive services improve contraceptive access and found that the quality of contraceptive counselling among telemedicine and office visits is similar. However, Meurice et al (2024) caution that social determinants influence the uptake of telemedicine contraception services.

While the researcher’s study sought to determine how the TOP services could be improved, the issue of illegal and unsafe abortions cropped up during data collection in both phase 1 and phases 2.1. and 2.2.

One of the doctors who is the head of the department of obstetrics and gynaecology at a tertiary provincial hospital mentioned that the complications caused by illegal / unsafe abortion affected their daily work, especially when they have to take the women to theatre. Abebe et al (2022) echoed the same sentiments about the complications that arise from “risky” abortions and that risky second stage abortions carried a greater risk of mortality and morbidity.

Some TOP providers mentioned that if they were not able to perform the termination on the day a client postponed at the health establishment, the women go to the unscrupulous providers because they become impatient and unwilling to

come on the date they are booked for the procedure. After this some women come back to the health establishment with complications which need urgent attention.

It was not possible to verify this information in this study or to quantify the size of the problem, but a study conducted in Soweto in 2018 by Gerdts et al (2018) found that the estimated proportion of people who ever attempted abortion was 12.1%. Approximately two thirds of these people had had a TOP in a facility and the remainder had had an abortion outside a facility which was, presumably “illegal”.

The risks, and the legal and financial costs of illegal abortions were explored in a scoping review by Rodriguez et al (2022) as well as the socio-economic impact of “unwanted” children, or as these authors refer to them as “unwanted progeny”.

A sobering conclusion to Rodrigues et al’s (2022) article is that abortion “legal or not, is an intrinsic part of human behaviour and, as proven by our history, individuals are likely to seek even unsafe means to obtain the desired result”. They believe that access to safe and legal abortion is a human right regardless of personal morals or opinions.

Post-abortion care and follow up is important not only to ensure she does not experience complications, but also to provide contraception counselling services. It could be argued that the woman is vulnerable at this time and ethical concerns may arise but there is little doubt that there is a need to curb further unwanted pregnancies for all the reasons raised above. An interesting and concerning finding by Netshinombelo et al (2022) who studied a community in KwaZulu Natal, was that the very issues that impact on access to TOP services also impact on access to follow up services negatively affecting post-abortion care services. They cite physical access issues (e.g. lack of transport) and stigma leading to verbal abuse by providers as well as poor quality care or ‘mistreatment” as reasons for women not accessing post-abortion services.

The final process issue relates to the poor record keeping and storage of records in the health establishments in the study which not only has the potential to impact on the quality of care but also on the operational efficiency of the health establishment and the ability of researchers to collect reliable data in an attempt to improve the quality of the services. A poor storage system affects the workload of staff members as they try to retrieve records, it can result in inefficient resource

allocation, may delay care given, decreased patient satisfaction and increase the chance of medico legal claims (Luthuli & Kalusopa, 2017).

Shaikh et al (2021) suggest the solution to the problem of poor record systems in health care is the introduction of health information technology and digital innovation. They believe that this will support policy and planning, public health, and personalisation of care. Mbunge et al (2022) conducted a literature review of South African literature to identify digital health technologies deployed in South Africa as a result of the COVID epidemic and found that although some technologies had been used, their implementation faced problems related to infrastructure, technological barriers, organisational and financial barriers, policy, regulatory and cultural barriers. It may be useful to learn lessons from the private health care sector where digital patients' records have been used for some time.

6.5. Conclusion

This chapter has explained and discussed the triangulation of the data from the phases of the study. The next chapter will provide the main findings of the study, and the recommendations which have been crafted in an attempt to answer the research question: How can TOP policy be better implemented in the services in the GDoH to align the implementation of the Gauteng province TOP guideline with the CTOP (Act of 1996) as amended by the CTOPA 2008? This will be followed by the limitations of the study.

CHAPTER 7 MAIN FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION OF THE STUDY

7.1. Introduction

This final concluding chapter will discuss the key issues that emerged throughout the research study, linking them to the research question: “How can the TOP policy be better implemented in the services in the GDoH to align the implementation of the TOP guideline and with the CTOP (Act of 1996) as amended by the CTOPA 2008?”

The recommendations are designed to assist the GDoH and other stakeholders to address the gaps identified in the implementation of the TOP policy.

7.2. Main findings of the study

The study was a multi-method study which included a scoping review, semi-structured interviews and an audit of the resources available to the health establishments for the implementation of the policy as well as the demand for TOP in the province. The findings of the various phases of the study were combined using Walt and Gilson’s Policy Framework to understand the factors impacting on the implementation of the policy by means of data and methodological triangulation.

7.2.1. Findings of the scoping review

Five themes emerged from the scoping review.

- Access to safe abortion services
- Knowledge and attitudes towards abortion
- Ethical considerations in abortion care
- Cultural and societal influences on abortion practices
- Policy and legal frameworks impacting abortion services

The findings indicated that there are still challenges in many countries as far as abortion is concerned because it remains a controversial issue. Women are still denied access to abortion especially in countries where there are restrictive

abortion laws. Women still travel long distances and in the United States of America some move from one state to another to access abortion.

Women do not only have a problem to access abortion in countries with restrictive laws as the issue of access is still rife even in countries with liberal laws such as South Africa. These access issues not only include geographic and legal issues but are negatively influenced by stigma and attitudes of health workers and the members of the community. Conscientious objection is allowed in many abortion policies in the world but impacts negatively on the availability of health professionals willing to conduct TOP. This in turn raises ethical issues which are not easy to address. Accessibility should not only be improved to those seeking TOP but also to contraceptive services to prevent unwanted pregnancies and as a post-abortion service. This requires a multi-pronged approach by policy makers. Failure to deal with access issues results in illegal and unsafe abortions with negative health, financial and social consequences. There is a lack of knowledge amongst members of the community and health workers regarding legal termination of pregnancy which needs to be addressed. This includes not only community awareness efforts but more care when obtaining informed consent from clients requesting TOP.

7.2.2. Semi-structured interviews with TOP providers, managers and doctors

TOP providers, managers and doctors had similar opinions as to the current situation regarding the TOP services in the GDoH as well as reasons for the service not functioning in an optimal manner. Staff members are stressed and although they blame the shortage of staff for a great deal of their stress, the results of phase 3 where the audit of demand was conducted indicates that their workload is less than they perceive. Many of the TOP providers working in the clinics work alone and their isolation may be impacting on their perceptions. In addition, these TOP providers are commonly required to provide services other than TOP in their clinics. Their feeling of isolation in compounded by the perceived judgemental attitude of colleagues and even to members of their own communities who do not approve of terminating pregnancies. A further problem is the perceived lack of support from managers some of whom themselves confirm that they do not give sufficient support to the TOP providers. There is a lack of much needed debriefing of

providers. A question was raised about the possibility of providing incentives for TOP providers which needs careful consideration. The problems relating to conscientious objection raised in the scoping review were echoed in the interviews with providers stating that this was one of the reasons for the shortage of providers. A suggestion was made to offer values clarifications workshops which also needs careful consideration as this may be seen as a means of coercion.

The audit indicated that most of the equipment required in the guidelines was present, but providers raised issues of intermittent shortages of medications and many raised concerns about the lack of physical space made available for the TOP services. Most agreed that there is an urgent need for an expansion of second trimester TOP facilities. If however, some of the logistical and efficiency problems relating to first trimester TOP's can be resolved this may not be such an urgent issue. The concern that the inefficiencies lead to illegal abortions was cited by many of the providers.

7.2.3. The audit of demand for TOP and available facilities and equipment

The one section of the audit which measured the demand for TOP was initially hampered by the lack of access to patient records due to the very poor storage systems of records in the clinics and hospitals. As a result, the registers were used for this section of the audit. They too were missing quite a few details despite those details being required in the CTOPA (2008) section a-k. Registers at the various health establishments did not contain a standardised set of information providing further challenges for data collection.

