

**Abortion services in South Africa: Challenges and barriers
to safe abortion care: Health care providers' perspectives**

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ABSTRACT

Unsafe abortion is a preventable phenomenon and continues to be a major public health problem in many countries especially in the developing world. Despite abortion being legally available in South Africa after a change in legislation in 1996, barriers to accessing safe abortion services continue to exist. These barriers include provider opposition to abortion, and a shortage of trained and willing abortion providers. The dearth of abortion providers undermines the availability of safe, legal abortion, and has serious implications for women's access to abortion services and health service planning.

Due to the relatively recent significant changes to abortion legislation in South Africa, little is known formally about the personal and professional attitudes of individuals who are currently working in abortion provision. Exploring the complex factors which determine health care providers' involvement or disengagement in services could provide important insights that could inform not only South African policy and service provision, but also that in developing country contexts.

A qualitative approach was used which included 48 in-depth interviews, one focus group discussion, and observations with a purposively selected population of abortion related health service providers, managers and policy influentials from the public and NGO sector in the Western Cape Province, South Africa. Data were analyzed using a thematic analysis approach.

The computer software package ATLAS ti 5.2 was used to facilitate data sorting and management.

Health care providers' views and experiences of abortion services were explored from within three domains of enquiry, and included the ways in which individual level, institutional and community contexts impacted on abortion service provision.

Health care providers' conceptualizations of abortion were influenced by a multiplicity of factors, including personal, moral and religious views, in which abortion was perceived by some as akin to murder or as a sin; whereas others viewed access to safe, legal abortions as an important component of a woman's right to

reproductive autonomy and choice, enabled by the new abortion legislation. Conflict between personal beliefs and professional practice were often mediated by establishing differing thresholds and boundaries in relation to abortion provision. Barriers to service provision included both structural and individual level barriers, and included limited and infrequent abortion and values clarification training opportunities, ambiguity and confusion regarding interpretation and implementation of conscientious objection and its subsequent impact on service provision, and experiences of isolation and stigma in the work place. Failed or poor contraceptive uptake and services were of great concern to providers, underscored by the perception that abortion had in many instances replaced responsible family planning by women requesting abortions. This perception was especially heightened by their experiences of some women returning for repeat or frequent abortions. Fragmented services, functioning and supported by a small dedicated group of abortion providers, who received little professional or emotional support from management or wider health structures, had serious implications for sustaining abortion services. A lack of clear policy guidelines and protocols to guide abortion service delivery further constrained adequate delivery of abortion services. Second trimester abortion services were explored as the contested domain of abortion was the most heightened with second trimester abortions. Many providers struggled to cope with the emotional and visual impact of encountering an aborted fetus.

The CTOP Act was significant for women's reproductive rights and health, and for overall public health in South Africa. However, the momentum for realizing the full extent of the legislation has been lost since implementation of the Act. In order for this momentum to continue there is an urgent need to address the provider shortage, and abortion education and training needs to be formalized and initiated in medical and nursing schools and should include ongoing training and support for abortion care providers.

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LIST OF ACRONYMS AND ABBREVIATIONS

| | |
|----------|----------------------------------------------------------------------------|
| ANC | African National Congress |
| CEDAW | Convention on the Elimination of All Forms of Discrimination against Women |
| CLA | Christian Lawyers Association |
| CTOP Act | Choice on Termination of Pregnancy Act |
| D&E | Dilatation and evacuation |
| DFL | Doctors for Life |
| DoH | Department of Health |
| EC | Emergency contraception |
| FDA | Food and Drug Administration |
| GDC | Global Doctors for Choice |
| ICPD | International Conference on Population and Development |
| IPPF | International Planned Parenthood Federation |
| IUD | Intrauterine Device |
| MCWH | Maternal, Child and Women's Health |
| MEC | Member of the Executive Council |
| MLP | Mid-level Provider |
| MRC | Medical Research Council |
| MSI | Marie Stopes International |
| MTOP | Medical Termination of Pregnancy |
| MVA | Manual vacuum aspiration |
| NGO | Non-governmental organization |
| PPASA | Planned Parenthood Association of South Africa |
| RHRU | Reproductive Health Research and HIV Unit |
| RRA | Reproductive Rights Alliance |
| SA | South Africa |
| SANC | South African Nursing Council |
| SRH | Sexual and Reproductive Health |
| TOP | Termination of Pregnancy |
| USA | United States of America |
| USAID | United States Agency for International Development |

| | |
|------|--------------------------------------------------|
| VC | Values Clarification |
| VCAT | Values Clarification and Attitude Transformation |
| WHO | World Health Organization |

GLOSSARY OF TERMS

Advanced practice clinicians: Includes physician assistants, nurse practitioners and certified nurse midwives.

Designated facility: The CTOP Act requires that facilities that provide abortion services be authorized (or designated) to do so by the National Department of Health. Therefore, a designated facility is a hospital or health-care clinic that has submitted an application and been authorized by the National Department of Health to provide abortion services.

Manual vacuum aspiration (MVA): An abortion procedure that uses a flexible plastic cannula, which is connected to a manual aspiration syringe with a locking valve to perform a uterine evacuation. In South Africa the procedure is used to perform an abortion up to 12 weeks gestation. It is a relatively simple and quick procedure.

Member of the Executive Council: Refers to the Member of the Executive Council of a Province who is responsible for health in that Province.

Mid-level provider: A health care professional including nurses, midwives and other non-physician clinicians.

Mifepristone: Mifepristone also known as RU 486 is an anti-progestogen drug that causes the gestational sac in early pregnancy, or the embryo or fetus at subsequent stages, to become detached from the uterine lining. Mifepristone also softens and opens the cervix. In 2001 the South African Medicines Control Council approved a

regimen of 600mg mifepristone and 800mcg misoprostol for medical abortions up to 56 days but this method is not yet available in the public sector in South Africa.

Minor: The South African Constitution defines a child, and perforce a minor, as a person under the age of 18 years. Similarly, international human rights instruments applying specifically to minors such as the Convention on the Rights of the Child, define a child as a person under the age of 18 years.

Misoprostol: Misoprostol (brand name Cytotec) is a prostaglandin that has been approved by the Food and Drug Administration (FDA) for the prevention of gastric ulcers. Misoprostol is also widely used for a variety of different obstetric and gynecological indications. Given the widespread availability of misoprostol and its low cost, in some settings, misoprostol may present a more feasible treatment option than other more effective, but expensive, drugs like mifepristone. Indications for which misoprostol may be used include cervical ripening before a surgical abortion in the first or second trimester; early abortion without mifepristone; labor induction in the second trimester; treatment of miscarriage or incomplete abortion; treatment of postpartum hemorrhage and labor induction at term.

TABLE OF CONTENTS

| | |
|-------------------------------------------------------------------------------------------------------|------------|
| ABSTRACT | II |
| ACKNOWLEDGMENTS | IV |
| LIST OF ACRONYMS AND ABBREVIATIONS | VI |
| GLOSSARY OF TERMS | VII |
| CHAPTER 1: BACKGROUND AND INTRODUCTION | 1 |
| UNSAFE ABORTION AND ITS CONSEQUENCES | 1 |
| BARRIERS TO ABORTION | 2 |
| PROVIDER PERSPECTIVES | 4 |
| KEY RESEARCH QUESTIONS..... | 5 |
| CONCEPTUAL FRAMEWORK..... | 6 |
| OVERVIEW AND STRUCTURE OF THESIS | 8 |
| CHAPTER 2: CONTEXT SETTING | 12 |
| PUBLIC HEALTH IMPLICATIONS OF UNSAFE ABORTION | 13 |
| Mortality from unsafe abortion..... | 13 |
| Morbidity from unsafe abortion..... | 14 |
| Challenges and difficulties..... | 14 |
| INTERNATIONAL ABORTION LEGISLATION: THE USA AND BRITAIN..... | 15 |
| Abortion law in the USA | 15 |
| Abortion law in Britain and Africa | 16 |
| HISTORICAL OVERVIEW IN SOUTH AFRICA | 17 |
| Abortion prior to the CTOP Act | 18 |
| Changes to reproductive health legislation and policy | 19 |
| Choice on Termination of Pregnancy Act of 1996 | 20 |
| The grounds for abortion | 20 |
| Who can provide | 21 |
| Counseling | 22 |
| Minors | 22 |
| Notification of abortions | 22 |
| CHOICE ON TERMINATION OF PREGNANCY AMENDMENT ACT 38 OF 2004..... | 22 |
| ISSUES IN IMPLEMENTING ABORTION LEGISLATION | 23 |
| Health care workers and conscientious objection..... | 23 |
| Abortion care training for midwives..... | 25 |
| Values clarification | 26 |
| SUMMARY AND CONCLUSIONS | 28 |
| CHAPTER 3: CONCEPTIONS AROUND ABORTION, ABORTION POLITICS AND PROVIDERS' EXPERIENCES | 30 |
| CONTESTED DOMAIN OF ABORTION AND REPRODUCTIVE POLITICS | 30 |
| CONCEPTUALIZATION OF THE FETUS | 33 |
| Fetal personhood..... | 33 |
| The fetus and abortion provision | 35 |

| | |
|----------------------------------------------------------------------|-----------|
| PROVIDERS' VIEWS AND ATTITUDES ABOUT ABORTION: GLOBALLY | 37 |
| Shortage of abortion providers..... | 37 |
| Health care providers' attitudes towards abortion | 39 |
| PROVIDERS' ATTITUDES AND EXPERIENCES OF ABORTION: SOUTH AFRICA | 41 |
| Monitoring and evaluation initiatives | 42 |
| BARRIERS TO ACCESSING ABORTION SERVICES | 43 |
| Provider attitudes towards abortion | 44 |
| Conscientious objection | 45 |
| SHORTAGE OF ABORTION CARE PROVIDERS..... | 46 |
| Second trimester services..... | 47 |
| ABORTION TRAINING | 48 |
| CONCLUSIONS..... | 48 |
| | |
| CHAPTER 4: RESEARCH METHODOLOGY | 50 |
| INTRODUCTION | 50 |
| RESEARCH STUDY DESIGN..... | 50 |
| RESEARCH SETTING | 51 |
| POPULATION AND SAMPLING..... | 53 |
| Population | 53 |
| Sampling | 54 |
| DATA COLLECTION | 56 |
| DATA ANALYSIS..... | 58 |
| ETHICAL CONSIDERATIONS | 61 |
| THE POSITION OF THE RESEARCHER | 62 |
| DIFFICULTIES ENCOUNTERED AND LIMITATIONS | 63 |
| CONCLUSIONS..... | 64 |
| | |
| CHAPTER 5: PATHWAYS TO ABORTION PROVISION | 65 |
| INTRODUCTION | 65 |
| NURSING MANAGER AND ABORTION PROVIDER: PUBLIC HEALTH SECTOR..... | 66 |
| NURSING MANAGER AND ABORTION PROVIDER: NGO SECTOR..... | 70 |
| INDEPENDENT DOCTOR AND ABORTION PROVIDER | 71 |
| CONCLUSIONS AND DISCUSSION..... | 73 |
| | |
| CHAPTER 6: CONCEPTIONS AROUND ABORTION..... | 75 |
| INTRODUCTION | 75 |
| CONCEPTIONS OF ABORTION | 76 |
| MORAL VIEWS TOWARDS ABORTION..... | 77 |
| Preservation of life..... | 77 |
| Childbearing and midwifery | 78 |
| Making the "right" choices..... | 80 |
| RELIGIOUS BELIEFS | 81 |
| REPRODUCTIVE RIGHTS AND CHOICE | 84 |
| Conflicting meanings around choice | 85 |
| Consequences of choice..... | 85 |
| Devolving choice..... | 86 |
| ABORTION LEGISLATION | 89 |
| Conscientious objection..... | 91 |
| SEPARATING THE PERSONAL FROM THE PROFESSIONAL..... | 93 |
| REASONS FOR SEEKING AN ABORTION..... | 96 |

| | |
|-----------------------------------------------------------------------------------------------------------|------------|
| Rape, incest and fetal abnormality..... | 96 |
| Socio-economic reasons | 97 |
| Contraception: relation between contraception and abortion | 98 |
| CONCLUSIONS AND DISCUSSION..... | 99 |
| CHAPTER 7: HEALTH SYSTEMS CONTEXT | 103 |
| INTRODUCTION | 103 |
| DESCRIPTION OF ABORTION SERVICES..... | 103 |
| DAY IN THE LIFE SKETCH OF ABORTION PROVIDER: DR C | 107 |
| NURSING MANAGER RESPONSIBLE FOR ABORTION SERVICES AT A SECONDARY LEVEL HOSPITAL: SISTER R..... | 109 |
| ABORTION AND VALUES CLARIFICATION TRAINING OPPORTUNITIES | 112 |
| Values clarification workshops..... | 113 |
| Abortion training | 117 |
| OPPOSITION TO ABORTION AND CONSCIENTIOUS OBJECTION..... | 119 |
| PROVIDER EXPERIENCES IN THE WORKPLACE..... | 126 |
| Stigma and burn-out | 126 |
| Quality of care | 128 |
| Space and location of services..... | 130 |
| Individual commitments | 132 |
| CONTRACEPTIVE SERVICES | 133 |
| Contraceptive failure | 136 |
| Emergency contraception | 137 |
| CONCLUSIONS AND DISCUSSION..... | 139 |
| CHAPTER 8: SECOND TRIMESTER ABORTION SERVICES | 145 |
| INTRODUCTION | 145 |
| GESTATIONAL AGE..... | 145 |
| PHYSICAL RESPONSES | 147 |
| EMOTIONAL RESPONSES..... | 148 |
| SECOND TRIMESTER ABORTION METHODS..... | 150 |
| HEALTH SERVICE BARRIERS | 154 |
| Infrastructural barriers | 154 |
| Stigma..... | 155 |
| PERCEPTIONS WHY WOMEN DELAY SEEKING AN ABORTION | 157 |
| Health systems limitations..... | 157 |
| Contraception..... | 158 |
| CONCLUSIONS AND DISCUSSION..... | 160 |
| CHAPTER 9: COMMUNITY AND WIDER CONTEXT..... | 165 |
| INTRODUCTION | 165 |
| CHURCH AND RELIGIOUS COMMUNITIES | 166 |
| FAMILY AND FRIENDS | 171 |
| POLITICAL AND IDEOLOGICAL DISCOURSES IN PUBLIC DOMAIN..... | 173 |
| Reproductive health NGOs..... | 173 |
| Conscientious Objection Workshops 2005-2006..... | 174 |
| National Department of Health Policy Workshop 2007: Conscientious objection and medical abortion | 176 |
| Legal challenges and submissions to Parliament 2007..... | 177 |
| Anti-abortion demonstrations | 179 |
| CONCLUSIONS AND DISCUSSION..... | 181 |

CHAPTER 10: CONCLUDING DISCUSSION AND RECOMMENDATIONS

| | |
|--------------------------------------------------------------------------------------|------------|
| | 185 |
| SUMMARY..... | 185 |
| EMERGING ISSUES AND IMPLICATIONS | 187 |
| ABORTION AS A CONTESTED DOMAIN..... | 188 |
| EMPOWERMENT | 190 |
| RELIGIOUS BELIEFS | 191 |
| CONTRACEPTION AND ABORTION | 192 |
| CONSCIENTIOUS OBJECTION | 193 |
| ABORTION TRAINING | 195 |
| SUPPORT AND RECOGNITION | 196 |
| RECOMMENDATIONS..... | 197 |
| REFERENCES..... | 199 |
| APPENDICES | 214 |
| APPENDIX 1: SOCIO- DEMOGRAPHIC DATA OF RESPONDENTS..... | 214 |
| APPENDIX 2: IN - DEPTH INTERVIEW GUIDE FOR SERVICE PROVIDERS/HEALTH MANAGERS..... | 215 |
| APPENDIX 3: CERTIFICATES OF CONSENT IN ENGLISH | 219 |

CHAPTER 1: BACKGROUND AND INTRODUCTION

Unsafe abortion and its consequences

Unsafe abortion is a persistent, preventable phenomenon and continues to be a major public health problem in many countries especially in the developing world (Grimes et al., 2006; WHO, 2004b). Unsafe abortion has been defined by the World Health Organization (WHO) as a procedure for terminating an unintended pregnancy, either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards or both (WHO, 2004b).¹

Unsafe abortion mainly endangers women in developing countries where abortion is usually highly restricted by law, and countries where, although legally permitted, safe abortion is not easily accessible. In these settings, women faced with an unplanned pregnancy often self-induce abortions through various means, or obtain clandestine illegal abortions from unskilled individuals with often fatal consequences. By contrast, if performed legally and in sanitary, safe conditions an abortion is a safe clinical procedure (Grimes et al., 2006). Despite the documented consequences of unsafe abortion it still remains one of the most neglected sexual and reproductive health problems globally (Grimes et al., 2006; WHO, 2004b).

