Accelerating the Pace of Progress in South Africa

An Evaluation of the Impact of Values Clarification Workshops on Termination of Pregnancy Access in Limpopo Province

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Ipas

Ipas works globally to increase women's ability to exercise their sexual and reproductive rights and to reduce abortion-related deaths and injuries. We seek to expand the availability, quality and sustainability of abortion and related reproductive-health services, as well as to improve the enabling environment. Ipas believes that no woman should have to risk her life or health because she lacks safe reproductive-health choices.

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Executive Summary

Although legal barriers to safe abortion in South Africa were lifted in 1996 after years of struggle, pervasive misunderstanding of the abortion law persists. Ipas South Africa collaborated with the Women's Health Directorate of the Limpopo Department of Health and Welfare (DoH) to create a provincial strategy for expanding and increasing access to termination of pregnancy (TOP) services for women who need them. Together, Ipas and the Limpopo DoH conducted 22 values clarification (VC) workshops for approximately 645 community members and health-care providers in the province in 2002 and 2003. The workshops were designed to encourage attitudes and behaviours that favour the protection of women's reproductive rights at the community level and greater compliance with the Choice on Termination of Pregnancy (CTOP) Act at the health-facility level.

This study employed a retrospective multi-method design to assess the impact of the workshops at the individual, community and facility levels. Qualitative and quantitative assessments of personal transformation were collected from 193 workshop attendees. Knowledge, attitudinal and behavioural indicators of change were measured. To gauge the impact of the workshops on the type and quantity of services offered, site visits were conducted in 20 hospitals and clinics before and after the intervention.

Major Findings

1. Participants found the workshops to be a helpful forum in which to consider diverse viewpoints. Participants overwhelmingly reported a positive, respectful climate; 97.4% perceived that everyone attending the workshops had an equal opportunity to speak and be heard.

2. Four out of five workshop participants demonstrated a firm grasp of the main elements of the CTOP Act; however, critical gaps still exist in their knowledge of the legal right to second-trimester abortion. Many participants were still unaware of the disparities in reproductive health that exist between Limpopo and other provinces.

3. Among the workshop participants, 48% reported that they were either generally or very supportive of TOP services prior to the advent of the workshops. Only 26% described themselves as initially opposed to TOP. This suggests that half of the recruited participants were favourably disposed to the issue before the workshop began.

4. There were few statistical differences in attitudinal or behavioural outcomes between those who reported prior opposition to TOP and those who voiced prior support. Most participants reported increased empathy, support and comfort regarding TOP service delivery.

5. Demonstration of manual vacuum aspiration (MVA) instruments was identified as a critical component of the workshop experience. Facilitators and participants reported that the demonstrations helped to dispel myths and misperceptions about the MVA procedure, which were root causes of some participants' fears and apprehensions about TOP.

6. Most attendees (52.4%) surveyed reported that they had pursued a follow-up action as a consequence of the VC workshops. Over a third had further contact with the facilitators. One in five (21.9%) attended a subsequent meeting on issues identified in the workshops.

7. Values clarification can motivate health workers to want to become trained TOP providers. Of the eligible nurses and midwives who lacked training in TOP prior to the workshops, all 10 (100%) reported a desire to be trained as TOP providers following the workshops.

8. Values clarification, provider training and equipment provision do not automatically lead to widespread inauguration of new TOP services in the medium term. Only two out of eight *designated-but-off-line* hospitals began to offer services following the intervention. However 36 letters requesting designation for TOP services were sent into the National Department of Health, all requests were granted in December 2004.

9. The VC workshops coincided in time with increased service delivery in low-functioning as well as well-established TOP facilities. Seven out of 10 facilities increased TOP service delivery over the 2003–2004 study period. The mean number of TOP services performed in a 90-day period more than doubled, increasing from 67 (±45) to 134 (±72) cases.

10. Although 89.6% of nurses and midwives were "very comfortable" with the provision of TOP services within their facility and as part of their job responsibilities, over half reported discomfort with providing non-judgmental care to women who need repeat abortions. A third reported discomfort with second-trimester services. Further research is needed to understand health-worker beliefs and needs in terms of service provision. There is also an indication that although services are being provided the providers have conflicting feelings regarding some of the more sensitive aspects of service provision. More emotional and psychological support may be needed to promote the non-judgemental approach to providing services.

This study offers encouraging findings about the impact of values clarification at the community, facility and individual levels, as well as providing important insight about enhancing the model to ensure the desired outcomes.

Introduction

Although legal barriers to safe abortion in South Africa were lifted in 1996 after years of struggle, pervasive misunderstanding of the abortion law persists. This study evaluates the effectiveness of an intervention called "Values Clarification (VC) Workshops," which is designed to transform attendees into reproductive-health and rights advocates who will facilitate access to comprehensive reproductive-health services in their communities and health facilities.

VC workshops such as those evaluated in this study are designed to not only shift attitudes and behaviours but to serve as a channel for soliciting the support of a given community for inauguration of new termination of pregnancy (TOP) services. This is a major priority of the Limpopo Department of Health and Welfare (DoH).

The Limpopo DoH identified a number of possible causes of the limited provision of TOP services in the province. These were, primarily: the negative attitude of managers and community members toward the provision of safe abortion services; the lack of trained providers and physical resources; and the many myths about abortion within the rural communities. The biggest challenges, however, were the lack of knowledge about and the inadequate implementation of the Choice on Termination of Pregnancy (CTOP) Act.

Limpopo is the province in South Africa where access to TOP services is possibly the most inadequate. "A survey of TOP services conducted during 2000 rated Limpopo as the province with the lowest number of TOP performed (Braam, 2002)". The province was ranked fourth based on the number of designated TOP facilities, but was next to last in the number of functioning facilities. Resistance to TOP service implementation—manifested in the forms of obstructive management, lack of staff allocated to provide the service and lack of adherence to national norms and legislation—has resulted in many designated facilities being unable to offer the life-saving service. Judgmental and at times hostile working conditions for TOP providers have hindered training and staff-retention efforts. TOP providers are often lost to the private sector. Where TOP services are available, they frequently rely on a single provider or exist precariously, subject to the will of one facility manager, cleric or local politician.

VC workshops, which were used successfully during the transformation process of health systems in South Africa in the late 1990s, were regarded by the Limpopo DoH as a credible vehicle for addressing the situation. During VC workshops, participants are given many opportunities to express their concerns. The purpose of the workshops is not to change opinions overnight, but to inform the participants and begin building an attitude of tolerance.

In some of the more rural areas of South Africa, communities are participatory and self-governing. Important decisions regarding the community are taken in consultation with elders and other influential representatives who may not hold public office. Religious and traditional leaders play pivotal roles in decisionmaking and the dissemination of new projects and services. Health-service implementation in the absence of community support tends to falter.

Traditionally, this implies that in order to inaugurate new reproductive-health services in a local clinic, the Community Liaison Officer (CLO) of the facility must consult the community, which will then decide whether to support the services. Although the process of soliciting community input and consent is widely acknowledged as essential to the successful launching of new services, the mechanisms and funding required are often difficult to find.

Stigma and passive resistance remain insidious barriers to the full realization of reproductive equality and justice in South Africa. Myths about women's motivations for terminating pregnancies and pervasive misperceptions about the aspiration procedure itself continue to hamper access to safe abortion services for the country's most disadvantaged women. Many individuals remain unaware that termination of pregnancy is legally available to every woman in the first trimester and under many circumstances in the second trimester. Limited awareness of the legality of TOP by the general public precludes the kind of demand-driven support seen for other reproductive-health services. The institutionalisation and sustainability of TOP services remain challenging due to this absence of community-wide support.

The Limpopo DoH invited Ipas, an international nongovernmental organization (NGO) with expertise in abortion policy, clinical training and research, to assist with the design, facilitation and financing of VC workshops, which had the dual purpose of educating diverse constituencies and involving them in the fulfilment of the CTOP Act. This evaluation was designed by a team of researchers and practitioners to measure the efficacy of the workshops.