A total of 2823 requests for TOP were made at the eight (8) clinics i.e. an average of 353 requests per clinic in the three-month period of review. A total of 2341 was made at the six (6) hospitals in the same period i.e. an average of 390 per hospital. The age range of clients in the clinics varied from 15 to 45 whereas the ages of clients accessing the hospitals ranged from 10 to 46. The majority of clients seen at both the clinics and the hospitals had no previous pregnancies when requesting termination with 29,25% having not had a previous pregnancy at the clinics and 29,6% at the hospitals. The percentages for the clinics for clients who had one previous pregnancy were 28,9% and at the hospitals 23,8%. The profile of clients

at both the clinics and the hospitals were fairly similar which is surprising given that the clinics should be dealing with first -trimester TOP and the hospitals only second trimester TOP. These statistics indicate that more effort should be made to encourage clients to access TOP services in the first trimester at the clinics and not to access services at the hospitals especially when considering the fact that the majority of clients seeking TOP from both clinics and hospitals are between 7 and 12 weeks of pregnancy.

7.3. Recommendations for the GDoH related to the findings of the study

The following recommendations are designed specifically for, and aimed at, assisting the GDoH and other stakeholders to address the gaps identified in the implementation of the TOP policy. Many of the recommendations are aimed at improving access to TOP services and several others are aimed at improving the working conditions of the providers, which, in turn will result in improved access and improved implementation of the policy.

7.3.1. Optimisation and expansion of available space for TOP services

- The results of the study indicate that there is lack of dedicated space for the provision of TOP.
- It is recommended that a dedicated space for provision of TOP be provided at the clinics to promote privacy of the patients. The researcher acknowledges that there are budgetary constraints due to other competing priorities, but as TOP services are also important for many reasons including the reduction of maternal deaths a diversion of funding to this effect is justified.
- In view of the limited space within the clinics, the provision of prefabricated buildings should be considered as a short-term solution. In hospitals the number of beds allocated for TOP should be increased.
- Virtual consultation should be implemented whereby the provider will take the history of the patients and give advice about accessing a facility where the patient can, with proof of having had the virtual meeting with a provider, be given mifepristone and be given a pamphlet on how to take misoprostol at home.

- The clinic times should be optimised to facilitate access by offering TOP services at times when other services are not provided such as in the afternoons or evenings.
- Providers should be given time back in lieu of any out of normal hours they work and time for them to complete administrative work should be ring-fenced during normal operating hours.

7.3.2. Conscientious objection and stigma

- While acknowledging the right of health professionals to exercise their right to refuse to participate in TOP, it is recommended that values clarification workshops should be held to address the stigma, and controversial issues related to abortion.
- It is further recommended that TOP training be included in the curriculum of the medical students and student nurses, as this will help them understand their legal obligations and their rights related to the provision of TOP services.
- An opt out clause should however be included in the training policy to allow for genuine conscientious objectors not to attend these sessions and thus ensure those students who have religious objections are not coerced to attend.

7.3.3. Intermittent shortage of abortion drugs

- The intermittent shortage of drugs such as mifepristone emerged as an issue preventing compliance to the TOP guidelines during interviews with both TOP providers and doctors. It is recommended that the pharmaceutical and therapeutic committees should advise the pharmacists at facility level to prioritize the ordering of mifepristone and ensure that the drug is available when needed.
- Further, the pharmacists need to attend in-service training on the importance of ensuring easy access to the abortion drugs so that access to abortion is improved.
- Pharmacy assistants should be employed at the clinics providing TOP services. They could be allocated to the clinics on a rotational basis to make this recommendation more cost-effective. For example, one (1) pharmacy assistant

could service five (5) clinics attending at each clinic one day a week to ensure stock outs do not occur.

- The NDoH needs to broaden the tender approval so that there is competition related to the procurement of mifepristone to encourage lower pricing and to ensure availability of the drugs when needed. Currently if the sole provider does not have stock, it is not possible for health establishments to procure the drug.

7.3.4. Management support

- The evidence from the analysis of the qualitative data indicated that management support was lacking and TOP providers felt alone.
- It is recommended that the managers whose facilities offer TOP should attend workshops on how to give collegial support and manage the services in such a way that they foster a non-judgmental and respectful environment where providers feel supported and valued.
- A mentoring programme should be made available to TOP providers where experienced providers can guide others. This could be done as an online programme to enable TOP providers to receive mentorship in the workplace.
- TOP providers should be given regular opportunities to attend peer support / debriefing sessions.

7.3.5. Provision of second trimester abortion services

- The findings of the study showed that facilities offering second trimester abortion are lacking. The study also revealed that many women bypass the clinics and go to the hospitals to request abortion.
- It is recommended that the number of facilities offering second trimester TOP should be increased.
- Patients should be made aware that they need to go for first trimester abortion to the clinics, and that they will be referred to the hospitals for second trimester abortion only.

- Further, it is recommended that robust family planning education of the patients be implemented and that part of this is making women aware of where to seek abortion care. This can be done in the family planning waiting rooms by means of easy-to-read pamphlets relating to abortion. The pamphlet should include the signs and symptoms of pregnancy. This recommendation stems from the finding that some women who requested TOP were not pregnant.
- It is also recommended that family planning providers should be more welcoming and friendly to the patients in order for the patients to utilize the service and not default resulting in an unwanted pregnancy.
- Mid-level nurses such as enrolled nurses, could be trained on medical abortion provision, but it is recognised that this would require a legislation change.
- Training on ultrasound usage needs to be strengthened to reduce the number of inconclusive scans which may be because the providers are not competent in interpreting the ultrasound results. It is recommended that guidelines relating to how to use ultrasound be developed and TOP providers attend training currently available to midwives at certain community health centres.

7.3.6. Complications related to unsafe abortion

- TOP providers should assist the women on the same day of the request and refrain from booking them to a later date which might lead them to go to illegal providers which in turn results in them going to the hospitals with complications.
- Municipal by-laws regarding the advertisement of illegal abortion services, often found on the street lampposts, need to be enforced and the advertisements removed.
- Illegal providers should be reported to the police and an effort should be made by police to arrest those illegal providers who are breaking the law.

7.4. Recommendations for further research and nursing education

Recommendations for nursing management are included in the recommendations listed above for the Gauteng Department of Health.

7.4.1. Nursing research

- Further research should be undertaken to extend this study to a broader population, covering all public and private health facilities in GDoH to obtain a better understanding of the factors impacting implementation the TOP policy.
- A study aimed at understanding the realities of nurse managers in the clinics which provide TOP services should be conducted to understand and improve their ability to provide support for the TOP providers.
- A study could be conducted to determine the reasons for women requesting termination of pregnancy as opposed to using family planning methods.
- An impact study could be conducted to determine the significance of complications following both legal and illegal terminations of pregnancy.

7.4.2. Nursing education

- The nursing education institutions need to incorporate TOP training in their curriculum so that when the nurse completes training, he/she will have the skills of TOP, and this will increase the number of TOP providers.
- The provision of ethical and legal aspects in the curriculum should be strengthened and the curricula should incorporate reproductive rights education.
- Nursing education institutions should consider using case-based simulations and role-playing to help nurses practice counselling, decision-making, and managing abortion care scenarios.
- Continuing professional development programmes should include training of managers and TOP providers on an ongoing basis.

- Workshops on reducing personal and societal biases that hinder service provision should be offered both to health professionals and to community members.
- Collaboration between nurses, doctors, and legal experts should be encouraged to enhance understanding and teamwork in the provision of TOP services.
- Nurses should be educated on legal protections available when reporting illegal abortion services or “whistleblowing”.