Worldwide, 48% of all induced abortions are unsafe. However in developed countries nearly all abortions (92%) are safe, whereas in developing country contexts more than half are unsafe (Guttmacher Institute, 2007). The consequences of unsafe abortion are numerous, impacting on maternal morbidity and mortality but also on children and families who may lose a family member or mother from abortion related deaths. Additional consequences of unsafe abortion include loss of productivity, economic burden on public health systems, and long term health problems for women such as infertility (Guttmacher Institute, 2007).

¹ A note on terminology: the terms abortion and termination of pregnancy (TOP) are both used in this thesis, although the latter term is used more widely in South Africa. The use of the term TOP is used when respondents used the term, whereas I will use the term abortion. Grimes and Stuart (2010) have argued that the term TOP should not be used because of its ambiguity and medical inaccuracy as “all pregnancies terminate, but not all abort” (Grimes & Stuart, 2010, p.94).

Almost all abortion-related deaths occur in developing countries, with the highest incidence in Africa where there were an estimated 650 deaths per 100,000 unsafe abortions in 2003 compared with 10 per 100, 000 in developed countries (Guttmacher Institute, 2007).

Barriers to abortion

The incidence of unsafe abortion is influenced by the legal provisions governing access to safe abortion, as well as the availability and quality of legal abortion services. Restrictive legislation is associated with a high incidence of unsafe abortion. In some countries, access is highly restricted; in others, abortion is available on broad medical and social grounds or on request. Abortion laws are diverse and can be complex. Even where it is legally permitted, safe abortion may not be easily accessible; there may be additional requirements regarding consent and counseling, and countries often impose a limit on the period during which abortion may be performed. In addition, the attitudes of medical staff may be discouraging, and abortion services may be insufficient to meet the demand, unevenly distributed or of poor quality. Finally, women themselves may be unaware of the availability of abortion services or their right to access them within the legal framework (Grimes et al., 2006; Sedgh, Henshaw, Singh, Bankole & Drescher, 2007).

Public health research on abortion has tended to frame the research in neutral scientific language, and has focused on the biomedical consequences of unsafe abortion so as to counteract the controversy surrounding abortion. However, focusing solely on the biomedical aspects of unsafe abortion negates the important role of broader social processes and socio-cultural contexts in which the issues surrounding reproductive rights and unrestricted access to safe abortions are located. Placing emphasis on the unsafe aspect of abortion, public health research runs the risk of overlooking the complexities of abortion as a contested social domain.

Despite induced abortion being legally available in South Africa after a change in legislation in 1996, barriers to accessing safe abortion services continue to exist. The

South African Choice on Termination of Pregnancy Act (CTOP) No.92 of 1996 promotes a woman's reproductive right to have an early, safe and legal abortion. As a direct result of this legislation, abortion related morbidity and mortality have decreased by 91.1 % (Jewkes & Rees, 2005, p. 250). However, despite this legislation there are still major barriers to women accessing abortion services. These barriers include, but are not limited to, provider opposition to rendering abortion services, stigma associated with abortion, a lack of providers trained to perform abortions, and a lack of facilities designated to provide abortion services particularly in the rural areas (Harrison, Montgomery, Lurie & Wilkinson, 2000; Mokgethi, Ehlers & van der Merwe, 2006; Varkey, 2000; Varkey & Fonn, 2000). Furthermore these barriers can also result in a delay for women to access services, resulting in an increase in second trimester abortions (Harries, Orner, Gabriel & Mitchell, 2007; Morroni & Moodley, 2006).

Second trimester abortions account for over 25% of abortions performed in South Africa and are a public health concern, given that every additional week of gestational age incurs a significant increase in the risk of serious complication or death (Bartlett et al., 2004; Department of Health, 2004).

In countries where legislation permits abortion, access to safe induced abortion may be restricted due to limited numbers of trained health care providers (Sheriff, 2009; Warriner et al., 2006). To improve access to safe abortion and conserve scarce health resources, some countries, including South Africa, have trained mid-level providers (MLP), i.e. health care providers who are not doctors, such as midwives and registered nurses, to perform first trimester abortions (Berer, 2009; Warriner et al., 2006). Despite these training initiatives in South Africa, a dearth of trained and or willing abortion care providers exists.

In recent years the number of abortions performed nationally and in each of the provinces, including the Western Cape, has increased substantially, indicating increased availability to abortion services (Department of Health, 2004). Despite this manifold increase in demand and utilization, challenges exist in the further expansion of services, due to a shortage of trained or willing abortion care providers (Harrison et al., 2000; Varkey, 2000; Warriner et al., 2006). The shortage of health care providers

who are willing or trained to perform abortions undermines the provisions of the CTOP Act, by limiting the availability of safe legal abortion, and has serious implications for women's access to abortion services and health service planning.

Provider perspectives

Due to the relatively recent significant changes to abortion legislation in South Africa, little is known formally about the personal and professional attitudes and experiences of individuals who are currently working in abortion service provision. Few studies have been undertaken in South Africa looking at providers' perceptions and understandings of abortion within the context of their daily practice. Those studies that have been conducted were undertaken soon after the implementation of the new abortion legislation (Harrison et al., 2000; Hord & Xaba, 2001; Varkey, 2000). Exploring how attitudes might have changed over time and how providers are responding to the changes is additionally important, and more recent studies are needed to assess these potential changes. Investigating the complex factors which determine health care providers' involvement or disengagement in services could potentially provide important insights that could inform not only South African policy and service provision, but would also be valuable internationally, especially in developing country contexts.

Central to understanding how and why abortion services are provided and organized in certain ways, and the factors that enable or constrain health providers from delivering abortion services, is the underlying role that perceptions and understandings regarding abortion play for those rendering the services. Moreover, the contentious nature of abortion and abortion politics is key to exploring why abortion services are organized and provided in the way that they are. This research therefore sets out to investigate the factors that enable or constrain health service providers from delivering safe, accessible abortion care services in the Western Cape Province, South Africa. Understanding the perspectives of providers on these issues and the subsequent impact they have on access to safe abortion services is an important unanswered question that is central to improving the availability and quality of abortion services in South Africa.

The overall aim of the research project is to inform the improvement of abortion service delivery for women, by providing insights into the understandings, attitudes and opinions of health service providers who are likely to play a critical role in determining access to and the quality of these services.

Health care providers' views and experiences of abortion services were explored from within three domains of enquiry: firstly, individual level conceptualizations of abortion and the ways in which understandings around abortion influenced decisions with regards to abortion provision; secondly, the ways in which the institutional environment and health systems context impacted on abortion provision; and thirdly, providers' relationship to their wider social environment and the ways in which community contexts intersected with abortion provision (Adapted from the ecological model to be discussed under conceptual framework).

The main research aim was to explore what factors enable or constrain health service providers from delivering safe, accessible abortion care services.

Key research questions

The research was guided by the following three key research questions:

1. How do health care providers conceptualize abortion and how does this impact on abortion service provision? (Chapter 6)
 - i) What are providers' perceptions, views and understandings around reproductive rights and choice?
 - ii) What are providers' perceptions, views and understandings around abortion, and how does this impact on abortion service provision?
 - iii) In what ways do individual, ideological, moral and religious or other factors influence providers' views and perceptions of abortion, and how does this in turn relate to abortion provision?

2. How does the health system context or institutional environment impact on abortion service provision? (Chapter 7)

i) How does the work environment enable or constrain provision of abortion services?

ii) What are the abortion training opportunities for health care providers, and how do they influence decisions around abortion provision?

iii) How do understandings and implementation of the abortion legislation enable or constrain abortion service provision?

iv) How does stigma around abortion in the work place enable or constrain abortion service provision?

3. In what ways do social and community contexts impact on abortion service provision? (Chapter 9)

i) How do cultural and ideological discourses in the wider community impact on abortion service provision?

ii) What kinds of relationships exist between providers, health care facilities and communities, and how do these relationships impact on abortion provision?

iii) What kinds of impact and influences do non- governmental organizations, religious organizations and civil society organizations have on abortion service provision?

Conceptual framework

The study was conceptualized within the framework of an ecological perspective (Bronfenbrenner, 1979), and was further informed by literature that highlights the contested nature of abortion (Ginsburg, 1989). The latter will be discussed in greater detail in the next chapter. I will be using a variation of the ecological model as described by Bronfenbrenner (1979) and McLeroy, Bibeau, Steckler and Glanz (1988)

as a guide and framework in addressing the key research questions as evidenced in the three domains of enquiry guiding the research process discussed above.

The study is based on a multilevel conceptualization, which the ecological model facilitates, of the factors that inhibit or enable abortion service provision. It is supported by the view that health services are not solely a product of, or influenced by, biomedical factors but are influenced by people's beliefs, views, attitudes, practices and interactions. This perspective is adapted from established approaches to understanding health systems and behavior, although this approach has yet to be applied to abortion service provision in South Africa.

An ecological perspective within a public health setting emphasizes both individual and contextual systems, and the interdependent and dynamic interrelations between the two. An ecological perspective thus encompasses context in the broadest sense of the word, to include physical, social, cultural, and historical aspects of context, including trends at the local and international level such as globalization, as well as attributes and behaviors of persons within these contexts (McLaren & Hawe, 2005, p. 6).

The defining feature of an ecological approach is that it takes into account the relationship between people at individual, interpersonal, organizational and community levels. The philosophical underpinning of an ecological perspective is that behavior does not occur in a vacuum (McLeroy et al., 1988).

Brofenbrenner's ecological model (1979) emanating from psychology and hence with an emphasis on behavior, views behavior as being affected by, and affecting, multiple levels of influence (McLeroy et al., 1988, p. 354). Specifically Brofenbrenner divides environmental influences on behavior into five levels of influence, i.e. intrapersonal, interpersonal, institutional, community and public policy:

1. Intrapersonal or individual level factors, which include knowledge, attitudes, beliefs, self concepts and meanings attached to different phenomena
2. Interpersonal level processes, which consist of formal and informal social networks such as family, friends, peers and work colleagues

3. Institutional level factors, such as social institutions with organizational characteristics and formal and informal rules and regulations for operation
4. Community level factors, such as relationships among organizations, institutions, and including families, personal friendship networks and neighborhoods
5. Public policy level, such as local and national laws and policies to regulate public health

Public policy is deemed important within this framework, as one of the defining characteristics of public health is the use of regulatory policies and procedures and laws to protect the health of the community.

Thus an ecological approach was used as a guiding frame to engage with the research issues and uncover the multileveled layers of meaning and practices surrounding the contested domain of abortion and health care providers' relationship to differing aspects of abortion provision on a personal level, within the health environment and wider community environment. An overview of the structure of the thesis and chapter outlines will now be provided.

Overview and structure of thesis

Chapter 1 introduces the background to the problem and the three key research questions guiding the research process, and introduces the conceptual framework or broader theoretical paradigm used to investigate the research problem and guiding the research process.

Chapters 2 and 3 provide an overview of the literature pertinent to the field of study and by so doing, seeks to explore in more depth theoretical concepts utilized in uncovering, making meaning of, and analyzing the research data.

Chapter 2 provides an overview of the public health implications of unsafe abortion globally, followed by contextual and historical background to abortion in South Africa, including the changes to the abortion legislation in 1996. Developments in

reproductive rights and abortion laws and reproductive health policies are discussed: firstly at the international level, notably in the USA and Britain, two countries that have had a direct influence on abortion policies and provision in South Africa; and this is followed by a closer examination of abortion legislation and policies in South Africa.

Chapter 3 provides a review of key abortion related literature both globally, predominantly in the USA where most of the research has been conducted, and locally within South Africa where the research study was located. The discussion of abortion related literature commences with a more theoretical focus on conceptualizations of abortion, locating abortion within the contested domain of abortion politics and the emergence of debates around fetal personhood. Moving from the more abstract to the more concrete, an exploration of abortion related research as it applies to health care provision, including providers' attitudes and experiences of abortion provision, is then explored with a focus on implications for continued service provision.

Chapter 4 introduces the research methodology employed in the study, and the applicability of qualitative research methods for this study, notably an under-researched and relatively new area of enquiry. Furthermore, abortion is a sensitive and controversial topic and as such required detailed and close examination of the complex issues which qualitative research facilitates. The study design, study setting, study population and techniques employed in data collection and data analysis are provided. Ethical considerations pertinent to the research study, which has as its central focus a highly contested and controversial subject such as abortion, is presented. The phenomenon of the researcher becoming part of the research process and the importance of reflexivity to address this process is provided. Difficulties encountered in data collection are acknowledged.

The next five chapters, i.e. Chapter 5, 6, 7, 8 and 9 presents the main research findings, presented according to the three domains of enquiry guiding the research question. Also included is a chapter providing an exploration of three providers' pathways into abortion provision, and an additional chapter on second trimester abortion provision.

Chapter 5 highlights providers' personal and professional pathways into abortion provision through the narratives of three abortion providers. Exploring decision making around abortion provision was a way to foreground providers' location within the health systems setting, and to provide historical and social context to abortion provision since the inception of the CTOP Act in 1996.

Chapter 6 explores providers' conceptualizations of abortion and how this impacts on abortion service provision. Exploring providers' understandings and perceptions around abortion provided insight into how perceptions around abortion influenced and informed daily practice.

Chapter 7 considers providers' relationships to their work environment, and explores the ways in which the health system context and institutional environment impacts on abortion service provision.

Chapter 8 has a specific focus on second trimester abortion services, as it was possibly the most contentious aspect of abortion provision as distinct from first trimester abortion provision.

Chapter 9, the final findings chapter, explores the ways in which health care providers' relationships with broader social and community contexts intersect with and impact on abortion service provision. Providers' social relationships with the wider community were explored, paying particular attention to the ways in which religious organizations, family networks, political and ideological discourses in the public domain including sexual and reproductive health non-governmental organizations (NGO) and anti-abortion opposition impacted on providers' decisions around abortion provision.

Chapter 10 highlights the conclusions drawn, provides a discussion of the main findings, and suggests recommendations for future research and general consideration.

This opening chapter provided an introduction to the research questions with which I entered the research site and the conceptual frameworks that have been drawn on to

guide the research process. I offer an added dimension to the ecological or multi layered approach to public health research by locating abortion service provision within the contested domain of abortion politics. The following two chapters will explore in more depth theoretical concepts utilized in uncovering, making meaning of, and analyzing the research data.

CHAPTER 2:

CONTEXT SETTING

The literature review presents a summary of the theoretical frameworks that have been drawn on in developing a conceptual frame for this research and for providing the theoretical language for analyzing the research data obtained in the field. In framing research questions and in deciding on research methodology I was initially informed by the body of research and theory that has emerged around reproductive rights and women's health, located within the broader confines of public health and epidemiology. Much research around abortion within the discipline of public health has been closely linked to advocacy and policy interventions to prevent the consequences of unsafe abortions. A limitation of this approach is that little attention has been paid to those who are expected to provide abortion services, and in turn how abortion is conceptualized outside of a biomedical construct.

This chapter will provide an overview of the public health implications of unsafe abortion followed by contextual and historical background to abortion in South Africa, including the changes to the abortion legislation in 1996.