Dynamics of Health Education and Behaviour Change

Workshops are often put forth as a solution to non-compliance with national laws or DoH norms and standards, and are frequently used as an intervention to address dysfunctional organizational cultures and other non-skill-based service-delivery obstacles. However, workshops are no panacea. The keys to changing attitudes and behaviour have been somewhat elusive to researchers seeking to identify them. Information may be a vital ingredient, but experts agree that knowledge is typically insufficient to prompt sustained moderation of ingrained behaviours. While no single theory explains the way groups change their thoughts and opinions about certain issues, experts in the field of health behaviour have defined some of the cognitive processes and conditions that can spur transformation (Prochaska el al., 1985, 1988, 1991, 1992). These processes include *consciousness-raising, social liberation, emotional arousal, self-reevaluation, commitment, countering, environmental control, reward and helping relationships.* Each process can be an important part of the package of essential stimuli needed to produce long-lasting changes.

Many authors also see attitudinal and behavioural changes as stages or steps of an ongoing process. Although disagreements abound on the specific terms for and number of stages, experts concur that one of the strategic precursors of any intervention is the identification of where each participant is located along an attitudinal and behavioural continuum. Certainly, all individuals approach conversations about reproductive freedom from a diverse array of starting points. Participants' beliefs about reproductive rights and health are influenced by scientific knowledge, personal experience and a variety of other personal characteristics. Experiential behavioural interventions can be most effective when they are tailored to reflect the place where each participant starts—this is known as stage *matching.*

However, not all interventions can be designed for homogenous, like-minded groups. It is highly likely that a mix of pro- and anti-choice viewpoints will be represented in the VC workshops and, in fact, given the dialectic nature of the workshops, such heterogeneity is arguably a critical ingredient.

Origin of Values Clarification Workshops

Values clarification (VC) is an umbrella term for any intervention aimed at changing attitudes by providing new information and facts and encouraging the critical rethinking of cultural myths and assumptions. The strength of VC workshops is found in both their methodology and effective implementation.

The methodology of VC workshops encourages participants to explore their personal value systems and relate them to the needs of women. Often this includes re-evaluating implicit and explicit societal norms. *Health Workers for Change*, which originated in South Africa as an intervention to improve quality of care by focusing on providers' interpersonal relationships with coworkers and clients, is one type of VC curriculum that focuses on critically analysing the current state of health-care programs in terms of attitudes, working conditions, the role of management and so on (Fonn and Xaba, 2001). This approach encourages researchers and participants to understand the root causes of various problems and develop appropriate solutions.

The basis of the *Health Workers for Change* methodology can be traced to Paulo Freire's approach to modern adult education and the theory of participatory research, both of which use awareness, reflection and action to initiate a process of positive social change (Haaland and Vlassoff, 2001). Since its conception, *Health Workers for Change* has been adapted for use in various locations throughout Africa and South America.

The Women's Health Project (WHP) adapted and specialized the *Health Workers for Change* methods for abortion-policy implementation and released a new curriculum, *Health Workers for Choice*, in 1996. As a descendent of *Health Workers for Change*, the *Health Workers for Choice* curriculum is based upon participation as a means of transformation. A safe forum for open discussion is created, allowing for a sharing of ideas that would not otherwise be voiced. An important element in this VC curriculum is the posing of problems as a pedagogical method for generating transformation and commitment (Haaland and Vlassof, 2001). The facilitators act more as guides than traditional teachers and more as equals than superiors, providing direction and relevant information but allowing the participants to self-determine the course of the session.

Description of the Values Clarification Intervention to be Evaluated

The intent of the Limpopo DoH and Ipas VC workshop collaboration was to reach six stakeholder groups in each of the six districts of Limpopo Province, for a total of 36 workshops. The six groups were: traditional leaders, traditional healers, midwives, members of faith-based organizations, municipal councillors and health-facility managers. Due to logistical challenges, it became necessary to combine stakeholder workshops, which was a logical choice given that many stakeholders hold more than one role in the community. Twenty-two workshops were actually held, seven of which (31.8%) were mixed groups. Despite the mixing of stakeholder groups and variation in facilitation, core content areas remained relatively constant in all workshops. Table 1 shows how the specific workshop content relates to cognitive processes of change.

Although participatory methodologies were used, workshop reports indicate that some didactic one-way presentations were included. Formal presentations about Ipas—the sponsoring NGO—and the MVA instrument were included in some workshops. The Limpopo DoH took advantage of the workshops to inform the participants about plans for the decentralization of services and about the work that has already been accomplished.

Even though, theoretically, participatory methods work best with flattened hierarchies, facilitator interviews suggest that encouraging high-status individuals to interact with lower-status individuals on an equal footing was sometimes challenging. Often, the real-life distribution of power remains salient even under workshop conditions. An acknowledged limitation of VC workshops is that transformational change is only feasible when the structural conditions permit. Where hierarchies and structures are inflexible, values clarification can cause frustration by raising expectations which go unmet (Pittman, Blatt and Rodriguez, 2001).

Although VC workshops do not rely on written materials, a brief participant handbook was used. Even though a great number of participants were unable to read, they requested workbooks that they could take back with them and use with the help of a literate community member.

Table 1: **Change Mechanisms of Selected Curricular Content**

Workshop Content	Change Mechanism
The history of abortion in South Africa from the 18th century to the present	Knowledge acquisition
The right of women to safe, accessible services	Countering misunderstandings about women's rights
The obligations, penalties and entitlements of the Choice on Termination of Pregnancy (CTOP) Act	Knowledge acquisition
A case study of abortion-related maternal death ("Zanele")	Emotional arousal and consciousness-raising
The rights and responsibilities of clients	Consciousness-raising and knowledge acquisition
The rights and responsibilities of providers	Self-reevaluation
Singing and dancing of the CTOP Act anthems	Emotional arousal
Signing of Personal Commitment	Fostering commitment to change
The uterine-evacuation procedure, including handling of an MVA aspirator	Countering misperceptions
Preparation of action plans	Fostering commitment to change

Adaptations

Intrinsic to the participatory methodology is the possibility for adaptation to the specific needs of the audience. Every workshop was unique in that the delegates had different backgrounds, came from different parts of Limpopo and spoke different languages. At one workshop, the content was simultaneously translated into four languages – Tsonga, Venda, Sepedi/Sesotho and English – to permit universal participation.

In keeping with the goal of local relevance, workshops were modified to reflect the perceived or expressed needs of stakeholder groups. Issues that emerged spontaneously during implementation were incorporated. The traditional healers' workshops were an example. In response to DoH concerns about unqualified traditional healers performing unsafe abortions, extra time was allocated to the theme of *referral* of traditional healers' clients to designated TOP facilities. Traditional healers, in turn, used the workshops as a forum for raising the issue of *counter-referral* of TOP clients from the health facilities to traditional healers for ritual cleansing.

The length of the VC workshops varied. Most participants (60.9%) reported attending a three-day event, whereas 14.1% recalled attending a two-day workshop, 4.7% reported attending a one-day event and 18.8% reported attending workshops that lasted four to seven days.

Description of the Values Clarification Workshop Participants

Approximately 645 people attended 22 workshops over a two-year period. The selection criteria varied by district and by stakeholder group. Most participants were individually recruited for the workshops by the District TOP Coordinators or the Limpopo Provincial TOP Coordinator.

The Coordinators recruited delegates for the workshops who could influence the communities and organizations of which they are members. In some cases, delegates were selected because of their respected status, political power and/or social or religious influence in the community. The midwives were selected from within each district, hospital by hospital. More than one in 10 (11.6%) were assigned by their managers to attend. A handful of participants attended two or more VC workshops.

Facilitator Characteristics

Success of the VC approach is highly dependent on the skill of the facilitators (Fonn and Xaba, 2001). Each workshop was led by a core group of five facilitators, while five additional facilitators from the districts were called in as needed.

Nine facilitators were employees of the provincial health authority and seven facilitators were also practicing midwives who provide TOP services. Eight facilitators were women. Two facilitators held leadership positions in the Provincial DoH, whereas the others held district managerial roles related to abortion services. The mean age of the facilitators was approximately 45 years. All had three years of education and training experience in termination of prenancy, except one who had five years of experience.