7.5. Limitations of the study

7.5.1. Methodological limitations

- The sample size was not as large as the researcher had intended as she had planned to include all the facilities that offer TOP in GDoH but did not receive permission to conduct the research in all of those facilities. The researcher collected data from eight (8) of the sixteen (16) clinics and six (6) hospitals. While audit data was collected at these facilities, three TOP providers withdrew for various reasons.
- Data availability was, to some extent, a challenge due to the non-availability of the patient records and poor record keeping in the registers of TOP requests.
- Data was collected for a 3-month period from November to January. It is uncertain whether the data in other months in the year would have been substantially different.
- It is possible that data both in the audit and the interviews may have differed from the clinics and hospitals not included in the study and the health establishments that were included only came from Gauteng which means that the data is not representative of the whole country. However, the study was deliberately targeted at improving compliance to the TOP guidelines in Gauteng.

- Due to the poor record keeping data regarding specific aspects e.g. marital status and reasons for TOP which are requirements in the guidelines, could not be assessed. This may have affected the reliability of the data.

7.5.2. Data analysis limitations

- The researcher may have been unconsciously biased as she had previously conducted research on the "experiences of the community health nurses regarding the provision of termination of pregnancy services in the Johannesburg Metro". This may have influenced her analysis of the qualitative data.
- The researcher had limited skills related to quantitative analysis and therefore only used descriptive statistics to analyse the data.
- The ethical requirement to keep patient data completely anonymous made it impossible to check if those who were referred to hospitals were counted twice. Double counting may therefore have occurred.
- There was some confusion in the registers regarding the patient's parity vs her gravity. It had to be assumed that the data provided referred only to the number of live births the client had had.
- In some cases, in the records, the stage of gestation on history and on examination differed. In this case the stage recorded on examination was used in the study.

7.5.3. External limitations

- The Guidelines which were used as a basis for the data collection tools had only been implemented one (1) year before the study commenced which may have influenced participants' compliance with the guidelines rather than the factors identified in the study.

7.6. Conclusion

Provision of abortion services has a positive impact on the lives of the women seeking the service. This was a multi-method study which included the scoping review, semi-structured interviews and an audit of requests for TOP and facilities and equipment available in order to explore and describe the factors impacting implementation of the TOP policy in GDoH.

The findings of the study revealed that all the cohorts of participants, namely TOP providers, managers and doctors, were passionate and about the work they were doing despite the shortcomings that they experienced related to shortage of medication, lack of space and stigma. The study further established that all the participants excluding the managers, and the doctors needed emotional and moral support.

The results of the study indicated that women requested abortion early in pregnancy but were delayed by the TOP providers who booked them to come back in two weeks which made them frustrated and then opt to go to the illegal providers. Many of these women had to go back to the healthcare establishments due to complications related to the unsafe abortion. The important additional challenges were highlighted and supported by the participants and confirmed by literature.

It can be concluded that the constrained working environment, and negative attitudes in the community and amongst health professionals has a negative influence on the implementation of the TOP policy. Based on the recommendations of this study, it is hoped that measures will be put in place to improve access to TOP and implementation of the TOP policy.

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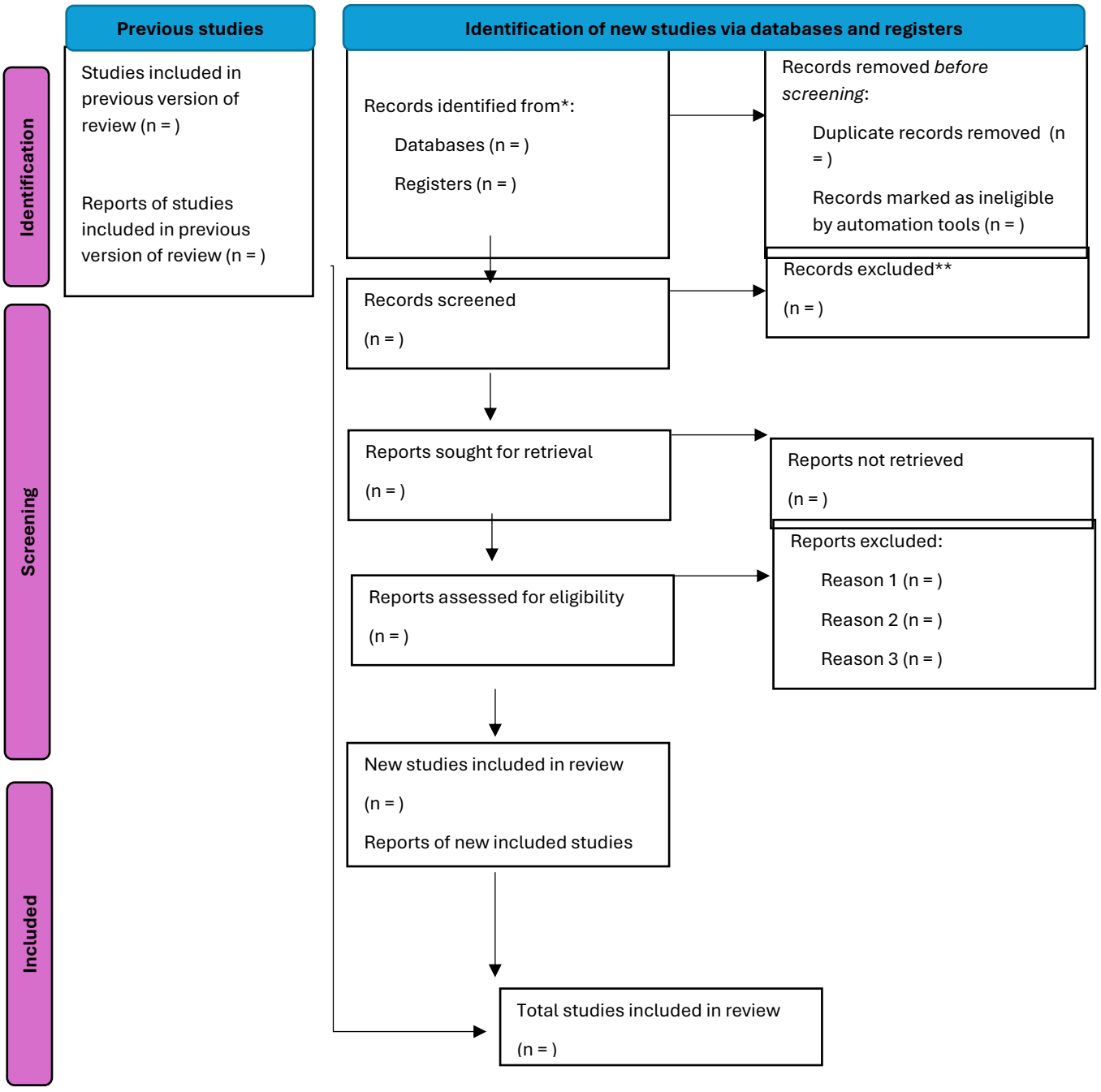
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9. LIST OF ANNEXURES

Annexure 1A: PRISMA updated Guide



Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).