The first section of the chapter will contextualize abortion within a public health and human rights framework, where women's access to safe abortion is viewed as both a public health and human rights issue. Attention will be given to developments in reproductive rights and abortion laws and reproductive health policies both internationally and regionally including South Africa. A brief overview of the laws and policies that regulate abortion globally with an emphasis on countries (i.e. the USA and Britain) that have had a direct influence on abortion policies and provision in South Africa will be provided.

Public health implications of unsafe abortion

Research on abortion within the discipline of public health focuses its attention on the public health impact of unsafe abortion on maternal morbidity and mortality.

Restricting access to safe abortion has serious implications for women's sexual and reproductive rights, health and well-being (Grimes et al., 2006; Shah & Ahman, 2009; WHO, 2004 b).

A significant body of abortion related research has been produced by for example the WHO and the Alan Guttmacher Institute, and has provided an important evidence base regarding the health and social consequences of unsafe abortion for women's lives (Henshaw, Singh & Haas, 1999; Sedgh, Henshaw, Singh, Bankole & Drescher, 2007; Shah & Ahman, 2009). Numerous public health preventive measures and policies have been advocated and developed, in an attempt to make abortions safe and accessible to all women, especially in the developing world, where the impact of unsafe abortion is most widespread. These measures have included advancing and expanding on existing medical technologies, techniques and medicines, advocating legalization of abortion in countries where abortions are illegal or highly restricted, promoting and expanding post abortion care, and extending first trimester abortion provision to mid-level providers (Berer, 2009; Warriner et al., 2006; Weitz, Anderson & Taylor, 2009).

Mortality from unsafe abortion

Measurement of the worldwide prevalence of abortion-related mortality and morbidity is difficult. Abortion-related mortality often happens after a clandestine or illegal procedure, making reporting problematic. Abortion is highly stigmatized and frequently censured by social, political, religious, or other factors (Grimes et al., 2006). Hence, under-reporting is routine even in countries where abortion is legally available. Unsafe abortion is a leading cause of maternal mortality; the WHO estimates that it causes 68 000 deaths and five million permanent or temporary disabilities per year, mainly in developing countries (WHO, 2004b). The prevalence of unsafe abortion remains high, with up to 39 unsafe abortions per 1,000 women

aged 15-44 in Eastern Africa, and 33 per 1,000 in South America. By contrast, developed regions, where almost all countries allow abortions with few restrictions, had an average unsafe abortion rate of two per 1,000. The consequences of unsafe abortion - death, serious injury, infertility and increased health care cost - are largely borne by poor women (Sedgh, Henshaw, Singh, Ahman & Shah, 2007).

Morbidity from unsafe abortion

Morbidity is a far more frequent consequence of unsafe abortion than mortality, but is determined by the same risk factors. Complications include hemorrhage, sepsis, peritonitis and trauma to the genital and abdominal organs, and many women are hospitalized for complications. Severity of complications is another important measure of effects on health. A standardized measure of the severity of complications was used in South Africa before and after changes to the abortion legislation in 1996. The proportion of women with severe complications fell substantially from 16.5% before legislative changes to 9.7% after the legislative changes, indicating how increasing access to safe legal abortions reduces abortion related morbidity (Jewkes, Brown, Dickson-Tetteh, Levin & Rees, 2002). These were important findings in terms of continued support for abortion reform, and used as leverage in influencing policy and practice.

Challenges and difficulties

The incidence of unsafe abortion is influenced by the legal provisions governing access to safe abortion, as well as the availability and quality of legal abortion services. In some countries, access is highly restricted; in others, pregnancy termination is available on broad medical and social grounds or on request. Abortion laws are diverse and can be complex. Even where it is legally permitted, safe abortion may not be easily accessible; there may be additional requirements regarding consent and counseling, and countries often impose a limit on the period during which abortion may be performed. In addition, the attitudes of medical staff may be discouraging, and abortion services may be insufficient to meet the demand, unevenly distributed, or of poor quality. Finally, women themselves may be unaware of the

availability of abortion services or their right to access them within the legal framework.

Whilst not detracting from the legitimacy and importance of placing attention on the profound consequences of unsafe abortion for women's sexual and reproductive health, public health research, as discussed in the above section, has tended to focus on the public health consequences of restricting access to safe legal abortions as measured by case fatality rates, incidence and other population measures to quantify unsafe abortion, and has tended to frame the research in neutral scientific language so as to defuse the controversy surrounding abortion. However, focusing solely on the biomedical aspects of unsafe abortion negates the important role of broader social processes and socio-cultural contexts in which the issues surrounding reproductive rights and unrestricted access to safe abortions are located. In placing undue emphasis on the unsafe aspect of abortion, public health research runs the risk of overlooking the complexities of abortion as a contested social construct.

International abortion legislation: The USA and Britain

While the first section of this chapter focused on the public health implications of unsafe abortion largely associated with restrictive abortion legislation and access, this second section focuses on abortion legislation internationally, more specifically abortion legislation in the USA and Britain as it strongly impacts on Africa, and South Africa. This will be followed by an overview of changes to the abortion legislation in South Africa post 1996.

Abortion law in the USA

In deciding on the case of *Roe v. Wade* in January 1973, the United States Supreme Court ruled that restrictive state abortion laws were unconstitutional, thereby legalizing induced abortion throughout the country. Despite this landmark ruling, restrictions on access remained for many women, such as various laws passed by the United States congress prohibiting federal funding of abortion, thus denying poorer women access to abortion services, and the Mexico City Policy or "Global Gag rule".

The “Global Gag rule” restricts NGOs in developing countries that receive USAID funding from engaging in abortion-related activities, including counseling and the provision of information regarding abortion. This has had severe negative implications for the funding of NGO’s sexual and reproductive health programs, and has seriously constrained conducting abortion related activities in a number of countries in Africa, including South Africa (Crane & Dusenberry, 2004). The situation might change with the new Obama administration having rescinded the “Global Gag rule” in January 2009, but during the study period the “Global Gag rule” was still in effect.

Abortion law in Britain and Africa

In addition to the USA, Britain has also had a marked influence on its former colonies, and left behind a legacy of outdated Common Law which governed abortion legislation. While abortion laws in Britain were liberalized in 1967, it has been a far slower process in Africa where these restrictive abortion laws to a certain extent remain (Engelbrecht, 2005; Ngwena, 2004).

Many African countries after gaining independence have been slow to reform their abortion laws. Factors contributing to the slow reform of abortion laws in Africa include social and economic crises, patriarchal systems, pro-natalist and religious beliefs and a lack of political will (Braam & Hessini, 2004).

South Africa, Cape Verde and Tunisia are the only three countries in Africa that allow abortion without restriction as to reason but with gestational limits (Guttmacher Institute, 2007). South Africa’s neighboring countries all have more restrictive legalization, ranging from only allowing abortion to save the woman’s life (i.e. Lesotho and Swaziland); in addition to saving the woman’s life and also allowing abortion to preserve physical health (Mozambique and Zimbabwe); and in addition to saving the woman’s life, preserving physical and mental health (i.e. Botswana and Namibia) (Guttmacher Institute, 2007). Lesotho, Swaziland and Mozambique (countries neighboring South Africa) amongst others, have maintained the same restrictive colonial abortion laws that were in place at independence (Ngwena, 2004).

Zambia is somewhat of an exception in that it has one of the more liberal abortion laws in Africa, yet continues to experience difficulties with access to safe services due to a variety of factors. These include policy restrictions, distance to health facilities, cost, lack of trained providers, and stigma (Koster-Oyekan, 1998).

Thus despite the development in reproductive rights advocacy for safe abortion and liberalization of abortion laws internationally and locally in South Africa, the majority of African countries still have restrictive abortion laws.

This next section provides an historical overview of reproductive health policy and services under apartheid with a focus on abortion and contraception, followed by a review of the current abortion legislation, namely the Choice on Termination of Pregnancy (CTOP) Act No. 92 of 1996 and its Amendment in 2004, and the ways in which the abortion legislation intersects with health care workers' constitutional right to conscientious objection. A closer examination of conscientious objection will be provided, as this was an area identified by scholars as unclear in relation to providers invoking their right to conscientious objection with regards to abortion provision. Abortion care training programs for registered midwives including values clarification will also be reviewed, as this has implications for ongoing training and sustainability of abortion services.

Historical overview in South Africa

The advent of democracy in South Africa in 1994 created a unique opportunity for new laws and policies to be passed, and was a watershed period for changes in South Africa, including changes with respects to women's health (Cooper et al., 2004). In terms of this study, the most notable changes were changes to the abortion legislation, which for the first time in South African history gave recognition to human rights, including reproductive rights (Ngwena, 1998).

Before 1994, there were no comprehensive women's or reproductive health policies in South Africa. Women's health services consisted mainly of maternal and child health services, with an emphasis on contraceptive services aimed at limiting population

growth (Cooper et al., 2004). In the South African context, contraceptive provision had racial undertones and demographic imperatives, as the government sought to control black population growth (Klugman, 1993). Long-acting injectable contraceptives were strongly promoted for black women, particularly in rural areas, while the oral contraceptive pill was promoted for white women (Cooper et al., 2004). By 1994, there were over 65,000 contraceptive service points in the country; this extensive availability of contraceptive services was in stark contrast to all other primary level health services, including reproductive health services, which were poorly developed and inaccessible to the vast majority of the population (Rees, 1994).

Abortion prior to the CTOP Act

Under Apartheid, abortion was permitted on extremely restricted grounds. It is estimated that prior to the legalization of abortion in 1997, 200,000 illegal abortions occurred annually in South Africa, and were associated with substantial preventable morbidity and mortality (Klugman & Varkey, 2001). Almost all of the 1,000-1,500 legal abortions performed annually during this period were among white women (de Pinho & Hoffman, 1998), indicative of the inequality based on racial grounds.

A brief description of the Abortion and Sterilization Act of 1975 will be provided as most respondents in this study were working as health care providers during the time while this restrictive abortion legislation was still in operation.

The conservative nature of the Abortion and Sterilization Act of 1975 was apparent in the restrictive manner in which the grounds for abortion were formulated, and the burdensome nature of the administrative procedures that had to be satisfied before an abortion could be performed (Ngwena, 1998). The 1975 Act did not provide for abortion on request, nor on socio-economic grounds. Moreover, it imposed no obligation on the part of the state to provide abortion services. By way of illustration, two doctors, other than the doctor performing the abortion had to certify that the woman met, at least one of the legal grounds for abortion. Access to safe, legal abortion was thus extremely difficult especially for the majority of the population. High numbers of backstreet abortions, incomplete abortions and deaths due to septic

abortions were clear indications that the 1975 Abortion legislation failed to provide access to safe abortion services (Engelbrecht, 2005, p. 67).

Changes to reproductive health legislation and policy

Emerging ideas on women's reproductive health policy in South Africa during the early 1990s were rooted in the democratic transformation and health sector reform that was taking place in South Africa more broadly, as well as in changing approaches to women's and reproductive health internationally. Globally, women's reproductive health was being re-conceptualized within a human rights and gender equality framework. Key conventions such as the 1994 International Conference on Population and Development (ICPD) in Cairo, and the 1995 Fourth World Conference on Women in Beijing made explicit the links between women's reproductive health, women's rights and socio-economic development, and emphasized a broadened definition of reproductive health (Cooper et al., 2004). Furthermore, unsafe abortion was declared to be a major public health concern both at the Cairo and Beijing conferences (Engelbrecht, 2005, p. 35). Both the ICPD and 1995 Beijing conference had a substantial influence on population policies and programs in developing countries, including South Africa (Engelbrecht, 2005).

Changes in the South African socio-political environment during this time created a window of opportunity for civil society organizations, which were already active in gender and women's health research and programs, to lobby for the creation of locally-appropriate women's reproductive health policies that were in tune with the international emphasis on human rights (Cooper et al., 2004).

Accompanying the changes in health legislation and policy in the post-1994 period (as discussed earlier) was a major restructuring of health programs and administrations, to better enable the implementation of these new laws and policies. For example, in 1995, a directorate of Maternal, Child and Women's Health (MCWH) was established within the National Department of Health. The creation of the MCWH directorate, with its specific focus on women's health, represented an important step in

acknowledging women's health as a priority area within the health services (Cooper et al., 2004). This directorate was to play a role later in attempting to clarify and formalize policy documents and protocols with regards to medical abortion and conscientious objection, key components of abortion provision, as will be discussed in Chapter 9, which focuses on the wider community context.

Choice on Termination of Pregnancy Act of 1996

It is within this context of legislative and policy changes in the area of women's reproductive health that the Choice on Termination of Pregnancy Act of 1996 was promulgated. The new abortion law intended to ensure accessible and available abortion services for all women, including those who were poor or were disadvantaged during apartheid, and most likely to suffer complications or die from unsafe abortions (Dickson-Tetteh & Billings, 2002).

The CTOP Act was passed in November 1996, and took effect from the 1st February 1997. The notion of abortion as a fundamental right is implicitly supported by a number of fundamental rights in the Constitution. These include the rights to equality, human dignity, freedom and security of the person, and the right to make decisions concerning reproduction, privacy, and access to health care services, including reproductive health services. The right to equality and the right to make decisions concerning reproduction have particular relevance for the recognition of a woman's right to choose whether to have an abortion in South Africa. A focus on the CTOP Act below is important for this study, as the CTOP Act was the primary and often only guiding document for the running of TOP services in the study sites (Dearham et al., 2009).

The grounds for abortion

The Act states that a pregnancy may be terminated at a woman's request during the first 12 weeks of gestation. Beyond 12 weeks and up to 20 weeks gestation, an abortion may be performed for any of the following reasons:

- if after consultation with a pregnant woman, a medical practitioner is of the opinion that the continued pregnancy would pose a risk to the woman's physical or mental health
- there is a substantial risk that the fetus would suffer from severe physical or mental abnormality
- the pregnancy resulted from rape or incest, or
- the continued pregnancy would significantly affect the social and economic circumstances of the woman.

From 20 weeks gestation onwards, abortions are available under limited circumstances, including those in which the continued pregnancy would endanger the woman's life, pose a risk of injury, or result in severe malformation of the fetus.

The most significant ground for abortion during the 13-20 weeks gestation period is the socio-economic ground. Including socio-economic reasons as a condition for a second trimester abortion makes it virtually impossible to refuse a legal abortion between 13-20 weeks, as most women in South Africa could view an unintended pregnancy as potentially affecting their socio-economic status.

Who can provide

Currently pregnancies of 12 weeks gestation or less can be performed not only by a registered medical practitioner, but also by a registered midwife or registered nurse who has completed a prescribed training course. The broadening of the class of health care professionals who can perform abortion to include midwives and registered nurses, introduced through the 2004 amendment to the Act and discussed in detail later, is a way of expanding access to abortion services especially in the rural areas. Abortions in the second trimester (13-20 weeks) can only be performed by a registered medical practitioner (i.e. a medical doctor).

Other key elements of the CTOP Act include pre- and post-abortion counseling, minors' access to abortion services, notification of abortions, provisions related to midwifery training, and duties of health workers including conscientious objection.

These are all elements pertinent to this study, and areas that respondents identified as problematic regarding implementation.

Counseling

The Act provides that regardless of the pregnant woman's age, only her consent is required for an abortion, and that non-mandatory and non-directive counseling be given before and after the abortion. The CTOP Act also indicates that counseling should include sufficient information to help women make an informed choice.

Minors

The CTOP Act allows for minors (persons under the age of 18 years) to request an abortion without the consent of their legal guardian or parent. The medical professional is obliged to advise the minor to consult with a parent, guardian or family member, however, the minor may choose not to do so. The constitutional right of woman to bodily and psychological integrity, including the right to make decisions concerning reproduction, is not age restricted.

Notification of abortions

Abortion facilities are required to complete monthly summary reports containing the number of abortions performed, clients' age group and gestational age. In addition facilities are obliged by the CTOP Act to complete an individual notification form for each abortion performed and the information is ultimately reported to the Department of Health. These forms are not always consistently filled in, resulting in statistical record keeping being neither consistent nor accurate.