Evaluation Methodology

The retrospective evaluation study design was multi-method. Following are the four main data elements:

1. A post hoc telephone or face-to-face survey of contactable participants.
2. Interviews with workshop facilitators.
3. A review of workshop reports and action plans, where available.
4. A site visit to explore service-delivery changes in facilities with a high concentration of workshop participants.

The four evaluation data sources provided answers to 10 distinct questions about the effectiveness of the intervention.

Table 2: **Evaluation Questions and Data Sources**

1. How satisfied were participants with the VC workshops? 2. How well did they understand the purpose of the VC workshop? 3. How much specific information on the CTOP Act did participants retain? 4. What was the impact of the VC workshop on participants' attitudes? 5. What was the impact of the VC workshop on participants' behaviours, both individual and collective?	**Participant interviews**
6. What were some of the implementation challenges in doing this work? 7. What were the strengths and weaknesses of the project?	**Facilitators interviews**
8. Did the workshops faithfully implement the participatory methodology? 9. Did the content of the intervention vary?	**Review of workshop reports**
10. What (if any) changes in quantity and quality of TOP care occurred at the health facilities following the workshops?	**Site visits**

Ethical review of the evaluation project had been granted previously by the University of North West, and permission to conduct the evaluation was granted by the Limpopo DoH. Participants were identified in the data only by an alpha numeric code.

Five experienced data collectors were trained to conduct the interviews and perform site visits. Facilitator interviews were conducted in March, 2004. Survey data were collected and site visits conducted from June 15th to August 15th, 2004.

An initial assessment of participant knowledge, attitudes and advocacy behaviours regarding the CTOP Act prior to the workshops was not possible to conduct. Therefore all participant information was gathered retrospectively, with the attendant risk of recall bias.

Names and affiliations were available for attendees of 15 out of 22 workshops (68.2%). Attendance rosters from seven of the 22 workshops (31.8%) could not be located. Sufficient contact information for visitation or telephone surveying was only available for 57.8% (373) of the 645 participants. The authors are confident that missing rosters were not systematically different from the rest and infer that the available sub-sample is representative of the total attendee pool.

Although attempts were made to interview the universe of 373 eligible participants, only 51.7% (193) of participants with contact information could be interviewed. Data collectors reported difficulty in reaching participants owing to high rates of staff turnover at public-health facilities (8.0%), disconnected phone numbers (13.2%) and inaccurate addresses (9.3%). Due to the high financial costs of travel across the rural province, face-to-face interviews were necessarily limited to 20 sites with three or more workshop participants. The overt refusal rate for telephone interviews was only 2.6%, whereas the proportion refusing face-to-face interviews was 4.5%. In the final sample, over half of the interviews (55.9%) were conducted by telephone and 44.2% were conducted in person.

All overt refusals appeared to be related to the condition of interest—abortion attitudes. By undersampling those participants with lingering opposition to TOP, this study may overestimate the effectiveness of the intervention. However, given the small proportion of overt refusals, this bias is likely to be inconsequential.

The content of workshop reports and action plans were reviewed to identify recurrent themes. For participant survey data, univariate and bivariate analyses were performed to explore relationships between participant characteristics and self-reported changes in knowledge, attitude and behaviour. The data were juxtaposed (triangulated) and discrepancies were investigated where possible. Significant differences with a p value of $< .05$ are indicated.

Sample Characteristics

As shown in Table 3, participants in the recruited sample were predominantly female (74.1%) and represented a broad range of often overlapping community and health constituencies across all six districts in the province. Midwives and nurses represented over a quarter of the sample (26.9%), followed by traditional healers and leaders (19.2%). Interviews were conducted in four of the eight major languages spoken in Limpopo.

Table 3: **Sample Characteristics (n = 193)**	n	%
Gender		
Female	143	74.1
Male	46	23.8
Missing Data	4	2.1
	193	**100%**
Health Workers		
Nurses and Midwives	53	27.4
Health Facility Management	17	8.8
Social Workers	14	7.3
Community Participants		
Traditional Healers and Leaders	37	19.2
Municipal Politicians	35	18.1
Representatives of Faith-Based Organizations	20	10.4
Community Liaison Officers	17	8.8
	193	**100%**
District		
Capricorn	61	31.6
Vhembe	42	21.8
Mopani	38	19.7
Waterberg	18	9.3
Bohlabela	15	7.8
Sekhukune	14	7.3
Missing Data	5	2.5
	193	**100%**
Language of Interview		
English	134	69.5
Tsonga/Shangaan	30	15.5
Sotho/Sepedi	28	14.5
Venda	1	0.5
	193	**100%**

Evaluation Results

The study results are presented below. Survey findings are presented first, followed by the results of site visits. Data from facilitator interviews and report content are included thematically throughout, particularly when they inform or contrast with data from other sources.

Participants' Positions Prior to the Workshop

To better understand the "mix" of positions on abortion held by participants prior to the workshops, their knowledge, attitude and behaviours were queried post hoc.

Participant Baseline: Knowledge

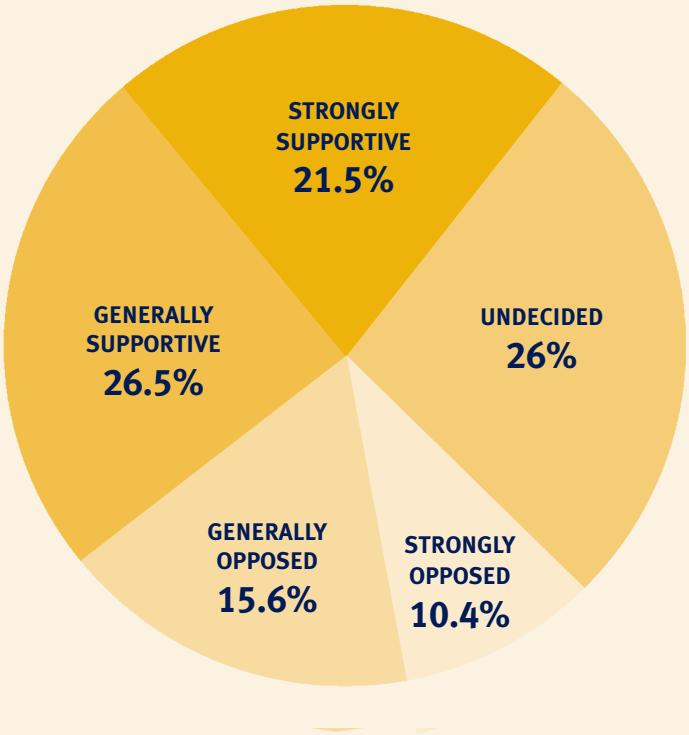
To try to gauge how much participants already knew before the intervention, they were asked retrospectively if they were able to adequately explain the CTOP Act to others *prior* to their attendance at the workshop. 53.6% of participants assumed that, prior to the workshops, they were "capable of explaining the CTOP Act to others". This suggests self-perceptions of prior legal knowledge were high among participants.

Participant Baseline: Attitudes

Participants' openness to dialogue and reflection often influence the degree of potential transformation in a given intervention. With regard to attendees' attitudes prior to the workshops, a clear majority (63.2%) reported feeling "comfortable discussing termination of pregnancy with peers". Slightly over half (58.0%) reported that they held "firm, established beliefs about abortion" prior to attendance.

When asked specifically about feelings toward termination of pregnancy, attitudes spanned the full range. Figure 1 shows that one-tenth described their initial position as strongly opposed (10.4%), 15.6% were "generally opposed" and 26.0% were undecided upon arrival. Among those predisposed to TOP, 26.5% were "generally supportive" and 21.5% described themselves as "strongly supportive".

Figure 1: **Initial Attitudes Toward TOP Services (n = 193)**



The 26.0% who opposed TOP offered diverse rationales. Their initial beliefs were often influenced by religious or legal attitudes. A female traditional healer from Capricorn articulated a commonly expressed sentiment when she said, "According to our religion, TOP was a sin." Traditional healers tended to be anti-abortion for other reasons as well—because they considered the procedure unsafe or did not understand the reasons why a woman would terminate her pregnancy. "I thought that abortion was dangerous," responded one male healer from Vhembe.