**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71 For more information, visit: http://www.prisma-statement.org/

Annexure 1B: Data Extraction Sheet

DATA EXTRACTION SHEET	
1. Author(s)	
2. Title of the article	
3. Title of the journal	
4. Year of study	
5. Country of origin/setting	
6. Type of publication	
7. Purpose of the study	
8. Type of research design	
9. Type of sample	
10. Number of subjects in the study	
11. Data collection	
12. Data analysis	
13. Key findings	

Source: De Souza et al., 2010 pp.106

Annexure 2A: Demand for Services

Clinic

Item	Per Client	Per Client	Per Client	Per Client
Booking First Trimester on time				
Contraception offered post-abortion				
Emergency transfer to provincial hospital				
Medical abortion requested				
Surgical abortion requested				
Age				
Marital status				
Race				
Occupation				
Staff on duty				

Hospital

Item	Per Client	Per Client	Per Client	Per Client
Booking for 2nd Trimester				
Drugs used for abortion				
Medical practitioner available				
Instruments used for abortion				
Age				
Occupation				
Race				
Future health problems				
Staff on duty				

Annexure 2B: Audit of TOP Resources (Phase 2)

Construct	Discipline	Level	Criteria	Yes	No	Comment
Gives access to medical and nursing staff	Medical	First trimester	At least one registered and TOP trained medical practitioner (doctor), nurse or midwife, full available during facility normal working hours			
		Second trimester	At least one registered and TOP trained medical practitioner (doctor), upon appointment,			
	Surgical	First trimester (MVA / EVA)	At least one registered and TOP trained medical practitioner (doctor), nurse or midwife, fully available during facility normal working hours			
		Second trimester (MVA/EVA)	At least one registered and TOP trained medical practitioner (doctor), upon appointment.			
		Dilatation and Evacuation (D&E)	At least one registered and TOP trained medical practitioner (doctor) at least one registered and TOP trained nurse or midwife to assist the medical practitioner (doctor), upon appointment.			
Gives access to an operating theater	Medical	First trimester	A list of facilities with operating theatre for referral			
		Second trimester	A list of facilities with operating theatre for referral			
	Surgical	First trimester (MVA / EVA)	A list of facilities with operating theatre for referral			
		Second trimester (MVA/EVA)	A list of facilities with operating theatre for referral			
		Dilatation and Evacuation (D&E)	A list of facilities with operating theatre for referral			
Has appropriate surgical equipment	Medical	First trimester	Surgical equipment not required			

		Second trimester	Equipped with manual and/or electric vacuum aspiratory device, cannulae, dilator, tenaculum, speculum, sponge, or ring forceps and relevant consumables			
	Surgical	First trimester (MVA / EVA)	Equipped with manual and/or electric vacuum aspiratory device, cannulae, dilator, tenaculum, speculum, sponge, or ring forceps and relevant consumables			
		Second trimester (MVA/EVA)	Equipped with manual and/or electric vacuum aspiratory device, cannulae, dilator, tenaculum, speculum, sponge, or ring forceps and relevant consumables			
		Dilatation and Evacuation (D&E)	Equipped with manual and/or electric vacuum aspiratory device, cannulae, dilator, tenaculum, speculum, sponge, or ring forceps and relevant consumables			
Supplies drugs for intravenous and intramuscular injection	Medical	First trimester	IV and IM Injections not required			
		Second trimester	IV and IM Injections not required			
	Surgical	First trimester (MVA / EVA)	IV and IM injections not required			
		Second trimester (MVA/EVA)	IV and IM injections not required			
		Dilatation and Evacuation (D&E)	Saline or anaesthetists (eg lidocaine) for paracervical or intra-cervical block. Utrotonic agent (misoprostol or IM/PO methergine or IV/IM oxytocin), IV Fluids if needed			
Has emergency resuscitation equipment and access to an emergency referral centre or facility	Medical	First trimester	As per Ideal Clinic Framework and Manual (Version 18). A list of contacts and address of emergency referral centers or facilities available.			
		Second trimester	As per Ideal Clinic Framework and Manual (Version 18). A list of contacts and address of emergency referral centers or facilities available			

	Surgical	First trimester (MVA / EVA)	As per Ideal Clinic Framework and Manual (Version 18). A list of contacts and address of emergency referral centers or facilities available			
		Second trimester (MVA/EVA)	As per Ideal Clinic Framework and Manual (Version 18). A list of contacts and address of emergency referral centers or facilities available			
		Dilatation and Evacuation (D&E)	As per Ideal Clinic Framework and Manual (Version 18). A list of contacts and address of emergency referral centers or facilities available			
Gives access to appropriate transport should he need arise for emergency transfer	Medical	First trimester	As per ideal clinic framework and manual (Version 18)			
		Second trimester	As per ideal clinic framework and manual (Version 18)			
	Surgical	First trimester (MVA / EVA)	As per ideal clinic framework and manual (Version 18)			
		Second trimester (MVA/EVA)	As per ideal clinic framework and manual (Version 18)			
		Dilatation and Evacuation (D&E)	As per ideal clinic framework and manual (Version 18)			
Has facilities and equipment for clinical observation and access to in-patient facilities	Medical	First trimester	Oxygen saturation monitor, blood pressure monitor, heart rate monitor, temperature monitor. In patient facility not required.			
		Second trimester	On or out-patient ward with bed. Recovery room for patient observations. Oxygen saturation monitor, blood pressure monitor, heart rate monitor, temperature monitor. In patient facility not required.			

	Surgical	First trimester (MVA / EVA)	Recovery room for patient observation. Oxygen saturation monitor, blood pressure monitor, heart rate monitor,			
			temperature monitor. In patient facility not required.			
		Second trimester (MVA/EVA)	Recovery room for patient observation. Oxygen saturation monitor, blood pressure monitor, heart rate monitor, temperature monitor. In patient facility not required.			
		Dilatation and Evacuation (D&E)	Recovery room for patient observation. Oxygen saturation monitor, blood pressure monitor, heart rate monitor, temperature monitor. In patient facility not required.			
Has appropriate infection control measures	Medical	First trimester	As per Ideal Clinic Framework and Manual (Version 18).			
		Second trimester	As per Ideal Clinic Framework and Manual (Version 18).			
	Surgical	First trimester (MVA / EVA)	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on availability of antiseptic (for cleaning of cervix)			
		Second trimester (MVA/EVA)	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on availability of antiseptic (for cleaning of cervix)			
		Dilatation and Evacuation (D&E)	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on availability of antiseptic (for cleaning of cervix)			
Gives access to safe water disposal infrastructure	Medical	First trimester	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on safe waste disposal facility for products of conception			
		Second trimester	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on safe waste disposal facility for products of conception			
	Surgical	First trimester	As per Ideal Clinic Framework and			

		(MVA / EVA)	Manual (Version 18), with emphasis on safe waste disposal facility for products of conception			
		Second trimester (MVA/EVA)	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on safe waste disposal facility for products of conception			
		Dilatation and Evacuation (D&E)	As per Ideal Clinic Framework and Manual (Version 18), with emphasis on safe waste disposal facility for products of conception			
Has telephonic means of communication	Medical	First trimester	Availability of landline or mobile telephone			
		Second trimester	Availability of landline or mobile telephone			
	Surgical	First trimester (MVA / EVA)	Availability of landline or mobile telephone			
		Second trimester (MVA/EVA)	Availability of landline or mobile telephone			
		Dilatation and Evacuation (D&E)	Availability of landline or mobile telephone			
Has been approved by the member of the Executive Council by notice in the Gazette	Medical	First trimester	Documentation of approval available upon request			
		Second trimester	Documentation of approval available upon request			
	Surgical	First trimester (MVA / EVA)	Documentation of approval available upon request			
		Second trimester (MVA/EVA)	Documentation of approval available upon request			
		Dilatation and Evacuation (D&E)	Documentation of approval available upon request			

Annexure 3: Semi-structured interviews Guide (Phase 2) TOP Providers

Demographic data

How long have you been a TOP provider? Please answer in years/months	
How many TOPs do you perform on average in a week?	
How many hours do you work per day?	
Do you work in the clinic / hospital over weekends?	
How many TOP providers work in one shift?	

Interview schedule for the TOP providers

1. What are the challenges you are faced with in your line of duty in relation to providing TOP services?
    - Could you explain that a bit more?
    - How could these be resolved?

2. Are all the resources needed for providing a TOP service available in your service?
    - If not why/ why not
    - How could a shortage of resources be resolved?

3. Please tell me about the support you need and receive from your supervisors/managers in assisting you to provide TOP services
    - Could you explain that a bit more?
    - Are their positive or negative consequences related to this support / lack of support?
    - If this is a problem, how could the issue be resolved?

4. Do you think the community in or at your place of work support TOP?
    - Why do you think that is the case?

5. Please share with me any other information you believe will help me understand the complexities of offering a TOP service better.