Choice on Termination of Pregnancy Amendment Act 38 of 2004

In February 2005, the CTOP Act was amended to the Choice on Termination of Pregnancy Amendment Act 38 of 2004 to allow a member of the executive council (MEC) to designate facilities that could provide abortion services; exempt a facility

providing 24 hour maternity services from having to obtain approval for abortion services; provide for the recording of information and the submission of statistics; allow a MEC to make regulations; and allow trained registered nurses (not only midwives) to perform first trimester abortions.

The amended CTOP Act aimed to make abortion services more accessible by removing cumbersome procedures to designate abortion facilities and allowing trained registered nurses to perform abortions of less than twelve weeks. In the main, the amendments were geared towards increasing women's access to safe abortion services and better governance of those services. It was envisaged that this could be achieved by accelerating the process of designation of facilities to provide abortion services as a provincial competency, and by increasing the pool of trained providers through extending abortion training for registered nurses. Furthermore, the amendment also aimed to improve the monitoring of abortion services by stipulating the frequency and manner in which abortion statistics should be collected and submitted, and making this process mandatory.

As mentioned above, in order to deal with the shortage of certified midwives the Amendment Act extended first trimester abortion provision to registered nurses, if they had completed the proposed abortion training course. Despite extending provision to registered nurses, no registered nurses have currently undergone training or are providing abortions in any of the designated public sector health care facilities in the Western Cape. The amended legislation had thus made no contribution to the ongoing shortage of certified nurses in the Western Cape (Smit, Bitzer, Boshoff & Steyn, 2009).

Issues in implementing abortion legislation

Health care workers and conscientious objection

Health care professionals' right to freedom of conscience with respect to abortion provision is a complex phenomenon both locally and globally, and will be discussed in more detail throughout this thesis. In order to investigate and unravel the complex

practices of conscientious objection by health care workers, an understanding of health care providers' constitutional right to freedom of conscience, belief, thought and religion in relation to a woman's constitutional right to access a safe, legal abortion is required. Conscientious objection thus raises issues of competing constitutional rights in relation to a woman's right to exercise reproductive autonomy and a health care worker's right to freedom of conscience, belief, thought and religion.

The rationale of the CTOP Act is set out in its Preamble and sets the context within which to interpret the Act. The Act promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs (Naylor & O'Sullivan 2005, p. 9). However the CTOP Act does not specifically mention a right to conscientious objection, but does set out duties regarding how health professionals are expected to act in terms of the legislation, and for this reason the CTOP Act and the Constitution should be read jointly for clearer guidelines on conscientious objection (Naylor & O'Sullivan, 2005; Ngwena, 2003).

As stated, the conscientious objection of providers who do not wish to perform abortions is supported by the constitutional rights of all South Africans to freedom of thought, belief and opinion. However, this support is limited by the professional obligation of health care workers to inform a woman requesting an abortion of her rights in terms of the Act. Necessary details that health care workers must provide include the circumstances in which abortion is legal, that no consent is required other than that of the woman, and the location of facilities where abortions are performed, and hence refer a woman to another provider or facility.

The requirements that providers who refuse to perform an abortion must give patients accurate abortion related information could be potentially problematic for some providers, who feel that providing such information to patients suggests that they support abortions. However, the professional obligations outlined in the Act are intended to ensure that a person's reproductive autonomy and her right to health services are not influenced by the personal beliefs of health care workers.

The South African Nursing Council (SANC) has drafted ethical guidelines with reference to abortion, which would apply to nurses in relation to abortion services, and sets out that:

A nurse may refuse to participate in the act of performing a TOP but must lodge in writing to their employer their refusal to perform an abortion and that a copy of the letter of refusal be placed in the nurses staff record. Furthermore, irrespective of any conscientious objection a nurse must provide the following to health care users; nursing care; basic assistance with the activities of daily living; emotional, physical and psychological support; prescribed medication and comfort and pain relief measures (Naylor & O' Sullivan, 2005, p. 18).

Under South African law, the right to refuse to provide abortion services applies only to the actual performance of the abortion (i.e. the abortion procedure). Hence, in terms of the law and the guidelines of the SANC, health care providers who are not directly involved with the abortion procedure cannot use their beliefs as a reason for not assisting a woman in her care. They also cannot deny routine nursing care and general assistance not related to the procedure. Further, in terms of the constitutional right of all South Africans to emergency health care, a conscientious objector is ethically and legally obliged to care for patients with complications arising from an abortion whether induced or spontaneous (Morrone, Buga & Myer, 2006, p. 38).

Abortion care training for midwives

South Africa is one of the few countries where certified midwives or registered nurses, key staff in primary health care facilities, are legally allowed to perform termination of pregnancies of twelve weeks gestation or less (Berer, 2009; Warriner et al., 2006).

A Midwifery Abortion Care Training program was initiated in 1998 by the Department of Health, in collaboration with local and international reproductive health NGOs such as the Reproductive Health Research Unit (RHRU) of the University of the Witwatersrand and Ipas, an international non-governmental

organization working in the field of sexual and reproductive health and rights, to train registered midwives throughout South Africa to provide abortion services using the manual vacuum aspiration method (MVA) (Dickson-Tetteh & Billings, 2002).

Vacuum aspiration is considered safer than sharp curettage, and the WHO recommends vacuum aspiration as the preferred method for uterine evacuation before 12 weeks of pregnancy (WHO, 2004a).

Training and certification of registered midwives, and subsequently in 2004, registered nurses, were identified as critical steps toward making high quality abortion services accessible to all women, especially in the rural areas (Dickson-Tetteh & Billings, 2002).

Currently nurses are trained in abortion care by the Western Cape Provincial Department of Health in collaboration with Ipas, South Africa and a few independent consultants. This course consists of a theoretical component of approximately two weeks followed by a practical component to assess trainees' skills in performing an abortion. Only once both the theoretical and practical components have been completed are nurses certified to provide abortions using the MVA method (Smit et al., 2009; personal communication Department of Health, Western Cape, 2009).

Currently at the two medical schools in the Western Cape, abortion education for medical students comprises one didactic lecture given by an outside lecturer and is optional. Similarly, abortion training and provision is optional for obstetrics/gynecology residents at the two medical schools in the Western Cape (personal communication, Head of Obstetrics and Gynecology, Academic hospital, October, 2009).

Values clarification

Abortion values clarification workshops, and more recently abortion values clarification and attitude transformation workshops, have been run in South Africa, initially by the Planned Parenthood Association of South Africa (PPASA) and later by Ipas, with the aim of creating a more enabling environment for abortion provision.

Values clarification (VC) workshops were initially provided prior to the implementation of the CTOP Act as a way to promote understanding around abortion, and were later included in the Midwifery Abortion Care Training Programs. Values clarification workshops were also organized independently of abortion training programs, as a way to address attitudinal barriers to abortion provision, and provide those involved with abortion services with a forum to engage and reflect on abortion related issues on both a personal and professional level.

Values clarification, which originated in the field of humanistic psychology, is both a theory and an intervention, underscored by the belief that people are responsible for discovering their values through a process of honest, open-minded self-examination (Turner, Hyman & Gabriel, 2008, p.109). As an intervention, values clarification was originally developed in the context of moral education in schools, but has since been widely adapted to such diverse topics as career counseling and decision making, and sexual and reproductive health.

As defined by Ipas, an abortion values clarification and attitude transformation (VCAT) intervention is a process conducted in a safe environment, in which individuals take responsibility to engage in honest, open-minded and critical reflection and evaluation of new or reframed abortion information and situations. The content is designed to be accessible, setting specific and personally relevant (Turner et al., 2008).

Abortion VCAT activities are designed to help participants surface, acknowledge and challenge their deeply-held assumptions and beliefs about abortion and related issues; discover their values and potentially transform their attitudes on abortion; and express their intentions to convey attitudes and act in a manner consistent with their affirmed values. VCAT was designed to move participants along a progressive continuum of support for abortion and related sexual and reproductive health care and rights: from obstruction to tolerance to acceptance to support, and then ultimately to advocacy for and/or provision of woman-centered, comprehensive abortion services to the full extent of the law (Turner et al., 2008).

Summary and conclusions

This chapter has provided a historical overview of key legislative and policy changes within the reproductive health arena in South Africa since 1994. Against a background of fundamental political change and the election of a new democratic government, and much socio-economic reform including the introduction of various policies and legislation in the field of women's health, the CTOP Act was introduced to ensure that all women in South Africa have access to safe, legal abortion services. This was in line with international developments in reproductive rights and health, which sought to ensure that women are not discriminated against on the basis of gender, race, religion or culture and to ensure women's right to reproductive autonomy.

The South African Constitution has provided a broad and unique framework for the protection and promotion of reproductive rights and health. It was within this changing political and health policy environment that far-reaching changes to the abortion legislation came about with the CTOP Act of 1996 replacing the previously restrictive Abortion and Sterilization Act of 1975. It has been argued that the Choice on Termination of Pregnancy Bill was the most contentious piece of legislation put before South Africa's first democratic parliament (Engelbrecht, 2005, p. 74). It is important to note that in passing the Bill in Senate the ruling African National Congress (ANC) did not allow its members to have a free vote. The possible reason for this was the desire to maintain a united front, rather than the fear of losing the vote, and a recognition that many ANC members, despite commitments to gender equality, were "devout Christians or Muslims" (Guttmacher, Kapadia, Te Water Naude & de Pinho, 1998, p. 193). A free vote would have permitted members of Parliament to vote according to their conscience, which may have been influenced by the contested and controversial nature of abortion. More than 60 ANC party members stayed away from the National Assembly on the day of the vote (Engelbrecht, 2005; Ngwena, 1998). These differences of opinion are important to note, and could possibly explain some of the problems in the subsequent implementation of the law, programs and services.

The next and second chapter of the literature review, will discuss the debates around the contested nature of abortion mainly emanating from within a North American context, where most of the research has been undertaken, and locally within South Africa, where this research study was conducted.

CHAPTER 3: CONCEPTIONS AROUND ABORTION, ABORTION POLITICS AND PROVIDERS' EXPERIENCES

The previous chapter, the context setting chapter, provided an overview of the public health implications of unsafe abortion internationally followed by contextual and historical background to abortion in South Africa including the changes to the abortion legislation in 1996. This chapter will commence by reviewing literature related to conceptions around abortion and abortion politics, and will be followed by a review of providers' experiences internationally, notably in the USA, and then by health care providers' experiences in South Africa. The discussion of scholarly works around abortion relates to four areas of importance to the research study, namely:

- (1) The contested domain of abortion and reproductive politics
- (2) Debates around fetal politics in abortion politics and abortion provision
- (3) Health care providers' views and attitudes towards abortion globally
- (4) Local abortion related research, with a focus on health care providers' attitudes and experiences towards abortion in South Africa

Contested domain of abortion and reproductive politics

Abortion more than most other medical procedures and practices has entered the public domain with vigorous highly charged debates. It elicits emotive responses involving numerous powerful stakeholders and role players including politicians, the Church, the medical and legal fraternity, civil society organizations, women's NGOs, as well as human rights and public health activists and advocates.

Scholarly works centering on the contested domain of abortion and reproductive politics have provided a useful conceptual frame from which to approach this study. This approach, emerging from various disciplines within the social sciences such as anthropology, sociology, psychology and gender and feminist studies, has extended

my ability to explore the key research questions in this study, and provided a more nuanced perspective on the contested domain of abortion research not always portrayed in public health and epidemiological research (Boyle, 1997; Gammeltoft, 2003; Ginsburg, 1989; Ginsburg & Rapp, 1995; Luker, 1984; Morgan & Michaels, 1999; Rylko-Bauer, 1996; Taylor, 2008).

Anthropological and cross cultural perspectives and research around the politics of reproduction pay particular attention to local context and the manner in which individuals or communities give meaning to their experiences of various reproductive health interventions and technologies. The value of an anthropological and cross cultural perspective on abortion can be located in documenting the socio cultural, economic, ideological and political complexity of abortion across cultures, and in identifying the processes and contexts that define abortion at various levels, including individual, community, and national levels of analysis, and how they articulate with each other (Rylko-Bauer, 1996).

Ginsburg (1987; 1989), in exploring the life narratives of abortion activists on both sides of the abortion divide in Fargo, North Dakota, reveals how the struggle over abortion rights, in this case with the opening of the first free standing abortion clinic, has become a contested domain for control over the constellation of meanings attached to reproduction in America (Ginsburg, 1987, p. 623). She argues that although the abortion conflict is clearly a contested domain, the features that distinguish the central actors are not always that obvious. Pro-choice and anti-choice activists do not always divide neatly along economic, occupational, or religious lines, suggesting that abortion politics need to be located within changing historical, social and political processes (Ginsburg, 1987, p. 624).

Related to this, “struggles over abortion are seen as symbolizing a much broader set of political, economic and ideological concerns relating to women’s productive and reproductive roles and competing meanings of gender, sexuality and motherhood” (Rylko-Bauer, 1996, p. 480).

The concept of “reproductive politics” is useful in exploring differing meanings and practices of abortion, and provides an important entry point to understand and frame

diverse aspects of abortion politics and provision both locally and globally (Ginsburg & Rapp, 1995).

Anthropologists working in the field of reproductive health have provided important insight into the manner in which reproductive technologies and ideologies are recreated and adapted by local communities, and the manner in which social experiences of reproduction and sexuality are historically and culturally negotiated, constructed and located. Ginsburg and Rapp's (1995) collection of studies on the anthropology of reproduction challenges traditional anthropological analyses of reproduction, by exploring the manner in which reproduction is structured across social and cultural boundaries at both local and global intersections. Their exploration of how the local and global intersect is particularly important for this study as global reproductive and abortion politics have had a significant influence on abortion politics in South Africa. This has particularly been the case with the important roles that international sexual and reproductive health NGOs have played in abortion advocacy, training, provision and support. Similarly, the effects of international anti-abortion politics have also been experienced in South Africa with the presence of pro-life Christian organizations and their role in anti-abortion politics.

Debates around reproductive rights and abortion are underscored by changing and diverse meanings associated with child bearing and motherhood, and women's reproductive roles in society. Luker's (1984) historical study on abortion and the politics of motherhood in North America shows how highly emotive and contested issues around abortion are linked to contrasting views of the place of motherhood in women's lives. She explores the ways in which changes in medical technologies, including the introduction of the contraceptive pill in the USA in the 1960s, impacted on women's lives regarding decision making around childbearing and fertility planning, thus enabling greater reproductive autonomy. Reproductive freedom brought about significant changes for women, as they were no longer solely defined by their reproductive roles as mothers and caregivers but also as wage earners, as opportunities emerged for women to enter the workforce on more equal terms. However, opportunities for women apart from child bearing and child rearing were also perceived by some as the devaluation of motherhood and marriage, and counter to women's expected roles in society as mothers and care-givers (Luker, 1984).

Related to diverse and changing meanings attributed to motherhood is the emergence of scholarly literature and contestations around fetal personhood and fetal autonomy, broadly referred to as fetal politics.

Conceptualization of the fetus

This section will discuss the literature that explores the manner in which the fetus and notions around fetal personhood have entered the abortion debate. The more abstract or theoretical arguments around the fetus within both the medical and public domain will be discussed first, followed by the more concrete everyday experiences of abortion providers who come into contact with aborted fetuses in their abortion care practices.

Fetal personhood

The emergence and centrality of the fetus as a person or living being existing separately from the mother has emerged over the past two to three decades in the USA and elsewhere, and has raised considerable discussion, both within feminist and pro-choice movements and anti-choice movements and discourse (Casper, 1999; Morgan & Michaels, 1999; Petchesky, 1987; Taylor, 2008).

Roe v. Wade, the 1973 Supreme Court decision legalizing abortion in the USA grounded women's right to abortion on the concept of constitutional privacy, designed to protect individuals from state intrusion into private decisions (Morgan & Michaels, 1999). Morgan and Michaels (1999) have argued that ironically the provision of privacy on the part of the Court has been accompanied by a growing public interest with fetuses, as a result of effective anti-abortion activity, and in part as a result of developments in medicine and technology that enable one both to visualize the fetus and to intervene regarding fetal surgery, pre natal ultrasound and other pre natal diagnostic methods (Morgan & Michaels, 1999, p. 1).