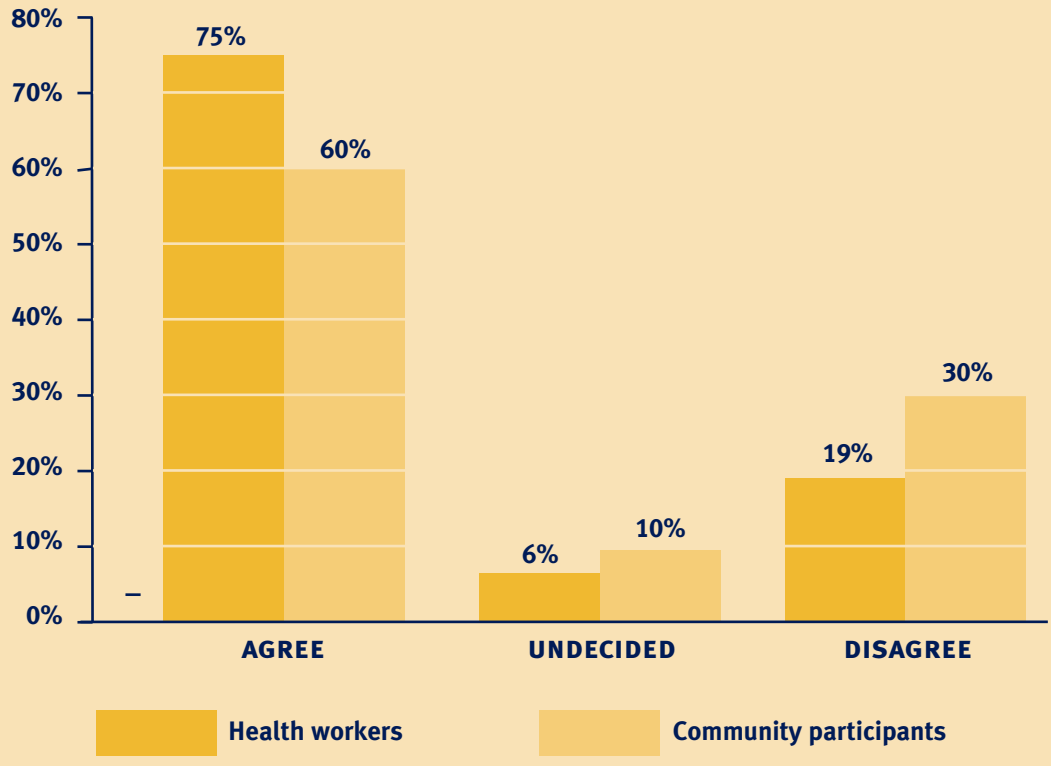
The 26.0% who were undecided reported either ambivalence or apathy. "I had a mixture of feelings about abortion," recalled a male participant from a faith-based organization in Vhembe. A female municipal councillor from Capricorn said, "I was just neutral about these issues." Sometimes the confusion arose because of lack of information regarding the TOP procedure or CTOP Act, rather than an inability to establish a firm opinion on the issue. For example, a male municipal councillor recalled asking questions before the workshop such as: "Was the Act really there? Could people have abortions legally?"

When asked how important the issue of TOP was to the participant personally, 44% indicated that it had little or no importance prior to the workshop, slightly fewer (38.4%) felt it had some or a lot of personal importance and 17.6% could not recall its personal relevance prior to the workshop.

Participant Baseline: Behaviour

To query attendees' prior actions on these topics, a set of retrospective behavioural questions were posed. With regard to participants' self-perceived involvement in the arena of women's issues, 77.6% already considered themselves to be "a part of Limpopo's movement to advance women's health and rights" prior to the workshop. When asked about activism on reproductive health in particular, 64.9% of attendees reported that had already been "working to overcome barriers to increasing access to safe termination of pregnancy in Limpopo". As shown in Figure 2, health providers and management were slightly more likely to perceive themselves as advocates for TOP than attendees from the community. These findings on advocacy self-perception contrast with the previous data showing most participants' initially limited depth of personal feeling about TOP.

Figure 2: **Stakeholders' Self-Report of Whether They Were Working to Overcome Barriers to Increasing Access to Safe TOP Prior to the VC Workshop**



Participant Perceptions of the Goals and Objectives of the Values Clarification Workshop

The evaluation sought to identify what participants felt was expected of them during and after the workshop. It was hypothesized that understanding the purpose of the workshop was a necessary precursor to subsequent engagement in personal advocacy or dissemination behaviour. Participants offered more than 30 separate workshop goals and objectives, almost all of which reflected the organizers' intent. Most responses (52.0%) alluded to the workshop as a learning opportunity. However, fewer than expected spontaneous responses described attitudinal (21.0%) or behavioural (25.0%) change as workshop goals. Moreover, almost none (2.0%) noted that the workshops were an opportunity for participants to *contribute* information as well as absorb it.

Table 4: **Participants' Spontaneous Report of the Desired Outcomes of the VC Workshops**

	%
Knowledge Acquisition	52.0
Changing Participants' Behaviours	25.0
Changing Participants' Attitudes	21.0
Providing Information to Organizers	2.0
Total	**100**

Some participants attended the program with expectations that did not match those of the organisers. For example, one facilitator noted that some traditional healers mistakenly believed that they were going to be trained to perform TOP in the course of the workshop, when in fact the emphasis was on discouraging informal practitioners from performing TOP. This incongruity may have resulted in participants' expectations not being met.

The most frequently stated purposes of the workshops were:

- to promote safe TOP services
- to educate attendees on the CTOP Act and dangers of backstreet abortions
- to improve attitudes about TOP services
- to encourage participants to feel more tolerant of differing perspectives on abortion
- to motivate participants to conduct education in their communities about TOP services and unwanted pregnancy

Infrequently mentioned by participants were the need for advocacy to expand access to services and the active provision of support for women and their providers.

Participant Satisfaction

Attendees reported a high degree of satisfaction with the format, content and facilitation of the VC workshops. Most (93.5%) did not feel that the length was excessive and over a quarter (28.6%) felt the workshops could have been longer. Participants overwhelmingly reported a positive climate, with 94.7% finding attendees respectful of divergent opinions, 96.9% finding facilitators respectful of different opinions and 97.4% perceiving that everyone had an equal opportunity to speak and be heard. Almost all (97.9%) reported attending the entire workshop.

Uniformity of Exposure to Workshop Content

Attendees were asked about specific content areas in an attempt to measure the uniformity of the workshop implementation. When queried about their exposure to different topics during the workshop, participants voiced a strong degree of coherence on the core elements, suggesting that fidelity to the key curriculum content was maintained across the workshops.

Table 5: **Uniformity of Exposure to Key Workshop Content (n=193)**

	Recalled %
Reasons why some women have unwanted pregnancies and resort to unsafe abortion	93.2
Equipment shortages in health facilities	93.0
CTOP law rights and requirements	90.4
Morality and religious viewpoints on TOP	90.0
Contraceptive services to reduce abortions	89.5
The rights and responsibilities of health workers	86.9
The staff shortages in TOP services in Limpopo	85.3
The role of health management in supporting TOP services	84.3
The rights of minors (adolescents under 18)	83.2
Violence against women	79.6
The ways women and men are raised in the family and taught to see life differently	77.0
The process of designation of new TOP services [1]	76.4
Transportation problems to health facilities	68.1

1 At the time the workshops were conducted, facility designation was a process driven by senior management. However, recent amendments to the CTOP Act have reduced the local burden to prove the capacity to provide services. Hospitals with maternity wards may apply for automatic designation to provide TOP services.

Participants showed modest levels of recall about the following content areas: the gender content, the designation process for new TOP services and transportation barriers. Only 77.0% felt that "the ways women and men are raised in the family" was a subject addressed in the workshop (see Table 5). Such gender issues were addressed in the reflection exercise "My Childhood", which was described by facilitators as unpopular. This may account for the fact that only three-quarters re-called the content.