Thank for your time

Annexure 4: Semi-structured Interviews Guide (Phase 2) managers and doctors

Main Question

1. What factors do you believe impact on the successful implementation of the TOP Policy in the GDH Services?

Probes

- Could you tell me more about ……. That you mentioned (same probe for each of the factors raised).

- In what way does (for each of the factors mentioned) impact on the successful implementation of the TOP Policy?

2. Are there any other challenges you face in trying to implement the policy?

Probes

- Related to the patients? Related to your managers? Related to the available resources? Related to your colleagues? Related to the community at large?
- How do these challenges impact on your work?
- How do you suggest the challenges are resolved?

3. How many dedicated termination of pregnancy beds do you have?

4. What challenges are you faced with that prevents you from doing a safe TOP?

5. Do you have all the resources for performing TOP? If the answer is NO – why? Is because of lack of space, beds, privacy, assistance, doctors etc.

6. Do you give support to the nurses who assist with TOP? If yes how?

7. How many second trimester booking do you get per week?

8. Are there any clinical problems you encounter because performing TOP? If yes please give me the problems you encounter

9. Are your doctors and nurse competent in the provision of second trimester TOP? If no why?

Thank you for your time

Annexure 5: Study Information Document

STUDY INFORMATION DOCUMENT

Study title: Factors influencing the implementation of termination of pregnancy policy in Gauteng Department of Health a multi- method study

Greetings

Introduction

[I / We, ……Daphney Tlhabela ……., is doing research on the factors influencing he implementation of the TOP policy in in Gauteng Department of Health ……. . Research is a process used in seeking new knowledge. In this study we want to learn about how to explore and examine the factors impacting on the provision of termination of pregnancy services in the GDoH. This will assist in making recommendations to the GDoH to improve the provision of TOP services in Gauteng.

The study will be conducted in three phases. The first phase involves a scoping review. The second phase consist of an audit to assess the demand for, and the resources available in the GDH for the provision of TOP. The third and fourth phases (which I am hoping you will assist with) consist of semi-structured interviews with TOP providers and managers, respectively. The objective of these phases is to explore and describe the TOP providers perceptions of factors impacting on the successful provision of TOP services in Gauteng and to explore and describe the managers and doctors' perceptions of factors impacting on the successful provision of TOP services in Gauteng.

Invitation to Participate: We are asking / inviting you to take part in a research study (or asking for your permission to include your child in a research study).

What is involved in the study. This could include but would not necessarily be limited to such features as:

1. Study design is multi- method study and you as the participants will be involved in answering questions that will be posed relating to the topic of the research.
2. The study will commence in February 2024 and will end in May 2024;

3. There are no procedures to be done you will only be required to answer the questions. The duration of the interview will be 45 – 60 minutes
4. The study will be conducted as an individual face- to -face interview and you do not need to fill in any form, you are going to answer question posed to you by the researcher and a tape recorder will be used to capture all what is said.
5. The questions asked will be asked and probing will be done in order to get to the gist of the answer. The questions asked will be related to termination of pregnancy and your experiences as the TOP provider.
6. **Risks of being involved in the study:** choice of participation in this study is voluntary, and no risks will be attached to participation or not.
7. **Benefits of being in the study:** there will be no financial benefits if choosing to participate in this study, however, participants will have access to findings of thestudy upon completion and refreshments will be provided during the interview as it may occur during a meal break.

8. A psychologist has been placed on stand-by to assist you should you experience distress from the questions that will be asked as termination of pregnancy is controversial and very sensitive. The services of the psychologist s are free.
9. **Benefits of being in the study:** Please note that there are no direct benefits to you as the participant. The benefits of this study will be the recommendations that will be made to the Department of health in order for them to improve the termination of pregnancy services which will benefit the women who will require to have their pregnancies terminated. Your participation is important in that it will bring change as far as termination of pregnancy is concerned.

You will be given pertinent information on the study while involved in the project; and after the results are available, you will be offered a free results summary , on request.

Participation is voluntary: refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. the Participant is otherwise entitled. You may discontinue participation at any time without penalty, or loss of benefits to which you are otherwise entitled. There is no requirement to provide a reason for withdrawing and any data collected on you will in default be destroyed, unless you specifically consents to its retention.

Reimbursements for "out of pocket" expenses may be allowed, there won't be any monetary reimbursement.

Confidentiality: Normally personal information will be treated in the strictest confidence and will only be available to the Principal Investigator (PI) and his/her Supervisor, in the case wherein the PI is a postgraduate student. The only exceptions - and all of them are rare - would normally be:

1. personal information may be disclosed if required by law
2. the Human Research Ethics Committees of the University may exceptionally require personal data to respond to a formal complaint, or for a compliance audit
3. the South African Health Products Regulatory Authority (SAHPRA) might conceivably require access to personal data, if conducting an investigation into a drug trial

You are assured that no individual will be identified by name in any report or publication arising out of the study. All data collected in the course of the study will be securely retained for two (2) years, if a scientific publication arises from the study and six (6) years, if there is no publication. Thereafter it will be destroyed accordingly.

Anonymity can usually only be guaranteed in questionnaires, whether in hard copy or online

Contact details of researcher/s: to enable prospective or actual Participants to get further information, or report adverse events, My contact number is 083 288 4271 and my email address: 1948105@wits.ac.za
and my supervisor's email address is: shelley.schmollgruber@wits.ac.za and her contact number is 011 488 4272 and Dr Sue Armstrong email address: sue.armstrong@wits.ac.za

Outputs

The articles will be shared to you on request after the completion of the study .

Contact details of HREC administrator and chair – for reporting of complaints / problems. The following text is recommended:

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Professor Paul Ruff, who may be contacted via any one member of the secretariat. The telephone numbers for the Committee secretariat are 011 717 2700/1234/2656/1252 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za, Rhulani.Mukansi@wits.ac.za, Mapula.Ramaila@wits.ac.za and Iain.Burns@wits.ac.za.
Thank you for reading this Study Information Sheet.
Date: November 2023

Non-standard items which may be included where appropriate

1. A statement that the particular treatment or procedure may involve risks to the participant (or to the embryo or fetus, if the subject is or may become pregnant) that are currently unforeseeable.
2. Anticipated circumstances under which participation may be terminated by the investigator without regard to the participant's consent.
3. Where genetic tests are to be done, a separated information sheet and consent form will be made available.
4. A statement that specimens would be stored for future research pertaining to the specific research question being studied and a separate participation information sheet and consent form will be made available. Specify how long specimens will be stored for, where they will be stored and whether these will be anonymized. If stored for future genetic testing, a further consent form will be signed.
5. If children (defined as persons below 18 years of age) are included as participants, it is likely that it will be necessary to produce a simplified version of the Information Sheet, using language or images and concepts which they are likely to understand and offering to help explain any points which are unclear to them. They will need reassurance that their parents or guardians know about the study and are willing to have the children participate, if the children so wish, *i.e.* both parties must agree to the child's participation.
6. A distress protocol may be necessary in the case of anticipated research-induced distress. *e.g.* questions that address issues of abuse, abandonment, previous negative sexual experiences, or traumatic memories may induce distress in the participants. A distress protocol must include the name and contact details of the registered counsellor who will provide the counselling, at no cost to the participant.

Thank you for reading this Study Information Sheet

Annexure 6: Participant Consent Form

Project Title: Factors influencing implementation of termination of pregnancy policy in Gauteng Department of health. A multi-method study

1. I have been given a Participant Information Sheet which explains the nature and processes involved in this study, which is attached hereto;
2. I was given time to read it, or had it read to me, in the language I best understand;
3. I was given time to ask any questions I wanted to and found any answers given to me to be reasonable and satisfactory;
4. I believe I fully understand why the study is being conducted and what the intended outcomes will be;
5. I understand that there will be no immediate benefit to me, should I agree to participate, nor will I receive any payment; conversely, participation will not cost me anything but my time;
6. I understand that, even if I initially consent to take part in the study, I may subsequently withdraw at any time and would not be required to give any reasons; if that happened, any data collected about me for the purposes of the study would immediately be destroyed, unless I give consent for it to be retained
7. I have been given a range of contact details, listed below. If I require further information or become concerned about any aspect of this study I am free to speak to any of these contacts.