Taylor (2008) explores how fetal sonograms in both clinical and popular spheres have entered into the social and political life in the USA, and demonstrates how ultrasound technology has entered into public consumer culture, by moving beyond the medical diagnostic sphere to non diagnostic “keepsake” ultrasound businesses, and anti-abortion clinics that use ultrasound as an attempt to make women bond with their fetus (Taylor, 2008, p. 145).

Feminist reluctance to engage in dialogue around the fetus is largely due to concerns that such engagements would cede to the pro-life movement its major premise, and so to foreclose the feminist insistence on reproductive freedom for women (Morgan & Michaels, 1999, p. 2). Despite this reluctance to engage with the meanings around fetal personhood, the fetus has entered the public landscape and public imagery in both developed and developing country contexts, through advanced medical diagnostics and through ultrasound images of the fetus, sometimes used in various advertising contexts, for example, that of cars. Moreover these studies highlight the manner in which the portrayal of the fetus through advertising takes it beyond the more traditional medical sphere of pre natal diagnostics and treatment to more everyday aspects of consumer culture.

Related to this Kumar, Hessini and Mitchell (2009, p. 631) have argued that conflating or linking a developing fetus with an actual baby through the popular media, culture and art, further embeds abortion stigma in popular discourse.

Whilst scholarly works which place the fetus at the center of reproductive politics have largely emerged in the USA (Ginsburg, 1987; 1989; Morgan & Michaels, 1999; Taylor, 2008), the emergence of the fetus in both medicine and the wider public discourse has similarly extended to South Africa, although this has occurred more within the sphere of anti-abortion politics, and through the media and advertising of consumer products such as cars, cellular phones and internet services.

Exploring how the fetus is constructed by public and medical discourses opens up the space to explore the complexities associated with competing notions around fetal personhood and autonomy versus the reproductive rights and autonomy of the mother.

Furthermore, the literature highlights the tensions between the moral significance attributed to the fetus or “life of the unborn” and the reproductive integrity of the mother. This tension between the rights of the fetus counterbalanced against the mother’s right to reproductive autonomy is central to engaging in the contested domain of fetal rights versus the mother’s rights. It is along these fault lines of whose rights takes precedence that the pro-choice and anti-choice debates are located. However, as scholars across disciplines have suggested, it is important to locate these debates and contestations within their social, political and cultural contexts (Boyle, 1997; Ginsburg & Rapp, 1995; Luker, 1984). Rather than engaging in philosophical questions around the ontological status of the fetus, one needs to explore the cultural contexts in which discussions around the fetus, as it relates to reproductive politics, arise (Morgan & Michaels, 1999).

A further area where contestation within medical science over what and when personhood is attributed to the fetus is in the realm of fetal surgery. Advances and developments in fetal surgery have brought to the fore changing notions of motherhood, fetal identity and personhood, whereby the fetal patient assumes a sense of autonomy outside of the pregnant woman’s body, often mediated by the doctors performing the surgery (Casper, 1999). Whilst the occurrence of fetal surgery might have little resonance with the politics of abortion in South Africa, it does bring to the fore differing ways in which fetal autonomy may be perceived by those within the medical domain and in the wider public domain, and may contribute to reconceptualizations of the maternal-fetal relationship.

The fetus and abortion provision

The more tangible or lived experience of the fetus in abortion provision and practice will now be explored. A small body of literature has explored the visual and emotional effects of dealing with aborted fetuses inherent to abortion procedures of more advanced gestational age (Gammeltoft, Tran, Nguyen & Nguyen, 2008; Harris, 2008).

Harris (2008), an American abortion provider, in attempting to “break the silence” about second trimester abortions, highlights the visual and visceral dimensions of second trimester surgical procedures, and the concomitant personal and psychological impact on providers (Harris, 2008, p. 74). For fear of playing into the hands of the pro-life movement, providers might censor themselves, fearing that honest acknowledgement of these difficulties may impact negatively on the pro-choice movement, and that such acknowledgement could appear to legitimate the pro-life position that second trimester abortion is “gruesome and morally unacceptable” (Harris, 2008, p. 74). Harris suggests that providers need to be open and honest about the complex and emotionally disturbing aspects of dealing with fetuses and fetal body parts inherent in second trimester surgical abortions, thus creating a space for providers to discuss and engage with the issues (Harris, 2008, p. 74).

She further raises the complex question as to how to deal with the emotional experiences of being faced with an aborted fetus, underscored by the need for these experiences to be acknowledged and supported:

What do we do when caught between pro-choice discourse that, while it reflects our values, does not accurately reflect the full extent of our experience of abortion and in fact contradicts an enormous part of it, and the anti-abortion discourse and imagery that may actually be more closely aligned to our experience but is based in values we do not share? Where do we go to talk about it? (Harris, 2008, p. 77).

Harris thus opens up important debates for health care professionals involved in abortion provision, by exploring and acknowledging the disquieting aspects of being exposed to an aborted fetus. Her research raises numerous less openly spoken about issues as they relate to the everyday lived experiences of abortion provision, as opposed to the more abstract arguments important to abortion rights and choice, and access to safe, legal abortion services.

Providers' views and attitudes about abortion: Globally

This section will firstly review studies undertaken in settings outside of South Africa, where most of the research on health care provider's attitudes towards abortion provision has been conducted, most notably in the USA.

A chronic shortage of abortion care providers in the USA has motivated studies on health care providers' attitudes towards abortion and abortion provision, underscored by the continued availability of legal abortions being limited by the number of physicians willing and trained to provide abortions. To this end studies have been undertaken exploring current and future health care providers attitudes and intentions towards abortion (Finer & Henshaw, 2003; Kade, Kumar, Polis & Schaffer, 2004; Lazarus, 1997; Lipp, 2008; Marek, 2004; Rosenblatt, Robinson, Larson & Dobie, 1999; Sheriff, 2009; Shotorbani, Zimmerman, Bell, Ward & Assefi, 2004).

Shortage of abortion providers

Despite induced abortion being one of the most common procedures performed among women in the USA, 84% of all counties did not have an abortion provider in 2000. Meanwhile the number of abortion providers has been declining, and more than half of abortion providers are 50 years or older, which has implications for sustainability of services (Grimes, 1992; Sheriff, 2009). However the largest contributor to the shortage of abortion providers is the lack of abortion education at the medical school and residency level (Sheriff, 2009). The shortage of abortion providers is further compounded by restrictions placed on advanced clinical practitioners (i.e. physician assistants, nurse practitioners and midwives) from providing abortion services, thereby exacerbating the provider shortage. Despite evidence that trained advanced clinical practitioners are able to conduct safe abortions, 44 states have laws prohibiting them from doing so (Sheriff, 2009; Weitz et al., 2009).

Sheriff (2009) traces the history of abortion in the USA as a way to uncover reasons for a shortage of abortion providers. Despite the watershed ruling (*Roe v. Wade*) in

1973 legalizing abortion, barriers to abortion access exist. She argues that perhaps the primary reason for medicine's failure to integrate abortion care into hospitals and mainstream medical practice was the intense stigma that remained connected to both the procedure itself and the physicians who performed it. Even after legalization, a small and dedicated group of physicians - mainly those who had already been performing abortions regularly - provided the majority of all abortions (Sheriff, 2009).

With hospitals neglecting to provide abortion care, services had to move outside of the hospital to independent women's health clinics. This further contributed to abortion provision being considered outside of mainstream medical practice, and further isolated providers. Furthermore, free standing abortion clinics and medical staff working within these clinics became targets of anti-abortion violence (Joffe, 1996; Sheriff, 2009).

However, the largest contributor to the shortage of abortion providers was a dearth of abortion education and training programs in medical and nursing schools, as well as in obstetrics/gynecology residency programs (Lazarus, 1997; Sheriff, 2009). Abortion training was either optional or elective, and the only area where residents could refuse to participate in a medical practice (Lazarus, 1997).

Another contributing factor to a shortage of trained abortion providers is medical residents' right to conscientious objection. Providers' invoking their right to conscientious objection has been another issue which has received some attention in scholarly works around abortion provision and training. Lazarus (1997) has argued the increasing politicization of abortion in the USA has led to increased conflict between physicians' personal morality and professional responsibilities and obligations towards their patients (Lazarus, 1997):

The public debate on abortion is about women and fetuses, their lives and health. But this emotionally charged and politically volatile issue is also about doctors. Abortion involves physicians' core ethical concerns about pregnancy and about life. It deals with a wide range of ethical problems regarding obligations and responsibilities. Physicians are faced with moral ambiguities compounded by ever increasing advances in prenatal diagnostics. Physicians

must ask themselves whether they will do abortions and if so on what terms. Should one only do those medically indicated for maternal survival or for fetal anomalies or should one do elective abortions believing in a woman's right to choose? (Lazarus, 1997, p. 1408).

Lazarus (1997) raises some interesting issues and engages with the complexities of conscientious objection, which in her findings often had less to do with personal conscience and more to do with working conditions and opportunities whereby refusal to be involved in abortion training or provision was a strategy to avoid extra work in an already demanding work schedule. She further engages with the impact of conscientious objection with regards to abortion provision and training on women's access to abortion services. Refusal to undergo abortion training and subsequent abortion provision further compounds the provider shortage, and in turn women's access to safe abortion services.

The right to refuse to participate in abortions raises philosophical and ethical questions as to when personal beliefs override professional responsibilities and obligations, and what limits should be placed on providers' rights to freedom of conscience. These bioethical and philosophical debates have more concrete application when women's access to abortion is limited or restricted, due to health care providers' refusal to provide care. Both Sherriff and Lazarus suggest ways of addressing these complex issues by engaging with these issues in an open manner. They argue ethical training, defined educational policy and institutional direction and guidance is required to avoid the continued shortage of doctors willing to perform abortions (Lazarus, 1997; Sheriff, 2009).

Health care providers' attitudes towards abortion

The shortage of abortion providers has led to studies examining the attitudes and intentions of current and future health care providers towards abortion. However, these studies have tended to focus on health professionals still undergoing their training and not currently practicing. Intention to provide abortion services may not directly predict provision of services (Rosenblatt et al., 1999; Shotorbani et al., 2004).

Lipp's (2007) comprehensive literature review of health care professionals' attitudes towards abortion identified four key determinants that influenced attitudes towards abortion provision. These were: personal attributes of staff, including whether attitudes could be influenced by personal experiences of abortion; religious beliefs; circumstances and reasons why women seek abortions; and gestational age of pregnancy (Lipp, 2007).

A study involving midwives and gynecologists in Sweden (a country with a liberal abortion law) found that one in five of the female respondents had experienced an abortion, and one-quarter of male respondents had a partner, friend or relative who had undergone an abortion, highlighting that attitudes towards abortion could be tempered by direct or indirect experiences of abortion (Hammarstedt, Jacobsson, Wulff & Lalos, 2005). Furthermore, for some providers personal experiences of being exposed to the morbidity and mortality associated with illegal, septic abortions were also influential in decisions around abortion provision (Romalis, 2008).

Religious beliefs were also found to be influential in providers' decisions around abortion provision, including objecting on the grounds of religious or moral beliefs, and a strong relationship between church attendance and negative attitudes towards abortion (Lazurus, 1997; Marshall, Gould & Roberts, 1994).

Providers' attitudes appeared to alter, depending on the circumstances of the woman seeking an abortion, such as reasons for the abortion and the advancement of the pregnancy, most notably second trimester pregnancies (Marek, 2004; Marshall et al., 1994). Circumstances which caused nurses to be more sympathetic towards abortion included the woman's mental and physical health being at risk, fetal anomalies, or an unplanned pregnancy being a result of rape (Marek, 2004; Marshall et al., 1994).

Involvement in second trimester abortions was particularly difficult for most providers, and gestational age limits or refusal to provide later gestational age abortions were found in many studies, contributing to a shortage of second trimester abortion providers (Gammeltoft et al., 2008; Harris, 2008; Lazarus, 1997; Marshall et al., 1994).

The above corpus of research related to providers' attitudes towards abortion employed predominantly quantitative methods, with the exception of one small study which had a qualitative component (Kade et al., 2004; Lipp, 2007; Rosenblatt et al., 1999; Shotobarni et al., 2004). These studies had some shortcomings, in that they did not explore how providers conceptualized abortion, or the complex and varied meanings attached to abortion. The focus was more on attitudes towards abortion and less on experiences of abortion provision, with the exception of a few studies (Kade et al., 2004; Sheriff, 2009). Contested issues around abortion were not explored in depth, largely due to the data collection methods employed, such as self administered postal questionnaires and surveys (Hammarstedt et al., 2005; Kade et al., 2004; Rosenblatt et al., 1999; Shotobarni et al., 2004). In-depth one on one interviews were not included in these studies, and might have elicited more detailed explorations of the issues. Furthermore, little information is provided on how providers resolved or mediated contested issues, and whether attitudes changed over time. This is important for understanding long term implications of abortion provision.

The preceding section of the literature review has focused on abortion related studies conducted predominantly from within the North American setting, where most of the scholarly works on abortion care has been conducted. The next section will discuss abortion related research as it applies to health care provision within the South African context, with a focus on health care providers' attitudes towards abortion.

Providers' attitudes and experiences of abortion: South Africa

The dominant literature emerging around abortion in South Africa has also, for the most part, employed quantitative research methodology, and with the exception of two known published studies have not focused exclusively on health care providers' attitudes or experiences of abortion (Harries, Stinson & Orner, 2009; Mokgethi et al., 2006).

Abortion related research conducted after the implementation of the CTOP Act in 1996 has focused on four broad areas, largely related to obstacles and problems with

abortion access and availability, and have included: monitoring and evaluation initiatives conducted five years after the implementation of the CTOP Act; barriers to accessing abortion services, including provider attitudes towards abortion and the impact of conscientious objection on abortion access; the shortage of health care providers trained to perform abortions, including second trimester abortions; and problems with abortion training which further compounds the provider shortage.

Monitoring and evaluation initiatives

Most research initially conducted after the implementation of the new abortion legislation focused on monitoring and evaluation of abortion services, commissioned by the National Department of Health and undertaken by local and international NGOs such as the Reproductive Rights Alliance, Ipas, the Women's Health Project and the Reproductive Health Research Unit.

Since 1997, research and monitoring initiatives accompanying the implementation of the CTOP Act have documented the increased availability of abortion services (Reproductive Rights Alliance, 2002 a; Reproductive Rights Alliance, 2002 b). In the first two and a half years after the new legislation the total number of reported abortions in public health facilities had reached 92,399 (Reproductive Rights Alliance, 2002 a). Within the first six months the number of legal abortions reported by public health facilities was more than twice the number legally conducted during the eight year period (1984-1991) prior to the reform (Varkey, 2000).

Furthermore, the new abortion legislation had been effective in reducing abortion related mortality, indicating a 91.1% reduction in deaths from unsafe abortion (Jewkes & Rees, 2005). This reduction in mortality after the abortion legislation showed that South Africa's new legislation had been successful in advancing women's health and rights (Jewkes & Rees, 2005). Despite increased availability of services and a significant reduction in abortion related mortality, problems with access were identified early on in the process (Varkey, 2000).

In 2000, the Women's Health Project at the University of the Witwatersrand conducted the first review of research addressing the implementation of the Act, and provided an overview of research undertaken between 1997 and 2000. The review explored both service delivery and community factors affecting women's access to abortion services, and identified additional areas for research. Findings suggested that little is known about provider-client information exchange, and that further research is needed on how to transform attitudes of current "gate-keepers" of abortion services. Support for both providers and users of abortion services was identified as an important area to be pursued.

This was followed by further research in 2002, when the Reproductive Rights Alliance undertook a five year review of the implementation of the Act. Abortion health care providers were interviewed, and raised a number of cross cutting issues, which they perceived compromised the quality of service delivery. All their concerns centered around a disabling environment in which to deliver effective care. These included inadequate human resource capacity allocated to service provision, resulting in high levels of stress and burnout; unsupportive management impacting negatively on abortion service provision; and abortion service provision being seen as a "glass ceiling" for career development, given the limited number of trained, practicing abortion health care providers (Reproductive Rights Alliance, 2002a).