Newly Acquired Knowledge

To measure participants' perceptions of newly *acquired knowledge*, the participants were asked to freely list what content of the workshop was new to them, if any. The opportunity to see and hold the manual vacuum aspirator (MVA) was the most commonly cited new content area. Facilitators felt that handling the aspirator helped clarify for the participants how minor the uterine-evacuation procedure in early pregnancy really is and counter the myths perpetuated by anti-choice factions.

"New Information" Learned in the VC Workshop in Rank Order

1. MVA equipment and how to use it
2. Rights and penalties under the CTOP Act
3. Awareness of the scope of the problem of backstreet abortions
4. The importance of comprehensive TOP services for women's health
5. The importance of being less judgemental of women who have TOP
6. The importance of being tolerant of others' viewpoints and ideas
7. The importance of communication and cross-referral in the health system
8. The importance of advocacy for new and better TOP services
9. The importance of supporting TOP providers
10. The role of gender and inequality in women's reproductive health

Even though most participants self-reported having adequate knowledge of the CTOP Act prior to the workshops, it was still the second most-often cited "new information". This suggests that participants may have overestimated their prior understanding of the law.

CTOP Act Knowledge Scores

When asked about specific entitlements and protections of the national CTOP Act, participants demonstrated a fair degree of knowledge on most aspects. Most participants were aware of women's (90.2%) and adolescents' (81.3%) decisionmaking autonomy and the legal penalties for obstructing the law (85.0%). As Table 6 indicates, after the workshops a considerable proportion of participants remained unclear on the broad range of conditions under which second-trimester services are legal.

Table 6: **Knowledge of Selected Aspects of the CTOP Act (n=193)**

	Correct answers (%)
The CTOP Act requires husbands or boyfriends to give written consent before a woman can terminate a pregnancy. [FALSE]	90.2
Up to how many weeks of pregnancy can a woman request TOP by a trained midwife? [12 WEEKS]	88.4
The CTOP Act mandates financial penalties and up to 10 years imprisonment for people who attempt to obstruct women's right to TOP services. [TRUE]	85.0
The CTOP Act requires pregnant adolescents to obtain written parental consent before they can undergo a TOP. [FALSE]	81.3
Can a woman have a TOP in the second trimester if the pregnancy resulted from rape or incest? [YES]	78.0
Can a woman have a TOP in the second trimester if the pregnancy threatens the physical health of the woman? [YES]	73.9
Can a woman have a TOP in the second trimester if the foetus has probable developmental defects? [YES]	71.2
Can a woman have a TOP in the second trimester if the pregnancy threatens the mental health of the woman? [YES]	66.5
Can a woman have a TOP in the second trimester if the pregnancy would significantly affect the social and economic circumstances of the woman? [YES]	40.3

Fewer than half of participants (40.3%) realized that TOP is legal up to 20 weeks when the pregnancy negatively affects the social and economic circumstances of the woman.

Knowledge of the Reproductive-Health Services Situation of Limpopo

Although reproductive-health access was a central topic during the workshops, statistics were not emphasized. Nevertheless, in the evaluation, participants were asked a series of specific questions regarding service provision and health outcomes in Limpopo relative to other provinces. Participants tended to assume that the Limpopo maternal-health profile is equal to or better than national averages. However, most nationally representative studies indicate that Limpopo remains consistently below the national average in contraceptive coverage, abortion rates and prevention of the complications of unsafe abortion. Table 7 shows that most of the workshop attendees were unaware of Limpopo's disproportionately poor access to contraceptive and TOP services and higher rates of abortion-related morbidity relative to the rest of the republic.

Table 7: **Reproductive-Health Service Delivery Situation of Limpopo (n=193)**

	Correct answers (%)
Although there are 45 health facilities in Limpopo that are designated by the government to offer safe TOP, the number of facilities that routinely offer TOP services is 26. [TRUE]	29.8
Compared with the rest of South Africa, the percentage of women of reproductive age using modern contraception in Limpopo is less than other provinces. [TRUE]	13.0
Limpopo has the lowest rate of TOP of any province in South Africa. [TRUE]	10.9
Compared to the rest of South Africa, the number of women with severe abortion complications measured in Limpopo Province is greater than the national average. [TRUE]	8.9

Participant Attitudinal Shifts

As anticipated, the vast majority of participants (97.4%) affirmed that the VC workshops increased their personal awareness of their own feelings. Table 8 reveals increased compassion regardless of participants' original position on the TOP issue. Predictably, those initially opposed to TOP were the most likely to be influenced by the workshop.

Table 8: **Self-Reported Attitudinal Shifts Attributed to the VC Workshop (n=188)**

Did the VC workshop ...	Previously positive toward TOP (%) (n=92)	Previously undecided about TOP (%) (n=47)	Previously opposed to TOP (%) (n=49)	Total (n=188)
... inspire compassion for people who provide TOP care?	97.8	97.9	85.7	93.2
... inspire compassion for women who undergo abortion?	97.8	97.9	87.5	92.7
... influence your thoughts or personal beliefs about the complex issues of abortion?	76.1	72.0	81.6	76.2

Two recurring reasons participants were originally against abortion were based on religion and legality. A female midwife from Vhembe said, "I took abortion as killing." Following the workshop, her belief was much different: "I now understand TOP is a normal service to be offered to those in need." Similarly, a female traditional healer from Capricorn who originally said that, "according to our religion, TOP was a sin," stated her new belief that "TOP is a cure."

Participants who were initially against TOP did not universally indicate that they now actively support the practice, but they did indicate a better understanding of why TOP services need to be available. For example, a male municipal councillor from Vhembe, who noted that prior to the workshop he believed that abortion was a sin, said:

"I now know that there are certain personal circumstances that warrant abortion. Safe TOP saves a lot of lives and reduces complications resulting from backstreet abortions. I also understand TOP to be saving government time and resources which should be used to treat complications resulting from backstreet abortions."

Open-ended responses suggested new appreciation of the personal and societal benefits of TOP, especially among the traditional healers. Many participants' initial beliefs tended to reflect a lack of understanding of the contextual factors involved in a women's decision to have an abortion and confusion regarding the safety of the procedure.

Participants also indicated enhanced appreciation for the importance of safe abortion. A male participant from Waterberg said that before the workshop he did not view TOP as vital. "Now I realize how important TOP is and that everyone should be made aware of it." A few participants noted that their supportive stance on abortion was reinforced by their participation in the workshops; only one participant said her negative view was strengthened by workshop attendance. Approximately 23% of those who initially affirmed that the workshop influenced their personal beliefs were not able to articulate a specific attitudinal change.

Health providers were asked if they thought that the VC workshops led to any noticeable change in the attitudes or behaviours of their colleagues. Almost three-quarters (74.6%) reporting having personally observed a change in their peers' behaviours.

To evaluate any tangible impact of VC workshops upon the quality of TOP care, a set of attitudinal questions about specific service-delivery situations was asked of the subset of the sample who work in health facilities. Participants were generally very comfortable with providing TOP services according to the law; however, over half expressed negative attitudes about the obligation to provide nonjudgmental care to women who request repeat abortions.

Table 9: **Health-Worker Attitudes Toward Specific Services and Clients (n=59)**

	Very comfortable (%)
Having TOP available at the facility where I work	84.7
Offering postabortion contraception to adolescents who would like to prevent future pregnancies	86.4
The availability of TOP for adolescents without parental consent	88.1
The availability of TOP after 12 weeks of pregnancy (second trimester)	62.7
The responsibility to provide TOP to the same woman on more than one occasion	47.5

Most nurses, social workers and midwives (89.6%) reported that they would feel "very comfortable" personally providing nonjudgemental counselling to woman about the range of options for managing unwanted pregnancies. Similarly, nine out of 10 eligible providers (89.6%) said they feel very comfortable providing care to TOP clients.