Contact details:

NAME, Daphney Tlhabela, telephone no. 083 288 4271 , or by e-mail at 1948105@wits.ac.za
NAME, Prof Shelley Schmollgruber , on telephone no. 011 488 4272 or by e-mail at shelley.schmollgruber@wits.ac.za and Dr Sue Armstrong on telephone no. 011 488 4271, or by e-mail at sue.armstrong@wits.ac.za

Professor P Ruff, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, who may be contacted via any one member of the secretariat. The telephone numbers for the Committee secretariat are 011 717 2700/1234/2656/1252 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za, Rhulani.Mukansi@wits.ac.za, Mapula.Ramaila@wits.ac.za and lain.Burns@wits.ac.za.

Name of Participant: _____

Date: _____

Place: _____

Signature or mark _____

Witnessed by:

Name of Witness: _____

Signature: _____

Date: _____

Signature: _____

_____

Annexure 7: Consent Sheet for Audio Recording of Study Participation



Consent Sheet for Audio Recording of Study Participation

Project Title: Factors influencing implementation of termination of pregnancy policy at the Gauteng Department of health a multi-method study

I hereby consent to audio recording of the interview[1], or focus group discussion[1], or classroom interaction[1]

I understand that:

- The recording will be stored in a secure location (a locked cupboard or password protected computer) with restricted access to the researcher and the research supervisor.
- The recording will be transcribed and any information that could identify me will be removed,
- The recordings will be erased within either (a) two (2) years of the publication of the research findings, or (b) six (6) years, if no publications arise from this research
- Anyone wishing to access this information in the future will first have to obtain the approval of the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg
- Direct quotes from my interview, without any information that could identify me, may be cited in the research report or other write-ups of research.

Name of Participant: _____

Date: _____

Place: _____

Signature or mark _____

Witnessed by:

Name of Witness: _____

Signature: _____

Date: _____

Annexure 8: Distress Protocol and Contact Details of Support Person

Factors influencing implementation of termination of pregnancy policy in Gauteng Department of Health – A multi-method study

DISTRESS PROTOCOL AND CONTACT DETAILS OF SUPPORT PERSON

The following is a procedural protocol for assisting participants who may become distressed while being interviewed for the "*Factors influencing the implementation of termination of pregnancy policy in Gauteng department of health"* research project. Because the study is rated as a medium risk which may trigger traumatic memories.

1. If the participant becomes distressed during the interview, the researcher will immediately stop the interview
2. Ask the participant if she/he is okay
3. Offer the participant a glass of water (which will have been placed on the table before the interview commences
4. If the participant continues to be upset, the interview will be stopped immediately
5. The participant will be assisted in calming down
6. The participant will be asked if it will be acceptable to call them later or the interview to be postponed to another date if he/she feels like she will be able to continue with the interview at the date the participant will be comfortable with
7. A referral letter with the name of the participant will be given to the him or her and the counsellor will be made aware of the referral
8. The counsellor will offer debriefing free of charge (pro – bono)
9. The participant will be accompanied to a place where he/she will meet the counsellor
10. After the debriefing a follow up call will be made to find out if the participant to make sure that they are okay
11. The name of the counsellor is Ms Ntombikayise Mdumbe contact details: 0823 398 9785
    Ethical principles will be followed especially autonomy, justice, and non-maleficence.

Daphne Tlhabela

PhD Candidate

Annexure 9: Request for Permission to Conduct the Study in GDoH



Daphne Tlhabela
Department of Nursing Education
Faculty of Health Sciences
University of the Witwatersrand
7 York Road
Parktown
2193

TO: MEC OF HEALTH AND WELLNESS

MS NOMANTU NKOMO-RALEHOKO

Dear Ms Nkomo-Ralehoko,

SUBJECT : REQUEST TO CONDUCT A RESEARCH IN GAUTENG DEPARTMENT OF HEALTH FACILITIES

My name is Daphne Tlhabela, I am a PhD student registered with the University of the Witwatersrand in the Faculty of the Health Sciences. The title of my research is: *Factors impacting the implementation of the Termination of Pregnancy (TOP) Policy in Gauteng Department of Health facilities – a multi-method study". .*

I hereby request to be granted permission to access the facilities and conduct my research. This is a multi-method study and will include face-to face interviews and a check list to look into the demand for TOP and the resources available to offer the service.

The study sites intended to be used are 14 (fourteen CHC in the five health districts and the 7 (seven) hospitals that offer second trimester TOP. TOP providers in the 14 CHCs, mangers and doctors in the 7 hospitals will be interviewed and an audio recorder will be used to gather all relevant information given by the participants.

I hereby apply for permission to conduct research in Gauteng Department of Health Facilities, once my proposed study has been approved by the Committee for Research on Human Subjects of the University of the Witwatersrand.

If you have any concerns about the research or need more clarity about the study procedures, I am available at Daphney.tlhabela@gauteng.gov.za my supervisors can also be contacted. They are: Prof Shelley Schmollgruber email:shelley.schmollgruber@wits.ac.za and Dr Sue Armstrong – email: sue.armstrong@wits.ac.za

Yours Sincerely

Daphne Tlhabela

PhD Candidate

Annexure 10: Request to CEOs to conduct the study

Daphne Tlhabela
Department of Nursing Education
Faculty of Health Sciences
University of the Witwatersrand
7 York Road
PARKTOWN
2193

TO: Chief Executive Office (named CEO)

Hospital (named facility)

Dear …….. (named CEO)

SUBJECT : REQUEST TO CONDUCT A RESEARCH IN ….. (named facility)

My name is Daphne Tlhabela, I am a PhD student registered with the University of the Witwatersrand in the Faculty of the Health Sciences. The title of my research is: *Factors impacting the implementation of the Termination of Pregnancy (TOP) Policy in Gauteng Department of Health facilities – a multi-method study". .*

I hereby request to be granted permission to access the facilities and conduct my research. This is a multi-method study and will include face-to face interviews and a check list to look into the demand for TOP and the resources available to offer the service.

The study sites intended to be used are 14 (fourteen CHC in the five health districts and the 7 (seven) hospitals that offer second trimester TOP. TOP providers in the 14 CHCs, mangers and doctors in the 7 hospitals will be interviewed and an audio recorder will be used to gather all relevant information given by the participants.

I hereby apply for permission to conduct research in Gauteng Department of Health Facilities, once my proposed study has been approved by the Committee for Research on Human Subjects of the University of the Witwatersrand.

If you have any concerns about the research or need more clarity about the study procedures, I am available at Daphney.tlhabela@gauteng.gov.za my supervisors can also be contacted. They are: Prof Shelley Schmollgruber email:shelley.schmollgruber@wits.ac.za and Dr Sue Armstrong – email: sue.armstrong@wits.ac.za

Yours Sincerely

Daphne Tlhabela
PhD Candidate

Annexure 11: Permission letter Thele Mogoerane Regional Hospital

GAUTENG PROVINCE

REPUBLIC OF SOUTH AFRICA

Enquiries: T. Mabizela Clinical Coordinator
Directorate: Staff Development
Telephone number: (011) 590 0109
Email: thandiwe.mabizela@gauteng.gov.za

Date: 27 July 2023

Ms D Tlhabela

Thelle Mogoerane Regional Hospital Management Team is pleased to grant you provisional permission to conduct your study to conduct research On The factors impacting the implementation of the Termination of Pregnancy (CTOP) Policy in Gauteng Department of Health Facilities. data will be conducted through obtaining information through "Prospective data collection" in your protocol for which you will obtain the ethics clearance certificate from the University of Witwatersrand for Full permission to be granted.