A critical lesson learnt from the South African experience was the need to prepare the health system, including health professionals, prior to the implementation of new laws. Another problem identified was that the professional medical and nursing associations were not a major force for or against the CTOP Act, and thus gave little leadership in encouraging their members to provide services. This was suggested as one of the contributing factors to reluctance on the part of both nurses and doctors to provide abortion services (Reproductive Rights Alliance, 2002a).

Barriers to accessing abortion services

Despite liberal abortion reform laws and increased availability and accessibility to legal abortion services, there are still major barriers to women accessing abortion services. These include provider opposition, stigma associated with abortion, a lack of

providers trained to perform abortions including second trimester abortions, and facilities designated to provide abortion services particularly in the rural areas.

Provider attitudes towards abortion

A dearth of studies has been undertaken in South Africa looking at providers' attitudes towards abortion within the context of their daily practice, of which there has been only one published qualitative study (Harries et al., 2009). A study looking at attitudes of medical students towards induced abortion at one South African university found that only about a tenth reported that they would perform or refer patients for abortion on request (Buga, 2002). However, although many of the medical students personally felt abortion was akin to murder, the majority would perform or refer a woman for an abortion under certain circumstances, which included a threat to the mother's life, and in situations of rape and fetal abnormalities. Religious affiliation and service attendance significantly influenced some of these attitudes and beliefs (Buga, 2002). This study was undertaken soon after the implementation of the new abortion legislation. Exploring how attitudes might have changed over time and how providers are responding to the changes is additionally important.

Similarly, Harrison et al. (2000), in a study exploring attitudes and beliefs about abortion among primary care nurses in a rural district of KwaZulu-Natal, found that in situations of rape, incest or saving a woman's life, nurses were more willing to support a woman seeking an abortion. Religious beliefs and practices also influenced providers' attitudes towards abortion - nurses felt that abortion was against their religious beliefs, analogous to killing another human being and counter to their professional responsibilities, which required them to "save lives not remove them" (Harrison et al., 2000, p. 426). This aspect of the study was based on a small sample of respondents in a traditionally conservative area of rural KwaZulu-Natal, and was conducted two years after the passage of the new Act. Notwithstanding this, it provides important insight into how, in the few years following the passing of the Act, opposition emerged, coupled with the perception that the law had been imposed by government without proper consultation and adequate broader based public education to address key issues around abortion (Harrison et al., 2000, p. 429). Both of the above studies were similar, in that health care providers were not supportive of

abortion on request, and religious and other cultural beliefs contributed towards their perceptions and intentions regarding abortion provision.

In an exploratory descriptive study examining the implementation of the CTOP Act in the Free State Province of South Africa five years after the implementation of the Act, providers' attitudes towards abortion were found to be influenced by religious beliefs, and concerns that women were abusing abortion services by using abortion as a form of contraception (Engelbrecht, 2005). Some providers similarly felt that abortion should only be available under certain circumstances such as rape or incest. Providers involved in abortion provision reported negative and hostile attitudes, accompanied by harassment and isolation from colleagues in the work place, with little support from management. A lack of clear policy guidelines with regards to abortion provision added to the strain (Engelbrecht, 2005). While these issues were enumerated and documented, they were not explored in depth, nor were understandings and meanings around abortion and what it meant in everyday practice examined.

A study conducted in the Western Cape from a "feminist anthropological" perspective explored how nurses' own social and cultural conceptions around abortion, motherhood and respectability informed their attitudes towards women seeking abortions (Cox, 2005). Similar to the study conducted by Engelbrecht (2005), providers were concerned that women were using abortion as a form of contraception (Cox, 2005). While this study had certain shortcomings, in that it provided limited empirical data to support the arguments and gave little voice to health care providers, it suggested ways to explore concepts around abortion which are not solely located within public health paradigms.

Conscientious objection

One of the main identified obstacles to women accessing abortions is the right of health workers to conscientious objection (Engelbrecht, 2005; Naylor & O' Sullivan, 2005; Ngwena, 2003; Reproductive Rights Alliance, 2002 a; Reproductive Rights Alliance b; van Bogaert, 2002).

Debates and discussions around health care professionals' constitutional right to freedom of conscience with regards to abortion provision and its impact on abortion access have emerged, predominantly amongst legal scholars and ethicists. Related to this Ngwena (2003), a constitutional law scholar, has argued that it was an oversight for the CTOP Act to omit to provide for conscientious objection, and set out the principles for determining its limits. As the Act stands, it does not provide guidance on the exercise of conscientious objection. The Constitution is the only available yardstick. Clear guidance would have served to reassure the proponents of conscientious objection to abortion, as well as the women wishing to access abortion services, that their rights are acknowledged and protected (Ngwena, 2003). He further argues that, because the CTOP Act is silent about the right to conscientious objection, it consequently falls on the Constitution to fill this omission.

Dhai and Moodley (2002) argue that the scarcity of abortion services in South Africa has serious ethical implications for health care providers, as for many women the service is a critical health need, yet substantial numbers of qualified health professionals refrain from performing it. They question whether the medical profession is fulfilling its responsibilities to women, and argue that whilst it is important to respect the rights of health professionals to freedom of conscience, it is equally important to respect the rights of women to access health care, and to have freedom and security over their bodies. However, none of these studies have explored how providers in South Africa make sense of, or understand, conscientious objection in terms of refusing to provide abortion care services.

Shortage of abortion care providers

In recent years the number of abortions performed nationally, and in each of the provinces including the Western Cape, has increased substantially, indicating increased availability and accessibility of abortion services in both the public and NGO sector (Department of Health 2004). Despite this manifold increase in demand and utilization, challenges exist in the further expansion of services, particularly through trained nurse or midwife service provision up to 12 weeks gestation (Dickson-Tetteh & Billings, 2002). The shortage of health care providers who are

willing or trained to perform abortions undermines the provisions of the CTOP Act, by limiting the availability of safe, legal abortion, and has serious implications for women's access to abortion services and health service planning.

The shortage of abortion providers is not a local phenomenon, but is present in other settings such as the USA, as previously discussed. South Africa is one of three countries where professional registered nurses and/or registered midwives, key staff in primary health care facilities, are legally allowed to perform first trimester abortions. Training mid-level providers was deemed critical to ensure the decentralization of first trimester abortions to primary health care facilities, and thus more accessible levels of health care. A randomized controlled trial undertaken in South Africa and Vietnam, comparing rates of complications of two groups of providers (nurses and doctors) performing first trimester abortions, demonstrated that nurses were equivalent to doctors regarding safety of abortion provision (Warriner et al., 2006). This should provide further impetus for exploring why, despite the known safety of this group of providers in conducting abortion procedures, abortion provision is still impeded by a shortage of trained abortion providers. Staff attrition and a shortage of health personnel throughout South Africa have further compounded the problem (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). A range of factors have impacted on the availability and supply of qualified nurses in South Africa. They have included the closure of some nursing higher education institutions, widespread migration of public health service nurses abroad for higher remuneration and better working conditions, as well as poor distribution of skills and numbers within facilities, and the added burden of HIV/AIDS into existing health personnel's workload (Coovadia et al., 2009).

Second trimester services

Second trimester abortions account for over 25% of abortions performed in South Africa, which is greater than other countries with legalized abortion such as the USA and Vietnam, where 12% or less of abortions occur in the second trimester (Department of Health, 2004; Strauss et al., 2004). Abortions performed after 12 weeks of gestation pose greater risks of medical complications than abortions

performed during the first trimester (Bartlett et al., 2004; WHO, 2004a). A dearth of trained second trimester abortion providers in South Africa, and more specifically in the Western Cape, has resulted in the outsourcing of surgical second trimester services to the NGO and private sector. Consequently second trimester surgical abortions are being provided by a roving team of three doctors employed by the Provincial Department of Health to provide abortions services in the public health facilities. Furthermore little is known about providers' experiences of and attitudes towards second trimester abortions in South Africa (Alblas, 2008; Dearham et al., 2009; Turner et al., 2008).

Abortion training

Integrally linked to an identified provider shortage, largely attributed to opposition to abortion, is limited abortion care training for mid-level providers. The impetus appears to have dissipated, and on-going training crucial for long term sustainability is sporadic and lacking any long term planning. Varkey (2000), in her review of abortion services three years after the implementation of the Act, noted that implementation was largely slow and geared toward meeting immediate service requirements, and lacked a long term sustainable plan. An area identified as early as 2000 was a notable shortage of trained mid-level abortion providers. This was largely attributed to negative attitudes toward abortion provision and the fact that abortion had not yet been integrated into the basic curriculum of nurse training institutions (Varkey, 2000, p. 87). Nine years later, Smit et al. (2009) concluded that no attempts had yet been made by nursing colleges and/or universities in the Western Cape to implement guidelines and/or formal abortion care training for nurses, since the abortion legislation came into effect in 1997. This clearly has implications for training of future mid-level abortion care providers and sustainability of services.

Conclusions

This chapter has been informed by literature related to more abstract notions around abortion and the contested domain of abortion politics, largely informed by debates

emanating from the social sciences and feminist studies. The discussion of scholarly works around abortion highlighted areas of significance to the research study, and included the contested domain of abortion and reproductive politics; debates around fetal personhood; and on a more concrete level, exploring health care providers' attitudes to and experiences of abortion globally and locally in South Africa.

Some of the issues to emerge in the North American setting and elsewhere have resonance in South Africa, especially with regards to abortion provider shortages, limited abortion training in medical and nursing schools, and the issues related to conscientious objection or refusal to provide abortion services. Despite a differing health systems context and social and economic conditions, important lessons can be drawn from developments in countries such as the USA, which has had a marked influence on abortion advocacy, provision, training and support in South Africa. Whilst the setting might be different, parallels can be drawn with the situation in South Africa. Abortion work is contested in most settings, and lessons learnt in settings where abortion has been legal and provided for a longer period of time, can be of relevance to South Africa.

CHAPTER 4: RESEARCH METHODOLOGY

Introduction

This chapter will describe the qualitative research methodology employed in the collection of empirical data. The rationale for the choice of qualitative research methods for this particular study will be presented. This will be followed by a discussion of the study design, study setting, study population, data collection and data analysis. Ethical considerations pertinent to the research study, which has as its central focus a highly contested and controversial subject matter such as abortion, will be explored. In the final section I will discuss the phenomenon of the researcher becoming part of the research process, and the importance of reflexivity to address this process. Difficulties encountered in data collection will also be highlighted.

Research study design

A qualitative approach was used which centered around 48 in-depth interviews, one focus group discussion (FGD), and observations with a purposively selected population of abortion related health service providers, managers and policy influentials in the Western Cape Province, South Africa.

Qualitative research is the most appropriate method for gaining an in depth understanding of social and behavioral phenomena. The key focus of qualitative research is on understanding and analyzing meaning within particular social contexts. How people or individuals understand their everyday life worlds and make meaning of everyday phenomena is central to qualitative research (Mays & Pope, 2000). Qualitative research also allows for investigation of relational aspects between individuals and systems, persons and culture, and behavior and social norm-making. Within health services research, including the health care environment, qualitative research is appropriate for exploring social phenomena such as beliefs and understanding of the social world as experienced or lived.

Thus qualitative research methodology was chosen for this research project for a number of reasons. Firstly, qualitative research was deemed the most appropriate for investigating the research questions and uncovering the ways in which providers conceptualized abortion, and the meanings attached to abortion practice and provision within the health care environment, including relations with wider social communities. Secondly, providers' perspectives and experiences towards abortion is an under-researched and relatively new area of enquiry, with little prior in depth investigation of the subject matter (Morse, 2003). Thirdly, abortion is a sensitive and controversial topic, and as such required detailed and close examination of the complex issues which qualitative research facilitates. Exploring a controversial and contested topic such as abortion would be difficult to validate with quantitative measures.

Morse (2003) has suggested that qualitative research methodology is used when little is known about a topic, the research context is poorly understood, the phenomenon under investigation is not quantifiable, the nature of the problem is not clear, or the researcher believes that the phenomenon needs to be re-examined (Klopper, 2008, p. 62).

Research setting

The study was conducted over a 24 month period, between 2006 and 2008, across three public sector primary health care facilities; eight hospitals (across three levels of care: primary, secondary and tertiary academic); four not for profit non-governmental organization facilities, three of which provided abortions and other sexual and reproductive health care services, and one provided "crisis pregnancy" counseling; and two primary health services linked to secondary and tertiary educational institutions which provided pre abortion counseling and referrals to designated abortion facilities (See Table 1, Appendix 1).

Research sites were based within the greater Cape Town area and three outlying peri-urban areas within the Western Cape Province, South Africa. The Western Cape

covers an area of 129 386 square km, and has a population of approximately 4.2 million people. An estimated 10,935 abortions are performed per year at 29 functioning designated abortion facilities in the province (Dearham et al., 2009).

The Western Cape has one of the best resourced health care systems in South Africa, and provides the second highest number of abortions per year, after Gauteng province. In addition, the Western Cape has the second highest number of abortion care providers per population, hence facilitating greater access to health care providers.

Currently services in the Province are being provided by a limited number of trained staff consisting of 14 nurses, three trained doctors in a roving team, and one additional trained doctor. Facilities provide a range of sexual and reproductive health care services, ranging from pre abortion care including counseling and referral, ultrasound to determine gestational age, to the provision of first and second trimester abortions, and post-abortion counseling and contraceptive services.

Abortions at public sector facilities are available free of charge, while NGO-based facilities offer a mix of free and fee-related services which, at the time of the study, ranged from 800 ZAR to 1,500 ZAR depending on type of abortion procedure and gestational age. Public health care facilities that offer first trimester abortions are for the most part provided by nurse midwives who have been trained and certified to provide first trimester manual vacuum aspiration (MVA) abortions up to 12 weeks. In 2001, the South African Medicines Control Council approved a regimen of 600mg mifepristone and 800mcg misoprostol for medical abortions up to eight weeks of pregnancy. This drug regimen has been available in the private and NGO sector since 2002. However, medical abortions for first trimester abortions are not yet available in public health facilities (Cooper et al., 2005).

With the exception of one health care facility, all second trimester abortions were provided by a “roving team” of three private abortion doctors who were employed by the Provincial Department of Health to provide abortions in designated facilities where there were no public sector health care providers willing to provide abortions. This roving team of three abortion doctors also provided abortions in the three of the NGO facilities.

Most second trimester abortions were performed using the dilation and evacuation (D&E) method. Misoprostol (Cytotec®) a prostaglandin analog that causes uterine contractions was administered to all abortion patients for cervical priming prior to the MVA and D&E procedure. The medication method of abortion for second trimester abortions using misoprostol-alone was used in some tertiary hospitals. The Western Cape is the only province in South Africa where the D&E method for second trimester abortions is currently offered on a limited scale in the public sector. In most other provinces in South Africa within the public sector, the medication method of abortion using misoprostol-alone is the preferred method for second trimester abortions.

| First trimester | Second trimester |
|-------------------------------------------------------------------|-----------------------------------------|
| Surgical procedure | Surgical procedure |
| MVA: misoprostol for cervical priming | D& E : misoprostol for cervical priming |
| Medical abortion | Medical abortion |
| Misoprostol and mifepristone only available in private/NGO sector | Misoprostol-alone |

The above descriptions highlight the differing ways in which services were organized.

Population and sampling

Population

The Western Cape Provincial Department of Health’s division of health districts and directory of designated abortion facilities was used as a base from which to select health care facilities and providers working within these facilities. Three sexual and reproductive health NGO facilities which were also designated abortion facilities were included, as these facilities play an important role in abortion care provision in the Western Cape, and furthermore, many providers work in both public sector and NGO facilities. A “crisis pregnancy” NGO was subsequently included in an attempt to include a facility that was not pro-choice, and two student health services linked to

secondary and tertiary educational institutions were also included, as providers in these facilities were involved in pre abortion counseling and referrals to abortion facilities.