Participant Behavioural Shifts

Almost all participants (96.3%) affirmed that the VC workshops had boosted their self-awareness of their actions. Table 10 clearly shows that a slight majority of attendees surveyed (52.4%) reported that, as a consequence of the VC workshops, they had begun "new activities". These activities generally can be subdivided into two types: diverse forms of advocacy and personal efforts to enhance the quality and quantity of reproductive-health care. New advocacy activities typically had three main target audiences: communities, health-care providers and municipal authorities.

Table 10: **Self-Reported Behavioural Shifts Attributed to VC Workshop (n=188)**

	"Yes" among those previously positive toward TOP (%) (n=92)	"Yes" among those previously undecided about TOP (%) (n=49)	"Yes" among those previously opposed to TOP (%) (n=47)	Total (n=188)
Has your personal behaviour changed as a consequence of VC workshops?	62.6	78.7*	77.6	70.2
Have you begun new activities as a consequence of the VC workshop?	50.5	59.2	50.1	52.4
After the workshop, did you have further contact with the organizers on any issues related to the workshop?	42.9	30.6	30.6	36.8

The VC workshops based on the *Health Workers for Choice* curriculum are designed to evoke behavioural change at the individual and/or collective levels. This study sought to distinguish between personal acts and those undertaken by united groups of stakeholders.

Individual Behaviour Changes and Advocacy Efforts

Over two-thirds of all participants attributed some form of personal behaviour change to their participation in the workshop. Those initially ambivalent towards TOP were slightly more likely to report changes in personal behaviour than those who were already pro-choice ($p < .05$). Examples of individual initiatives illustrate the range of directions taken. With regard to community-oriented initiatives, efforts centred upon disseminating information or providing support to facilities. Those projects took a number of forms, including meetings, workshops, youth groups, video sessions and church sermons.

Health providers reported making incremental improvements in the quality and quantity of services. "I established an isolated new ward for the people who come for TOP," said a female senior health manager from the Vhembe district. "I gave more staff to the ward. A number of beds were added." Several health-care providers and community leaders reported beginning to provide individual client counselling. A female social worker from the Capricorn district said, "I am giving pre- and post-counselling about TOP in my office."

A handful of participants reported petitioning the local government for changes. They advocated for TOP provision or information dissemination by directly addressing a government body or official. One female municipal councillor said she "wrote a motivating report to [the] mayor asking for workshops".

Collective Actions

It was hypothesized that some subsets of workshop attendees might establish sufficient group cohesion, known as *collective identity*, that they would jointly pursue advocacy activities. However, the "Action Plans" workshop exercise which would have facilitated the development and pursuit of joint activities appears not to have been employed uniformly. In theory, the problems that emerged in the workshops were to be matched with proposed solutions and action plans were to be generated on the individual, community and societal levels, making the workshops an initial step on the road to improvement. In practice, the action plans exercise was not always completed in the same way or with the same understanding in all workshops. Few action plans could be located after the workshops.

When asked if they remembered generating action plans, only 55.7% could remember this exercise. Moreover, when asked specifically to name a sample "problem" and "solution" pair outlined in the action plan, less than half (48.9%) could provide one. The facilitators themselves struggled with keeping track of the action plans that were generated, and in some cases could not even remember the action-planning portion of the workshop.

Most participants (64.0%) recalled discussing the potential need to meet again as a group. However, only 36.8% said they had contacted the facilitators in the months following the workshops about issues that had been raised. These tended to be individuals who were positively inclined toward the issue of TOP access prior to the workshop. About one in five (21.9%) reported that they had held a subsequent or follow-up meeting to continue to address the action plan developed in the workshops.

Even though the action plans were not widely remembered, collective actions did occur. One group activity mentioned was dissemination of the workshop ideas within local health-care facilities. An effort was made to meet with and positively influence non-attending health professionals in their approach to and provision of TOP services. A female traditional healer from the Vhembe district said, "The traditional healers who attended VC workshops in our community held a meeting with nurses from the local clinic where we gave feedback about the workshop."

One male participant from a faith-based organization in the Capricorn district responded: "In our church context we now have youth rallies and speak about TOP. [The] Council of Churches wants to embark on a campaign to help spread the message."

Change at the Health-Facility Level

As mentioned above, a preponderance of the 64 health-care providers in the sample (74.6%) reported behaviour change in their workplaces that they attributed to values clarification. Most commonly, staff demonstrated a positive change in attitudes, taking a more tolerant, affirmative stance on TOP services, the providers of those services and the women who use them. One responder said, "They don't gossip when people come for TOP services—they take it as a usual or normal service." At some facilities, this change in attitude resulted in an improvement in the provision of TOP services as well: health providers' ability to professionally and correctly respond to TOP clients and their situations increased. For example, health providers at one facility were able "to understand what TOP is, [and] able to give information to clients". Another visible change was enhanced communication, both among staff members and between staff members and their clients. "They can talk freely about TOP and family planning," said one health worker. One participant noticed no change.

Table 11: **Participant Reports of Health-Facility Improvements by Type**

Change in Health-Care Facility	Number of Responses
More positive attitudes	24
Improved TOP services	11
Improved communication	9
Other	6
Total	**50**

Interpretations of the presence or absence of behavioural change following the VC workshops need to be contextualized by information about the health facilities included in the study. Researchers have shown that the capacity for change can be a function of the structural characteristics of the health system (Fonn and Xaba, 2001). Most of the health facilities in which workshop participants work do not currently offer TOP care. When asked how much the CTOP Act affected their work at the health facility, almost a third of the health providers (31.7%) responded that the CTOP Act did not affect their work at all. A similar proportion (31.8%) reported that their work lives were "somewhat affected" and 36.5% reported being "very much affected" by the CTOP Act.

Encouraging Training of New Providers

The researchers were interested in discovering if frontline health-care providers who attended VC workshops would subsequently show interest in becoming trained providers of TOP care. From among those who were eligible and not yet trained, all 10 (100%) reported that they were keen to be trained as TOP providers. Twelve of the 45 midwives in the sample (26.6%) were already trained as providers by the time the evaluation was fielded and 10 were offering services.

Site Visits

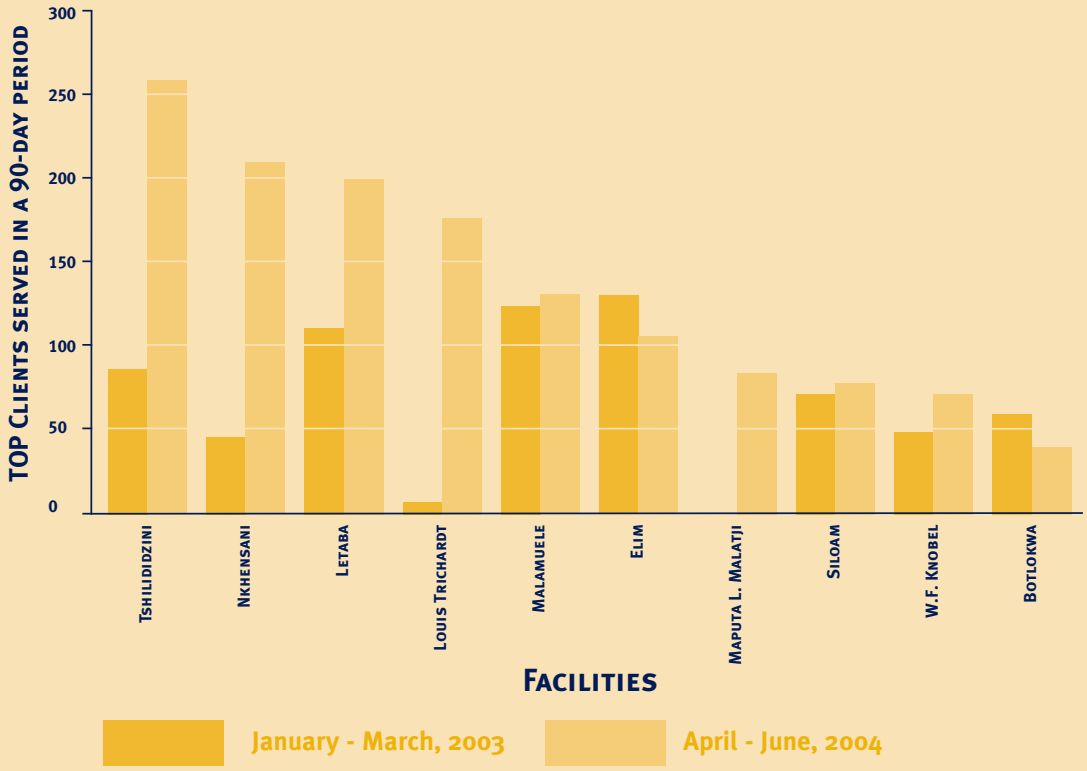
To observe any tangible changes at the facility level, a subset of health facilities was purposefully selected. Twenty sites were chosen where three or more staff had participated in VC workshops. Half were designated-but-off-line and half were rendering TOP care. Log books, equipment and staffing were measured following the workshops in June 2004 and compared to their 2003 pre-workshop status. Interviewers assessed both the type and quantity of TOP services provided in contrast to a baseline survey (Mitchell et al., 2004).