The following condition must be adhered to otherwise permission will be withdrawn:

- Only the research and/or research methods outlined in the protocol presented to the Research Committee should be conducted and/or followed otherwise the research will be cancelled.
- Once the research is finalized the results and recommendations of the research should be submitted to the Clinical Education and Training Unit

Please note that you can only get full clearance once you provide the hospital with the Ethics Clearance Certificate

Dr Malaka

Chief Executive Officer

Thelle Mogoerane hospital

Annexure 12: Permission letter to conduct study at Kalafong Tertiary Provincial Hospital

GAUTENG PROVINCE

HEALTH
REPUBLIC OF SOUTH AFRICA
KALAFONG HOSPITAL PRIVATE
BAG X396
PRETORIA
0001

ENQUIRIES : MS PM MONYEPAO

TEL: 012 318 6995

EMAIL: Patricia.Monyepao@aautenq.qov.za

REF : KPTH /2023/JULY NHRD : GP 202307_064

TO: Ms D Tlhabela

RE: CONDITIONAL APPROVAL TO CONDUCT RESEARCH

TITLE: Factors influencing implementation of pregnancy policy in Gauteng Department of Health.

Conditional permission is hereby granted for the research to be conducted at Kalafong Provincial Tertiary Hospital. Please note that full approval will be granted on receipt of Ethics approval as well as the registration number from the NHRD.

This approval is given in accordance to the "Promotion of Access to Information Act, No 2 of 2000" and it is expected of each investigator to ensure that all patient personal information will be managed and kept safe in agreement to the act.

Please note that in addition to receiving approval from the hospital research committee, you are still required to arrange the logistics with the relevant departments. You are obliged to inform this committee in writing of any amendments made to this protocol. Importantly, you require full approval (not conditional approval) before data collection can commence.

Informed consent for participation of research subjects and collection of data remains the responsibility of the researcher.

The hospital reserves the right to revoke this consent to do research in the facility if any misconduct with regards to patient participation or inappropriate behaviour on behalf of the researcher comes to

You are also required to submit your final report or summary of your findings and recommendation to the office of the Chief Executive Officer.

Kind regards

PROF VAN ZYL

CHA PER N: •RESEARCH COMMITTEE DA . 7 %/vza

Ethics approval submitted:

Approved.

PROF VAN ZYL

CHAIRPERSON:

RESEARCH COMMITTEE DATE: DATE:



Annexure 13: Permission letter to conduct study at West Rand District Health

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

WEST RAND DISTRICT
FAMILY MEDICINE

Dr. E.E.WENEGIEME
Telephone: (011) 951 6219
Cell: 078 399 3190 / 067 419 6257
Email: weneqiemeeqbert@qmail.com
Email: weneqiemeueqbert@qauteng.qov.za

Date: 11 August 2023

PI Name and Surname: Ms. Daphney Tlhabela

Email: Daphney.Tlhabela@gauteng.gov.za

NHRD REF NO: GP 202307 064

Title Factors influencing implementation of pregnancy policy in Gauteng department of Health — a multi-method study.

Protocol: I have studied the protocol, and it is well articulated. Sample size will not impact service delivery.

The location where the study will be conducted: West Rand District Health

Facilities Requirements:

1. There will not be an additional load on nursing staff, e.g. asking them to recruit patients for study
2. Support services e.g. administration staff including clerks, and reception staff will not be part of facilitating this study (IT Specialist)
3. Consumables e.g. swabs and gloves will not be used in these facilities
4. Laboratory tests will not be done in the above-mentioned facilities
5. Equipment's e.g. BP cuffs belonging to these facilities will not be used
6. Space (office space/counselling cubicles) of these facilities will not be used but the location of the interview will be negotiated according to the interviewee's preferences may be hospital offices at a time convenient for the interviewee
7. Communication e.g. announcements, and handing out leaflets will not be undertaken in these facilities (Survey Questionnaire)
8. Dates, days of the week, and times you wish to access the facilities should not be determined by the researcher without knowledge of the facilities
9. There will be no additional OPD visits for this study
10. Admission of patients will not be part of this study

Ethics: Provisional Approval granted by HREC as provided by the researcher

Funding Source: Researcher

Take note that you will need to share your findings and recommendations with the facilities to assist with future clinical policies.

We wish you well during this project. For any additional information, feel free to contact our department.

Regards.

Dr Wenegieme (DRC WRD)

WEST RAND DISTRICT FAMILY MEDICINE

Dr. E.E.WENEGIEME

Annexure 14: Permission letter to conduct study West Rand District Health

Telephone: (011) 9516219 Cell:
0783993190 0674196257
wenegiemeegbert@gmail.com
Wenegiemeuegbert@gauteng.gov.za

GAUTENG PR(HEALTH REPUBLIC OF SOUTH AFRICA

E Date: 11 August 2023

PI Name and Surname: Ms. Daphney Tlhabela

Email: Daphney.Tlhabela@gauteng.gov.za

NHRD REF NO: GP 202307 064

Title Factors influencing implementation of pregnancy policy in Gauteng department of Health — a multi-method study.

Protocol: I have studied the protocol, and it is well articulated. Sample size will not impact service delivery.

The location where the study will be conducted: West Rand District Health

Facilities Requirements:

1. There will not be an additional load on nursing staff, e.g. asking them to recruit patients for study
2. Support services e.g. administration staff including clerks, and reception staff will not be part of facilitating this study (IT Specialist)
3. Consumables e.g. swabs and gloves will not be used in these facilities
4. Laboratory tests will not be done in the above-mentioned facilities
5. Equipment's e.g. BP cuffs belonging to these facilities will not be used
6. Space (office space/counselling cubicles) of these facilities will not be used but the location of the interview will be negotiated according to the interviewee's preferences may be hospital offices at a time convenient for the interviewee
7. Communication e.g. announcements, and handing out leaflets will not be undertaken in these facilities (Survey Questionnaire)
8. Dates, days of the week, and times you wish to access the facilities should not be determined by the researcher without knowledge of the facilities
9. There will be no additional OPD visits for this study
10. Admission of patients will not be part of this study

Ethics: Provisional Approval granted by HREC as provided by the researcher

Funding Source: Researcher

Take note that you will need to share your findings and recommendations with the facilities to assist with future clinical policies.

We wish you well during this project. For any additional information, feel free to contact our department.

Regards.

Dr Wenegieme (DRC WRD)

Annexure 15: Permission letter to conduct study at Sedibeng District Health

GAUTENG PROVINCE

HEA2TH

REPUBLIC OF SOUTH AFRICA

Sedibeng District Health Services
Enquiries: Ms. N. Tuswa
Tell: 016 950 6255
Email:Nomonde.tuswa@gauteng.gov.za

Ms. Daphney Tlhabela
University of Witwatersrand
P.O. Box 8014
Westgate, 1734

Dear Ms. Tlhabela

RE: FACTORS INFLUENCING IMPLEMENTATION OF TERMINATION OF PREGNANCY POLICY IN GAUTENG DEPARTMENT OF HEALTH - A MULTI-METHOD STUDY

Please be informed that permission has been granted for you to carry out the above-mentioned research at Sebokeng Hospital and Johan Heyns CHC in Sedibeng District Health Offices. It is noted that you have already obtained Provincial Ethics Committee as well as Research Ethics Clearance from the University of Witwatersrand.

Kindly note that a copy of the report on the findings (especially) that concerns Sedibeng District Health Services should be submitted to the Chief Director's office at the completion of the study,

This permission is also subject to the conditions stated in the protocol and any change in design and methodology must be communicated to the Chief Director.

We wish you success in your research endeavours.