At the time of the research there were 40 designated public sector abortion facilities in the Western Cape. However not all were providing abortion services, due to the non-availability of abortion care providers. Of the 40 designated abortion facilities, 29 were functioning as abortion facilities. However, five of these 29 functioning facilities were outsourced to either a private doctor from the team of roving doctors from the Cape Town metropole area or were outsourced to Marie Stopes International (MSI).

The Western Cape Health districts are divided into five regional health districts:

1. Cape Town Metropole
2. Tygerberg
3. West coast/Winelands
4. Boland /Overberg
5. Central Karoo and Eden District

Four of the five regional health districts listed above were included in the study, in order to obtain an urban and peri-urban mix and reflect the range of abortion care services offered in the Western Cape Province. The fifth district, the Central Karoo /Eden District was not included due to geographical distance and funding constraints. In addition, abortion services in the Central Karoo and Eden districts are currently outsourced to MSI, as there are no public sector abortion care providers to provide services in this region. Public sector patients at MSI clinics in the Central Karoo and Eden district are not expected to pay for abortion services.

Sampling

Study participants were purposively selected to include five main groups of respondents. Criteria used to select participants were by professional category and type of abortion service provision. Participants were divided into the following five groups:

1. Health care providers trained in abortion services and performing abortions, including nurse midwives performing first trimester abortions, and doctors including general practitioners and obstetrician/ gynecologists providing first and second trimester abortions.
2. Providers working in abortion services who were not performing abortions but involved in other aspects of abortion provision, including nurses involved in pre and post abortion care counseling, administration of abortion related medications, referrals and other aspects of abortion care provision, and social workers involved in pre abortion counseling.
3. Providers not involved in abortion provision, including doctors and nurses who absented themselves from abortion provision and care, and counselors involved in pre abortion and pregnancy options counseling.
4. Health care managers in facilities providing both abortion and/ or reproductive health care services, including nurses or doctors in senior management positions responsible for overall abortion service provision oversight within a particular health care facility or health district.
5. Policy influentials involved in sexual and reproductive health care services and abortion, including senior program managers and directors in both the public and NGO sector providing both abortion and/ or reproductive health care services.

No register or other enumerated list was available to use for selection of potential respondents. However, information including a list of possible contacts obtained from the Assistant Director for Reproductive Health services, and a list of designated abortion facilities in the Western Cape, assisted in identifying a pool of health personnel from which the study sample was selected. Further possible contacts were obtained from this pool of health personnel. Every effort was made to select both those providing abortion services and those not providing abortions. Accessing those providers who were opposed to abortion and not willing to provide services was more

difficult, and I relied on contacts obtained from other informants and social networks to access these providers.

A total of 48 in-depth interviews and one focus group discussion (comprising four counselors) were conducted with health care providers, health care managers and policy influentials, who were involved in a range of aspects of abortion service provision in the public and NGO sectors (see Appendix 1). Policy influentials were included as they play a pivotal role in policy and guidelines as they relate to abortion policy and practice, similarly senior hospital managers not directly involved in abortion services were included as they play a key role in abortion service provision and oversight.

Data collection

Potential participants were approached by the study staff, either at their place of work or via telephone or e mail contact, and invited to participate in the study. The purpose of the research study was explained to all participants before being asked to provide informed consent.

Owing to the sensitivity of the subject matter, and respect for privacy of participants, individual face to face interviews were deemed the most appropriate method for data collection. Although focus group discussions (FGD) are sometimes considered suitable when researching taboo or sensitive topics (Kitzinger, 1995, p. 300) they were not considered suitable, due to time constraints and logistically being able to get a group of providers together in one facility during working hours. Furthermore, most providers intimated that due to divergent views around abortion they would not be comfortable engaging in a group setting. There was one exception, where a single focus group discussion was held with four participants at their request, as they felt more comfortable speaking in a group rather than on an individual one on one basis. These providers had chosen to work at this particular center as they all held similar views around abortion, and stated that they preferred to speak in a group. The interview guide was adapted accordingly to facilitate discussion.

Research instruments in the form of an interview guide (see Appendix 2) were open-ended, and included probes for potential additional issues that could emerge as important concerns amongst the providers interviewed. Key categories explored in the interviews were: conceptions and understandings around abortion, reproductive rights and choice and the abortion legislation; experiences of working in a facility providing abortions; perceptions around women seeking an abortion; providers' relationships with their wider community; and the relationship between their professional practice and personal ideologies.

Respondents were also encouraged to raise other related avenues of discussion. Similarly, interviews did not necessarily follow the questions in sequential order, but rather focused on the ways in which respondents approached the issues. The interview guide was piloted in advance among a smaller group of providers (sampled from a similar community) and revised to ensure flow and clarity. Findings from the pilot study are not included in the overall study findings.

In order to ensure that really detailed information is gathered, interview methods require experienced researchers, with the necessary sensitivity and ability to establish rapport with respondents, to use interview guides flexibly, and follow up questions and responses (Pope, van Royen & Baker, 2002). The in-depth interviews and focus group discussion were conducted by four experienced qualitative researchers (including myself) who were comfortable with the subject matter, so as to ensure a non judgmental open approach to the potentially sensitive topic. Most interviews including the FGD were conducted in English, the language spoken by the majority of providers in the work setting. Three interviews were conducted in Afrikaans (per the respondents' request) by one of the interviewers who was proficient in Afrikaans. Interviews were approximately one to two hours duration and were held in a private setting, either at the provider's place of work or at a convenient location. All interviews including the FGD were digitally recorded and transcribed verbatim by an independent transcriber. In three instances the interviews were translated from Afrikaans to English by the same independent transcriber. Transcripts were checked for accuracy by the research team (i.e. the four who conducted the interviews) on completion of transcriptions.

A range of informal observations were undertaken at five of the health care facilities, and at various Provincial Department of Health Sexual and Reproductive Health meetings, which were also attended by some of the study respondents. These meetings provided me with opportunities to observe respondents in another setting but engaging with similar issues explored in the interviews. Meetings and observation opportunities formed part of the evidence base and assisted in interpreting what people explored in interviews. Recording impressions and recounting the day's research activities in a journal was invaluable, and provided depth and nuance to the interview process, which in some cases was confined by location and time.

Socio-demographic data were collected prior to the interview, and included gender, age, religious affiliation (when provided), category of provider, and years of experience as a provider.² The majority of respondents were female (87%), the median age of providers was 45.1 years (range 39-65), and the median number of years working as a provider was 23.7 years (range 9-40). Religious affiliation was 79% Christian, with 21% reporting that they did not practice a particular religion (see Appendix 1).

Making decisions around when to end data collection was based on several factors. The primary one was saturation of themes, and all efforts to include a large diverse sample of health care professionals had been achieved. Funding constraints and geographical distance to some of the research sites also influenced decisions to end data collection.

Data analysis

Data collection and analysis were inter-related, and an iterative process to allow questions to be refined and new avenues of inquiry to develop. Data were analyzed using a thematic analysis approach, in which main themes and categories were identified and analyzed within and across data (Boyatzis, 1998; Braun & Clarke,

² The median age of this cohort of providers was below the median age of providers in a more recent health service audit of abortion services in the Western Cape where the median age was 55 years (Dearham et al., 2009).

2006). Following Braun and Clarke (2006), thematic analysis can be considered a method in its own right, and the benefit of thematic analysis is its flexibility. By not being fixed to one way of analyzing data, it provides a flexible and useful research tool which can potentially provide a rich and detailed yet complex account of data (Braun & Clarke, 2006, p.78). However despite its flexibility, thematic analysis requires clear guidelines to ensure that analysis is theoretically and methodologically sound.

The analysis was essentially data driven, and initial categories for analyzing data drawn from the interview guide, and then themes and patterns were identified after reviewing the data. The computer software package ATLAS ti 5.2 was used to facilitate sorting and data management (Scientific Software Developments, Berlin, Germany). While software packages can assist with this process, and offer assistance for managing large data sets, they are not a substitute for thorough knowledge or “immersion” in the data, which enables the researcher to identify connections and patterns, to make systematic comparisons, and to develop interpretations (Pope et al., 2002, p.150).

All transcripts were thoroughly reviewed by myself and by members of the research team. I led the data analysis process and developed a preliminary list of codes and code definitions. These were subsequently refined through discussion. Additional codes were added during the coding process, as unexpected or unanticipated issues emerged. The transcripts were coded individually by members of the research team and then cross checked by another member of the research team for coder variation. Any coding discrepancies encountered were discussed and resolved by consensus. Memos were recorded alongside the coding process, and were useful in exploring relationships of links across categories, or reflections about a particular phenomenon (Bernard, 1994). The data was then reviewed for major trends, crosscutting themes were identified, and issues for further exploration were prioritized for final analysis. Writing up the analysis occurred during the coding process together with the recording of ideas and memos and issues for further exploration. As Braun and Clarke (2006) have argued, writing is not something that occurs at the end of analysis but continues throughout the coding /analysis process (Braun & Clarke, 2006, p. 86).

Apart from using a thematic analysis approach, paying attention to discourse and identification of key events were useful in providing further insight into the data analysis process.

Triangulation of data was undertaken to ensure research rigor and consistency. Triangulation was between the interviews and observations undertaken at health care facilities and various meetings. Semi structured observations and attendance at numerous reproductive health care meetings and conferences at local and national level were undertaken for the purposes of triangulation.

The primary sources of data collection were in-depth interviews with a range of health care professionals involved in abortion care provision. Semi structured observations, were undertaken at five of the health care facilities, and at various provincial and other sexual and reproductive health meetings. These observations included spending time at the various health care facilities, speaking to health personnel, and generally observing the day to day running of the health care facilities. I recorded my impressions, took note of providers' interactions with clients seeking an abortion, the space where providers worked, and their interactions with colleagues and other health personnel. Note taking did not occur at the health care facility, and if it did it was in a private space to avoid generating discomfort or appear as if I was monitoring or surveilling staff or patients. On three occasions, I observed with the client's and provider's permission, the abortion process, which included pre abortion counseling, the procedure and post abortion counseling. This occurred at two of the NGO facilities where the physical infrastructure and private space facilitated the process. These facilities were notably different to public health facilities regarding physical comfort and privacy for both clients and providers, and thus more suitable to observation of care. These meeting and observation opportunities formed part of the evidence base, and assisted in interpreting what people raised in interviews, as well as in exploring slippages and gaps found in some of the interviews.

Ethical considerations

Ethical approval to undertake the study was obtained from the Research Ethics Committee, Faculty of Health Sciences, University of Cape Town (REC REF: 271/2004; 415/2007), and the World Health Organization Research Ethics Review Committee. Approval to conduct the study in public sector health care facilities was obtained from the Western Cape Provincial Department of Health and from the NGO facilities.

All study participants provided written informed consent prior to the interview process. Permission was also obtained to digitally record all interviews. A copy of the University of Cape Town Research Ethics Committee approval to conduct the study was provided to all participants at their request. Providers working in public sector hospitals were correspondingly given a copy of the Provincial Department of Health's approval to conduct the study.

Confidentiality and anonymity was ensured in the following ways. All interviews were digitally recorded, no names were attached to the transcripts, and respondents were identified by an identification number and date of interview. Participants were assured that in all forms of dissemination, including publications and dissemination meetings, participants would not be identified by facility or any other identifier. Bearing this in mind, no names of respondents and health care facilities or other research sites is provided in the findings section of the thesis or alongside any quotes or narratives.

All data collected was managed and reviewed only by the research team conducting the research and access to the information linking individuals to data was restricted to the research team. All data were closely controlled and stored in locked files and password protected computer files. Digital recordings were erased once they had been cross checked after data transcription.

To deal with emotional discomfort during or after the interview process, participants were offered post interview counseling and support by an independent counseling

service should they require such services. No respondent requested the service. Respondents were not remunerated for participating in the study.

The position of the researcher

In a study such as this one, where face to face interviews were conducted, it is important to acknowledge the researcher as a positioned subject (Fetterman, 1989). Unlike quantitative research, qualitative research allows and encourages the process of self reflexivity, and acknowledges the researcher's relationship and possible influence on the research process. Much has been written about self reflexivity in qualitative research, most notably in the field of anthropology (Clifford & Marcus, 1986; Geertz, 1988).

The process of self reflexivity and acknowledging my role in the research process proved to be useful on numerous levels. Firstly, my position as a staff member within a university department involved in research and advocacy around abortion and collaborations with reproductive health NGOs and the Provincial Department of Health facilitated access into the field and accessing possible research participants. Secondly, my prior experience as a health care professional, albeit in a North American context, enabled insight and a level of familiarity with observing daily routines in a health institutional context and observing medical procedures and activities. Thirdly, prior ethnographic experience as a Masters student in a community health care centre in the Western Cape provided me with added field work experience. Prior experience of work and research in health care institutions made me aware of the possibility of eliciting socially desirable responses to some of the more difficult questions around reproductive rights and choice as it related to abortion. However it became difficult to assess whether my personal or professional experiences affected participants' engagement with the research process. Endorsement for the study by the University of Cape Town, and being assured of the Provincial Department of Health's permission to conduct the research, appeared to be very important to most respondents, and allayed concerns around a controversial subject.

Difficulties encountered and limitations

Difficulty in accessing health care providers that were openly opposed to abortion initially proved to be difficult. Once providers felt comfortable engaging with the issues, and were assured of a private place in which to be interviewed and not necessarily at their place of work, accessing providers who were uncomfortable with abortion provision became easier.

Similarly, accessing anti-choice organizations proved to be difficult. After observing pre abortion counseling undertaken by an outside organization at a public sector hospital in Cape Town, and after further enquiries from the nurse in charge of abortion services, and a subsequent internet search, it was established that this organization was a Christian-based organization opposed to abortion. We then contacted the organization and asked them whether they would be willing to be interviewed for the study, which they agreed to but preferred to be interviewed as a group.

Whilst the research was undertaken in a province that is better resourced and has more designated abortion facilities and abortion providers than other provinces in South Africa, with the exception of Gauteng, issues to emerge in this study had resonance with other provinces (Engelbrecht, 2005; Ngwena, 2005). While the health systems and political and social contexts might be different elsewhere, many issues were similar and further reinforces the notion of abortion as being contested in many settings despite legalization.

The study findings reflect the local South African context, particularly given that the legality of abortion varies widely in Africa and elsewhere. Nevertheless, some of the findings relating to providers experiences had resonance with other settings, most notably the USA, despite the law and the health care system being different. Abortion remains contested worldwide, and learning experiences in South Africa could be translated elsewhere and may provide useful insight into other settings, including developing country contexts where abortion rights have not been achieved.

Conclusions

This chapter has set out to discuss the research methodology employed in the collection of data. The applicability of qualitative research methodology for this study was explored. All aspects of the data collection process, including sampling of the target population, data analysis and ethical considerations were explored in detail, as an important component of providing rigor in qualitative research is to make the research methodology explicit and detailed. Reflexivity, an important component of qualitative research, was discussed, acknowledging the ways in which personal and professional experiences might have informed the research process. The next five chapters present the findings of the empirical research.

CHAPTER 5: PATHWAYS TO ABORTION PROVISION

Introduction

In this first findings chapter, narratives of three abortion providers' personal and professional pathways into abortion provision will be explored, as a way of providing historical context to providers' experiences and responses to abortion provision since the implementation of the new abortion legislation in 1997. Their narratives point to some of the issues that emerge in the subsequent findings chapters, and provide by way of illustration the social contexts in which many providers were located. These narratives not only underscore personal and professional trajectories into abortion provision around the time of the CTOP Act, but also the historical and political context to the contested process of abortion provision in South Africa. These three narratives were selected as they highlight the complex issues at play in relation to providers varied decision making about abortion provision. The focus on this introductory findings chapter will be on those providers who had chosen to be involved in abortion provision, as they were more forthcoming in their reasons than providers who were not involved in abortion provision.