Among designated-but-off-line facilities, only two out of 10 — Seshego and Maphuta L. Malatji hospitals — started offering TOP services after the VC workshops. Eight others remained non-functional. Two Capricorn clinics, one of which had been pending designation prior to the workshop, obtained designation. Thirty-six others throughout the province have received letters of designation.

Positive increases in service delivery were observed in seven out of 10 on-line health facilities. Over the evaluation period, the mean number of TOP services performed in a 90-day period more than doubled, increasing from 67 (+/-45) to 134 (+/-72) cases. The median increase was 48. As shown in Figure 3 (see page 36), among facilities where a decrease was noted, the decline was modest, ranging from seven to 25.

It is important to emphasize that these improvements are not exclusively attributable to VC workshop attendance, because the training and equipping of facilities was occurring while the workshops were being offered. The largest observed increases in caseloads occurred in places where Ipas either trained or provided equipment. Five new providers were trained in the facilities that experienced an increase in caseloads, while three were trained in those that recorded a slight decrease in caseloads. One of the institutions that experienced the most drastic increase, Louis Trichardt Hospital, had no new midwives trained but did address the MVA-instrument shortage.

Figure 3: **A Comparison of TOP Caseloads in Selected Facilities Before and After Staff Participated in VC Workshops**



Positive Outcomes Not Captured in the Formal Evaluation

In addition to those aspects specifically measured in the study, there were other ancillary outcomes that merit mention. Foremost was the fact that the Limpopo DoH assumed a visible leadership role throughout the implementation and evaluation processes and increased its ownership of and leadership on the TOP issue in general. Letters from 36 facilities requesting designations as TOP service provision sites were forwarded to the National Department of Health. Permission was granted to these facilities in December 2004.

Additionally, interest was stimulated by the intervention as word of the workshops spread through the communities. Limpopo Province and Ipas have received numerous requests for more VC workshops and other provinces have also indicated interest.

Discussion

This section considers the implementation findings in the broader context of the reproductive-rights movement. Departing from a strictly research perspective, effectiveness is discussed here from the point of view of the need to maximize strategic investments in low-resource settings.

The large proportion of mixed groups in the workshops suggests the feasibility of implementing intensive large-scale interventions. While heterogeneity among participants may limit the opportunity to tailor the workshop content, it can also increase the potential for development of alliances across stakeholder groups. Such helping relationships are a key ingredient of behavioural change.

The workshops were also heterogeneous in terms of the participants' attitudes. One important question left unanswered by this study is whether the workshops were targeting the "right" kind of person. It is striking that 64.9% of attendees reported that they had *already* been working to increase TOP *access before* attending the workshop. It is also noteworthy that 48.0% were supportive of TOP services prior to the intervention. This raises the question about the cost effectiveness of the intervention. Is it unnecessary to fund an intervention for those who already fully support CTOP Act? Is it equally important to try to encourage a transition from "support" to "advocacy" as it is to move stakeholders from "opposition" to "tolerance"?

Further research using observational methods is needed to determine how the mix of participants in VC workshops affects the outcomes, and whether recruitment of fewer advocates is a viable and more cost-effective strategy. This research should explore what role pro-choice attendees play that cannot be played by the facilitators, and whether there is a critical minimum number of advocates who need to be present in order for the exercises to "work".

The VC workshops seemed to inspire more individual shifts than collective action. One possible explanation for this is that, collectively, strategizing or "owning" the local implementation challenges, was under emphasized. The desired outcomes of the workshops may need to be better clarified in future. The high number of follow-up activities conducted by individuals may signal that the action plans are not essential. One possible reason for the limited recall of action plans and personal commitments is the low level of literacy among some participants, which limits the effectiveness of written exercises.

Assessing the Validity of the Study Results

Since this study did not measure pre-workshop activism, causality between workshop participation and advocacy behaviours cannot be confidently established. However, the association ascribed by participants themselves reinforces the notion of a causal link.

It is prudent to approach all responses cautiously, especially those indicating the most dramatic shifts in beliefs and behaviour, in light of the fact that some facilitators expressed concerns over the sincerity of some of the promises made during the workshop. One Coordinator commented, "I like the personal commitments, but some other people they write commitments as if they are changed people whereas they are not—they just say that for the sake of progress."

However, the consistency of the positive findings does lend credence to the notion that values clarification is effective. The activities described and the service-delivery improvements did not lend themselves to embellishment in the way that other self-reporting does.

Further support for the validity of these results can be found in the findings of an earlier study which parallel those described here. In 1996, in response to the passage of the CTOP Act that same year, the Planned Parenthood Association of South Africa (PPASA) conducted a pilot evaluation of seven VC workshops in the Western Cape and found them to be an effective way of changing attitudes toward TOP (Marais, 1996)[2].

2 Although similar in many respects to those workshops conducted by Ipas, the intervention and evaluation approaches of the two organizations differed in their target audience, geographic focus and assessment methodology. PPASA collected both pre- and post-workshop data, strengthening their conclusions. However, actual behavioural changes and community-level impacts were not assessed. The PPASA workshops were specific to one stakeholder group—health-care workers—and lasted one day only. The evaluation results of the VC workshops were similar to the findings here, with participants becoming more favourable toward TOP and more compassionate in their approach to TOP patients (Marais, 1996).

Limitations of the Evaluation Design

There are numerous limitations to the retrospective design, including the fundamental impossibility of confidently concluding that perceived knowledge is newly acquired. The researchers managed this weakness to the extent possibly by carefully wording the questions and using triangulation to corroborate findings. The inability to trace almost half of the contactable participants limited the sample size and compromised the ability to assess the effectiveness of the intervention among specific stakeholder groups and geographical districts. Some of the recall issues identified in the study may be a reflection of the significant time lag between attendance and survey and not necessarily a weakness of the intervention. Conversely, the selection bias alluded to previously may overstate the value of the workshops in changing attitudes and behaviours. Finally, post hoc assessments of this type are prone to social-desirability bias. Fortunately, the service-delivery improvements observed from the site visits are less susceptible to these biases since they use a pre- and post-test design and tend to measure more verifiable topics. On the other hand, site visits are prone to cross-contamination by contemporaneous interventions such as the midwife training and equipping projects.

Recommendations

Future iterations of the VC workshops can be enhanced to maximize their impact in a number of ways, including through modifications in recruitment, curricular content, implementation and monitoring.

Recruitment

1. Enhance the selection criteria for the intervention to ensure participant self-motivation.
2. Assess the pre-workshop attitudes and behaviours of potential participants. At a minimum, this would include conducting both a pre- and post-workshop survey of baseline knowledge, attitudes and behaviours.