Recommended / Not

Prof. OB Omole Recommended Not recommended / Recommended as amended
Chairperson: Sedibeng District Research Committee
Date: 12/02/2014

Approved / Not approved /

Ms. M.A. Madolo / Not approved / Approved as amended

Acting Chief Direc or: Sedibeng District Health Services Gauteng Health Department Date:

14/02/2024

NHR REF: GP_202307_064

Sedibeng DHS, Cnr Frikkie Meyer & Pasteur Blvd, Private Bag X 023, Vanderbijipark

Annexure 16: Permission letter to conduct study at Tshwane District Health



TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

DATE ISSUED: 08/02/2024
PROJECT NUMBER: 11/2024
NHRD REFERENCE NUMBER: GP 202307 064

TOPIC: Factors influencing the implementation of the termination of pregnancy policy in Gauteng Department of Health

Name of the Lead Researcher:	Ms Daphney Tlhabela
Name of the Co-researcher:	Professor Shelley Schmollgruber Dr Sue Armstrong
Facilities:	Soshanguve Block JJ Clinic Stanza Bopape CHC Laudium CHC
Name of the Department:	University of the Witwatersrand

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: APPROVED

(Interviews should not be done during patient consultation time. Researcher to arrange with Facility Manager to interview participants either during lunch or after working hours)

.....

Dr. Manei Letebele-Hartell Date 12/02/2024

Chairperson: Tshwane Research Committe

Annexure 17: Permission letter to conduct study at Ekurhuleni District Health Thele

EKURHULENI HEALTH DISTRICT RESEARCH PERMISSION

Research Project Title: Factors Influencing Implementation of Pregnancy Policy in Gauteng Department of Health – A Multi-Method Study.

NHRD No: GP-Not yet applied

Research Project Number: 02/08/2023/02

Name of Researcher(s): Ms Daphne Tlhabela

Division/Institution/Company: University of Witwatersrand

Date of review by the EHDRC: 16 August 2023

DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT RESEARCH COMMITTEE (EHDRC)

- This document certifies that the above research project has been reviewed by the EHDRC and permission is granted for the researcher(s) to commence with the intended research project.
- Facilities approved for the research: Jabulane Dumane CHC and Nokuthela Ngwenya CHC
- Participants' rights and confidentiality must be maintained throughout the study period and when disseminating the findings.
- No resources (financial, material, and human resources) from the health facilities will be used for the study. Neither the district nor the health facilities will incur any additional cost for the study.
- The study will comply with Publicly Financed Research and Development Act 2008 (Act 51 of 2008) and its related regulations.

Annexure 18: Permission letter to conduct study at Tembisa Tertiary Provincial Hospital

GAUTENG PROVINCE
REPUBLIC SOUTH AFRICA

Enquiries: Dr D P Moloi
Tel: (01 1) 41 1-3531 Fa(011) 410-8421
Email:
Dieketsena.Moloi@gauteng.gov.za
Ref: 9/3/3/1

TO: MS. DAPHNEY TLHABELA

FROM:

DR. D.P. MOLOI
CHIEF EXECUTIVE OFFICER LERATONG HOSPITAL

SUBJECT:
REQUEST TO CONDUCT RESEARCH: FACTORS INFLUENCING IMPLEMENTATION OF PREGNANCY POLICY IN GAUTENG DEPARTMENT OF HEALTH - A MULTI-METHOD STUDY

DATE: 14 AUGUST 2023

Permission has been granted to conduct research study entitled: Factors influencing implementation of pregnancy policy in Gauteng Department of
Health— a multi-method study based on the conditions indicated from Policy Planning and Research Department. For further arrangement contact Dr Phanzu on 01 1 411 3508/9.

Kind regards

CHIEF EXECUTIVE OFFICER
/cnk
2023/08/14

LERATONG HOSPITAL
ADCOCK STREET, CHAMDOR
2023 -08- 1 4
PRIVATE BAG X2078
1740 MOGALE CITY
LERATONG HOSPITAL

It would be appreciated if you could share your result of the research with the Management of Leratong Hospital. Thank you for showing interest in

ANNEXURFE 21 SUPPORT LETTER TO CONDUCT STUDY AT GDoH

Annexure 19: Supporting Letter Pending HREC Approval

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Dear Human Research Ethics Committee (HREC) Chairperson
The Department of Health has reviewed the proposal of Ms Daphney Tlhabela on "Factors influencing the implementation of termination of pregnancy policy in Gauteng Department of Health', and agrees that it be submitted for HREC approval.

The department supports the study pending HREC approval.

Dr Bridget Ikalafeng

Deputy Director: Research and Epidemiology

Date:

Annexure 20: Approval letter for the Proposal



Private Bag 3 Wits, 2050

Fax: 027117172119

Tel: 02711 7172076

Reference: Mrs Sandra Benn

E-mail: sandra.benn@wits.ac.za

18 July 2023

Ms D Tlhabela Person No: 1948105

9779 MSEBE STREET

Johannesburg

Dobsonville Ext 3

1863

South Africa

PAGE

Dear Ms Daphney Tlhabela

Doctor of Philosophy: Approval of Title

We have pleasure in advising that your proposal entitled Factors influencing implementation of

termination of pregnancy policy in Gauteng Department of Health - A multi-method study has been

approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher

degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn

Faculty Registrar

Faculty of Health Sciences

Annexure 21: Ethics Clearance from the University of the Witwatersrand

WITS UNIVERSITY

UNIVERSITY OF THE WITWATERSRAND
JOHANNESBURG

R49 Ms D Tlhabela

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL) CLEARANCE CERTIFICATE NO. M231001

NAME:	Ms D Tlhabela
DEGREE: PhD	(Principal and Co-Investigators)
DEPARTMENT:	School of Therapeutic Sciences Department of Nursing Education Medical School University
PROJECT TITLE:	Factors influencing implementation of termination of pregnancy policy in Gauteng Department of Health - a multi-method study
DATE CONSIDERED:	27/10/2023
DECISION:	Approved unconditionally
CONDITIONS:	This approval applies only to the study sites listed in Annex 1 attached Further sites may be added on presentation of evidence of management approve to the HR (Med)
NOTE:	If contact information regarding student study participants is required, please contact t e Registrar's office <Nicoleen.Potgieter@wits.ac.za>
SUPERVISOR:	Professor S Schmollgruber and Dr S Armstrong
APPROVED BY:	Professor Ruff, Chairperson, REC (Medical)

DATE OF APPROVAL: 1 February 2024 EXPI DATE: 31 January 2029

This Clearance Certificate is valid for 5 years from the daapproval. An extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and ONE COPY returned to the Research Office secretariat on the 3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to submit details

to the Committee. I agree to submit a **yearly progress report** in the format available at https://wits.ac.zalresearch/researcher-supportfresearchethics/ethics-committees/. This report is due annually, for the duration of the Clearance Certificate, beginning on the first anniversary of Date of Approval above. Unreported changes to the study may invalidate the clearance given by the HREC (Medical).

Signature of Principal Investigator Date

Annex 1

Protocol No. M23/10/01 Ms D Tlhabela

Study sites approved under this Clearance Certificate

Stud site	Date of HREC (Med) Approval
1. Chiawelo CHC	2024/02/01
2. Chris Hani Baragwanath Academic Hospital	2024/02/01
3. Hillbrow CHC	2024/02/01
4. Jabulani Dumani CHC	2024/02/01
5. Johan Heyns CHC	2024/02/01
6. Kalafong Hospital	2024/02/01
7. Kgabo CHC	2024/02/01
8. Laudium CHC	2024/02/01
9. Lenasia South CHC	2024/02/01
10. Leratong Hospital	2024/02/01
11. Nokuthela Ngwenya CHC	2024/02/01
12. Randgate PHC	2024/02/01
13. Sebokeng Hospital	2024102/01
14. Sedibeng CHC	2024/02/01
15. Soshanguve CHC	2024/02/01
16. Stanza Bopape CHC	2024/02/01
17. Stretford CHC	2024/02/01
18. Tembisa Hospital	2024/02/01
19. Thelle Mogoerane Hospital	2024/02/01
20. Zola CHC	2024/02/01

Professor P Ruff
Chairperson: Human Research Ethics Committee (Medical)

2024/02/01