Curricular Content

1. Match the exercises to the needs of the participants. For example, if advocacy behaviours are a desired outcome for those already supportive of TOP services, it would be wise to include advocacy skills training.
2. If action plans are important, ensure that they are consistently developed and emphasize implementation.
3. Modify action plans and personal commitment forms for the non-literate.
4. Replace the "My Childhood" section with a more popular exercise that better conveys the linkages between gender oppression and abortion.
5. Include more content on the specific health and epidemiologic conditions of the local context, so that participants appreciate disparities where they exist.
6. Devote some time to the issue of second-trimester abortion. Because most abortion-related maternal deaths in South Africa occur in the second trimester, greater attention needs to be paid to providing safe second-trimesters services for women who need them. Attendees in this workshop were not clear about the circumstances under which second-trimester care is permitted.

Monitoring and Ensuring Impact

1. Collect valid contact information and solicit consent from participants for ongoing communication.
2. Maintain archives of attendance records, action plans and workshop reports.
3. Facilitate ways for the groups to meet again if they desire to continue working together.
4. Clearly articulate the post-workshop goals and expectations to the participants.

Conclusions

This study sought to evaluate the effectiveness of VC workshops and to make recommendations for their further refinement. While VC workshops are no "silver bullet", this study clearly shows that they have an important role to play in expanding TOP access. VC workshops are effective in addressing issues such as: misunderstandings of the facts, deleterious underlying societal assumptions about women, and the lack of peer support for TOP advocates. Through strategic consideration of real cases, VC workshops humanize the issues by tying them to lived experiences. VC workshops make it easier for stakeholders across the spectrum to appreciate the importance of safe abortion services.

While the workshops did not change all negative opinions overnight, they did inform participants and favour a shift toward tolerance. Moreover, the workshops inspired a proportion of attendees to take ownership of the issue of reproductive freedom and to assume personal responsibility for resolving service barriers.

The VC workshops are not a quick fix for ingrained opposition to TOP, nor are they likely to stimulate a sea of change in entrenched bureaucracies with structural problems such as the Limpopo DoH. However, this study shows that VC promotes incremental progress on multiple levels. The authors suggest that the effectiveness of the VC design can be enhanced by instituting some small changes in the recruitment for as well as the content and implementation of the workshops. VC workshops are most effective when provided as part of a comprehensive package that also addresses equipment, training and policy obstacles.

Opening minds and hearts to the abortion issue is a complex process. The importance of identifying the tools needed to achieve this change at the personal, community and facility levels has never been greater, however, and the role of values clarification in that process is increasingly clear. VC workshops are flexible enough to adapt to diverse cultural contexts and heterogeneous populations yet rigorous enough to be meaningful and promote tangible results.

Glossary

Collective Identity	**Collective identity** is a shared sense of "oneness" that is developed when individuals recognize themselves as part of an interconnected group due to attributes and experiences that they share, or that they believe they share. People typically use collective identity to contrast themselves to one or more sets of "others".
Commitment	**Commitment** can be defined as a specific pledge to do something or the more general state of being bound emotionally or intellectually to a course of action. It is a reflection of individuals' intentions to change their behaviour, as well as their belief in their ability to change.
Community Liaison Officer (CLO)	A **Community Liaison Officer** is an employee of a health facility whose job is to work with community stakeholders to enhance community participation in, access to and satisfaction with health services.
Consciousness-Raising	**Consciousness-raising** is the process of achieving greater awareness. It is frequently used to describe the process of recognizing one's own needs or the significance of a political or social issue. Consciousness-raising requires individual effort to seek out new information and to gain understanding and feedback about a particular problem, whether that problem is personal or societal.
Countering	**Countering** is the act of substituting a problem behaviour with an alternative action. The goal is for the countering behaviour to be a more healthy response. An example would be eating carrot sticks instead of smoking a cigarette.
Counter-Referral	**Counter-referral** is the reciprocal act of sending a client to and from health-service providers in a network.
Designated Facility	The CTOP Act requires that facilities that provide TOP services be authorized (or designated) to do so by the national Department of Health (DoH). Therefore, a **designated facility** is a hospital or health-care clinic that has submitted an application and been authorized by the national DoH to provide TOP services.

Designated-But-Off-Line Facility	**A designated-but-off-line facility** is a hospital or clinic that has completed the application process and been registered as a designated TOP facility, but has yet to begin providing TOP services.
Dialectic	**Dialectic** is an adjective that refers to a methodology for arriving at the truth via the consideration of contradictory ideas using a question and answer format. The "Socratic Method" is dialectic.
Didactic One-Way Presentations	**Didactic one-way presentations** are instructive sessions featuring lecture and textbook instruction, rather than demonstrations, laboratory study or small group work. In these presentations, knowledge is only passed one way — from the instructor to the class participants—because there is no opportunity for participants to share knowledge or experiences with the instructor or other participants.
Emotional Arousal	**Emotional arousal** is the process through which individuals both experience and express feelings about the behaviour of interest. Frequently, emotional arousal and a heightened interest in behaviour change are caused by a sudden emotional experience related to a problem behaviour.
Environmental Control	Individuals who use **environmental control** when changing a behaviour are restructuring the external environment or controlling situations and other causes that trigger the problem behaviour. For example, some women learn to avoid friends who indulge in negative, hopeless thinking and seek out those who are more optimistic.
Flattened Hierarchies	Organizations and meetings with **flattened hierarchies** elicit involvement and responsibility from individuals at all levels. By allowing lower-status individuals to participate in decisionmaking processes on an equal level with higher-status individuals, flattened hierarchies enable more than one perspective to be considered as decisions are made and allow for two-way information sharing.
Group Cohesion	**Group cohesion** may be defined as the degree to which a group operates as a unified entity. Many identify it as a feeling of solidarity with other group members.

Helping Relationships	**Helping relationships** are crucial to most self-change, providing support from caring others that can be accepted, trusted and utilized by those attempting to change. The most helpful relationships vary with the stage of change the "changer" is in. Walking with a friend, exploring desired changes with other women, and making a pact to work on a particular change with someone else have all been mentioned as actions characterising helping relationships.
Heterogeneous	A **heterogeneous** group is one that is not uniform in its composition. It is composed of individuals with dissimilar characteristics and experiences.
Participatory Methods	**Participatory methods** combine multiple steps and techniques that involve the public—which may be defined as average citizens or stakeholders in a particular policy or project—in decision-making processes. Participatory methods can be used to increase participation in the planning, implementation and evaluation of community programs and policies.
Post Hoc	The defining characteristic of anything that occurs **post hoc** is that it occurred after the event in question. Therefore, a post hoc assessment is conducted after the entire workshop has concluded.
Problem-Posing as a Pedagogical Method	**Problem-posing as a pedagogical method** is a way to teach learners problem-solving skills while they are also learning content knowledge. Problem-based learning allows learners to examine real-world situations while receiving resources and guidance from a tutor or mentor. Dialectic or Socratic methods are examples of problem-posing as a pedagogical method.
Reward	A **reward** is something given to oneself or to others in return for the performance of a desired behaviour. The reward process provides positive reinforcement and encourages continued self-management of a behaviour change.
Self-Reevaluation	The process of **self-reevaluation** requires an individual to examine his or her values on a cognitive and emotional level with respect to a problem behaviour. Self-reevaluation can be especially useful in helping individuals see the connection between a seemingly minor behaviour problem and a greater sense of self.

Silver Bullet

A universal solution to a difficult or intractable problem may be referred to as a **silver bullet**. The notion is that the proposed action is a guaranteed means of attacking the problem or defending against a threat.

Social Liberation

The process of **social liberation** is possible when society provides new opportunities which allow individuals to begin or continue a behaviour change. Social liberation through advocacy work and empowerment education can be especially valuable for individuals who are relatively deprived or oppressed.

Stage Matching

Experts believe that behaviour change is most successful when the behaviour-change processes used are fit, or matched, to the stage of change the individual is in (for example, contemplating, initiating or maintaining a change). The use of **stage matching** helps ensure that the processes being used to support the behaviour changes correspond with the individual's goals and aid them in moving forward in the behaviour-change process.

Traditional Healer

A **traditional healer** is an individual who seeks to cure his or her clients of pain or illness through the use of plants, herbs or other cultural practices. Individuals may see a traditional healer instead of or in addition to receiving care from a medical provider.

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