Asking providers how they came to be involved in abortion provision was considered important as a way to open up discussions around what was for many providers a sensitive topic, evidenced by initial difficulties in commencing the discussion process. Many providers stated that they had not had prior opportunities to explore or engage with their personal views around abortion and experiences with abortion services.

Key themes to emerge from providers' narratives around their personal career trajectories into abortion provision were: personal reasons including the consequences of unsafe, illegal abortions; opportunities to empower both themselves and clients and political resonance of the new abortion legislation.

The trajectory into abortion provision is explored through the narratives of three abortion providers: two nursing managers who also provided first trimester abortions in both the public and NGO sector; and a doctor, an independent abortion provider within the public and NGO sector. The first two providers were working within the health services with the advent of the CTOP Act, whereas the third provider came from abroad to assist in abortion services and training, and was initially supported by international funding.

All attempts have been made to remove identifying information, including naming health care facilities, to preserve anonymity.

Nursing manager and abortion provider: public health sector

The first narrative of a Senior Nursing manager, who also performed first trimester abortions, provides historical insight and context to establishing abortion services in the Western Cape with the promulgation of the CTOP Act in 1997. In following his professional career trajectory, one is able to gain a historical perspective on how the new abortion legislation impacted on health care providers' everyday practices.

Tracing his nursing career, he described how he skillfully negotiated his way through the hierarchical, constraining structures of the medical institution in which his professional legitimacy as a nurse was challenged. However, his years of experience as a theatre (operating room) nurse provided him with the requisite skills and expertise to provide first trimester surgical abortions. He narrated his path to becoming an abortion provider thus:

I worked in theatre all my professional life, until the Act was introduced in 1997, and then I started working in TOPs. The doctor in charge decided to remove me from theatre, made my post a special TOP post, and put me between two hospitals, to get the services going at one of the hospitals, which I did for a year.

Interviewer: Could you describe how you made the transition from being in theatre, to being involved in abortion?

When the Act came into being, and the hospitals were instructed to deliver a service, very few hospitals actually did deliver a service at that time, and the nursing service managers asked nursing staff what they thought and would there be anyone interested in helping with the service. I was the only one in our theatre complex that was available because in those days it wasn't as easy a procedure as today. So there was active participation needed from nursing staff.

They asked everybody who wanted to be involved and I as a registered nurse was willing to work there. After the routine gynecology slate we did TOPs, and we slowly progressed from there. I mean it was very difficult for me because it was a very antagonistic position to be in, everybody wanted to see what we were doing but nobody was willing to help the patients or us for that matter. It was actually quite ludicrous in the beginning because the nursing staff used to sit with the patients and pray for them and cry and go on, it was a big disruption. But slowly that sort of became better, but my position didn't become better for a long, long time because it was seen by the staff, and I think that holds true up until today, it was seen by that particular theatre staff as a volunteered job that I volunteered to do TOPs, so therefore I still had to participate in my normal duties.

Doing TOPs was not considered part of my daily work schedule. I think that's still true in most places today where there's an anti TOP feeling. Staff think that you volunteer for it and therefore you need to bring your 100% to your job, plus doing TOPs must be extra.

With regards to TOP training, the training was obviously designed for nurses, for nurse driven programs. I became proficient very quickly as I had theatre skills and was proficient with surgical instruments. I then went on to attend the second TOP training course in the country. The RHRU [Reproductive Health Research Unit] had a program. They developed a curriculum that was approved

by the South African Nursing Council and they took the delegates from the nine provinces ...³ we did the theoretical training.

But I had great difficulty to get the practical part completed because nobody wanted to become a practical training site, nobody wanted to oversee TOP providers in order for them to gain competency levels. I needed to do 40 hours of practical training and 20 cases, but it was difficult to reach the 20 cases because they didn't do enough TOPs for me to reach that number. I then took matters into my own hands as I was already very skilled.

The doctor who was supposed to be in charge of my practical training I never actually saw him. On my last day I phoned him and I said to him, "well I'm here, I want to be evaluated", but he was obviously slightly negative about this program and said he doesn't believe in this, and he's already heard from his registrars that I am capable of doing this, so I must just leave my documentation there and he will sign it. I was slightly pissed with that because I didn't think that that was professional enough, but in any case up to this day I never saw the doctor, but he signed the papers, so, then I went back to my hospital with this new paper that I have, which meant absolutely nothing, because the mind change was still not made in the hospital's and the management's minds, that a nurse could perform a surgical procedure. It was very difficult for them because I was obviously gaining power and TOPs are a very empowering sort of thing for providers, especially nurse providers.

Interviewer: When you say they are empowering ...

Because you become more confident, you do a different function that is not in your normal role, people look at you differently. I was lucky in the fact that I was a male, so it was easier for me to work with the doctors, also the fact that I was a theatre nurse helped a great deal because I had a lot of respect already and competence levels that the doctors felt okay with. We all knew each other

³ The indication of ... in respondent extracts indicates a pause in the conversation or a section has been shortened for ease of reading.

well, there was those that told me I was a murderer, and there were those that told me they did not want to be involved, and there was those that helped me when they needed to and there were those that were always willing to help, so it was quite good, but still it was difficult for me to go that step further so I started slowly by doing cases.

There was a gynecologist at the time, under whose name they put my TOP list, it was so engrained in their minds that they could not put my name on the operating lists. During this time, I had many occasions where doctors came into the theatre, they wanted to do a case and they said that I must go and wait with my patients because they are doctors and they need to do their surgeries first. It was difficult for doctors to grasp that, there was also this feeling of uneasiness in the hospital, because my colleagues and peers felt that I was gaining power too quickly and you know other people are losing control over me. But finally slowly it worked. I slowly but surely took over from this doctor and I started running the TOP clinic by myself.

This clinic was the place where all the patients who couldn't get access to a TOP service were sent to. This was also the place where we dealt with the huge backlog of TOP cases. We worked every day, five days a week. The work load was huge at this time, I saw 35 patients a week all by myself. In addition I had to be out of the clinic by 12 o'clock, the staff wanted me out because the next clinic was run by a doctor who was more important than me, and I'm only a nurse you know.

Paradoxically within this new evolving and highly contested environment, being an abortion provider and being able to perform first trimester abortions was seen as “empowering”, affording a degree of clinical independence especially as a nurse. The struggle to implement and provide abortion services was played out on many levels. The narrative reveals how he had to overcome resistance to abortion provision from all sectors, further underscored by his own marginalized position as a nurse trying to work in a space that was traditionally viewed as a surgeon's domain, yet as a nurse he found the clinical autonomy empowering. His personal account of establishing abortion services also provides insight into the haphazard way in which

services were implemented and the difficulties in completing training. Due to opposition from other health professionals, services were initially provided by a committed few, and this continues to be the case.

The notion of empowerment is further extended in the second narrative of a nurse provider, who similarly held dual positions as both a nursing manager and abortion provider. She elaborated on how she came to be working in a not-for-profit sexual and reproductive health care clinic, after having spent many years working within the public health sector.

Nursing manager and abortion provider: NGO sector

Well it might sound kind of strange, but I was at a point in my life when I needed a job, and I felt comfortable doing family planning, but the whole scenario of TOPs was new for me. It was an adjustment, a shift in your mindset, and I just discovered that, well now I'm dealing with what was going wrong with family planning out there, you see. This health care clinic had just recently opened in 1998 in South Africa. I saw it as a good opportunity to work here. I was divorced and a single parent with three children who I had to support, and this [NGO clinic] afforded me opportunities not available within provincial government clinics.

She further described how her experience of dealing with morbidity and mortality associated with septic abortions had been a motivating factor in her decision to become involved in TOP services, and underscored her need to be involved in services from their inception. Juxtaposed against her own empowerment as an abortion provider, she viewed the CTOP Act, which supported reproductive rights, as equally facilitating of “women’s empowerment”:

I think having nursed patients who came in with septic abortions, and who were quite ill and distressed ... subsequently, even though there was a big space of time between nursing them and eventually coming to work in TOP, that was one of my motivating reasons. And the fact that it was a new Act that came in – a

new legislation that was implemented – and being part of that, was very important for me, because it all had to do with women’s empowerment, you see. By providing women with a choice and access to safe TOPs we are able to give women a voice and hope. But it’s also not only about access to TOPs, it’s also about providing comprehensive care, including family planning, discussions around what are your options and choices, and taking into account the clients’ own circumstances. We are able to offer a range of family planning methods and have opportunities to provide comprehensive counseling.

Providing comprehensive pre and post abortion counseling was considered an important aspect of her work, and she viewed her involvement in abortion provision in broad terms.

Independent doctor and abortion provider

The third narrative of an independent abortion provider originally from abroad highlights the somewhat serendipitous nature of moving into abortion provision, but is also similar to the other two narratives in that all three providers felt empowered by what they were doing, and by providing women with reproductive choices and access to safe abortions. However this provider had more opportunities to be exposed to women’s reproductive health issues on a more global level:

I was looking for other work, but that is a long time ago in the 70s. I had finished my studies and I worked about six years in internal medicine, but what I really wanted to do, was go and work in developing countries. I wanted to have different types of work experience, such as surgery, gynecology, to get all that experience to work abroad, but I had two small children and it was very difficult to change my direction. ... Then I saw the advertisement about an abortion clinic, they were looking for a doctor for just half a day a week. This seemed interesting and I thought let me try that out, so I started working there plus the job that I already had. I found it quite interesting and started working in the abortion clinic part- time, three times a week. It was a bit broader, they did not only do abortions but also sterilizations and artificial insemination, and I found

it quite interesting. I thought it would be something I would only do for a while. The funny thing is that it's not only me but most of my colleagues who went to work in this field with the idea I'll do this for a while and then, because you don't have the feeling this is my career, I'm going to be an abortion provider, you do that for a couple of years, but somehow I never got out again.

My personal circumstances changed and I decided to move to another place in the country, then I came to a real abortion clinic, where they did nothing else. I did it for a while, and thought I want something else, but I was divorced, I had children who I had to support and other financial commitments. If I was going to do something else, I had to be trained first, and I would not earn anything, so, I was a bit stuck. For a while I didn't feel good, but then suddenly, I realized but why don't I just continue with this, I'm good at it, and then I saw it in a different light, I was doing a good job. I quite liked it, so, it was more of a perception of other people that always gave me the idea of okay you just do that for a while, one does not continue being an abortion provider. I would meet colleagues after a couple of years and they would ask, "What are you doing now?" And I would reply "well, I'm still working in the abortion clinic". "Are you still doing abortions?" that is the reaction you get, and that gives you the idea, it is not something you keep on doing.

Most people including colleagues that have not been involved in abortion cannot understand why you are doing this, and there was not much understanding for that. But then I got more involved internationally too, I became the adviser for the abortion association in my country, and I went to the International Conference on Population & Development (ICPD) in Cairo [1994], I went to the Fourth Conference on Women in Beijing [1995] as well and I met lots of people, and made a lot of contacts internationally too, and that made it much more interesting.

The above narrative suggests that abortion provision was considered something that one did for a limited period and not considered a permanent vocation. While initial involvement in abortion provision was motivated by financial reasons and opportunities for change, once working within abortion care and realizing that she

was good at what she was doing, it provided fulfillment and no longer seemed like a transient occupation.

Conclusions and discussion

This introductory chapter has traced how three individual providers made decisions about abortion provision throughout their careers, and how these decisions were affected by the possibilities for clinical autonomy, the political context of abortion care in South Africa post 1994, and providers' personal experiences and responses to the public health impact of illegal, unsafe abortion.

Providers' discussions of their professional career trajectories into abortion provision suggested a complex interplay between personal and social circumstance, and experiences with unsafe, illegal abortions as a key reason for deciding to be involved in abortion provision. For some, these reasons tended to intersect with circumstances. While not directly seeking out work in abortion services, providers took opportunities as they were presented, sometimes for financial reasons, or because it provided a means of expanding their skills and practice. Furthermore, for those who had decided to perform abortions, opportunities to expand existing skills and being able to "empower" both themselves and women seeking an abortion were important reasons to become involved in abortion provision. Overall, providers who were involved in abortion provision described being caught up in the momentum of change within reproductive health policies in South Africa post 1994.

The consequences of unsafe abortion with associated morbidity and mortality as motivating reasons for providing abortions has resonance in other settings, where abortion providers often work in more threatening and restricted circumstances but are motivated to continue providing abortions (Harris, 2008; Romalis, 2008; Sheriff, 2009).

The notion of abortion work as being transient and not considered a regular vocation, especially for doctors, was to emerge throughout the study. This was possibly related to the difficult conditions under which many providers worked, with little support

from managers and other stakeholders, and also to the marginalized nature of abortion work (Harris, 2008; Joffe, 1996; Sheriff, 2009). Notwithstanding, some abortion providers continued to provide services despite limited support and recognition.

The notion of abortion work being viewed as empowering, related to opportunities for professional nurses and midwives to be allowed to perform first trimester abortions, has not emerged in other settings such as Vietnam, where mid-level providers are similarly allowed to perform first trimester abortions (Berer, 2009).

This chapter has traced how individual providers made decisions about abortion provision throughout their careers, and how these decisions were affected by the availability and expectation of training, the social and political context of abortion care at any given moment, and their own personal convictions. Thus the purpose of this chapter was not to answer the research questions per se, but to rather set the scene and give a sense of the texture of providers' decision making and interpretations of their experiences. The next chapter (Chapter 6) will explore providers' conceptualizations of abortion and how this impacted on abortion service provision.

CHAPTER 6: CONCEPTIONS AROUND ABORTION

Introduction

In the previous chapter, providers' personal and professional pathways into abortion provision were explored through the narratives of three abortion providers. Exploring decision making around abortion provision and how this came about was a means to foreground providers' social location within the work environment, and to provide historical and social context to abortion provision since the inception of the CTOP Act in 1996.

This chapter will focus on providers' understandings of abortion and how this impacted on abortion service provision. Exploring providers' conceptualizations of abortion will provide insight into how views around abortion influenced and informed daily practice.

Health care providers' conceptualizations of abortion were influenced by a multiplicity of factors. These factors included personal, moral and religious beliefs around abortion. Understandings and attitudes towards reproductive rights and choice, framed within the wider discourse of South African reproductive health care and the attendant liberalized abortion legislation, were also influential in shaping providers' attitudes towards abortion. In addition, abortion as a medical practice, and the ways in which providers aligned themselves with the responsibilities of medical practice, will be examined. Finally, how providers viewed the abortion client, including their reasons for seeking an abortion, will be explored as possible determining factors towards decisions around abortion provision.

Key themes emerging from conceptions and views around abortion included:

- i) the manner in which moral beliefs influenced decision making and practice around abortion

- ii) the ways in which religious beliefs and ideology influenced decision making and practice around abortion
- iii) understandings and perceptions around reproductive rights and choice
- iv) the ways in which the CTOP legislation framed and influenced decisions around abortion provision, including interpretations of conscientious objection
- v) abortion as a medical practice, and the ways in which providers separated their personal beliefs from professional practice
- vi) reasons for women seeking an abortion as influencing attitudes towards abortion

An overarching theme to emerge in this chapter was the diverse and complex ways that providers managed their conflicting views towards abortion. This was achieved by creating differing thresholds and boundaries vis a vis abortion provision, and is key to understanding issues emerging in the next chapter, which focuses on the health systems context of abortion provision. Differing levels of abortion care were related to these personal thresholds in respect of moral and religious beliefs around abortion, and prescribed legal and policy requirements around abortion provision.

In order to understand providers' varied responses to abortion, and hence different levels of abortion provision, it is useful to provide a brief overview of the different types of work provided by health care providers, not necessarily in terms of their professional category, but in relation to the types of work they were willing to perform. Firstly, there were those directly involved in the abortion procedure; secondly, there were those involved in less direct aspects of abortion provision such as a referral and pre and post abortion counselling; and lastly, there were those who absented themselves from all aspects of the abortion process, limiting themselves to less contentious aspects such as contraceptive provision and general nursing duties. These differing levels of care were linked to conflicting views around abortion and reproductive rights and choice, and will be explored further in the next chapter.

Conceptions of abortion

Introducing the topic of abortion and respondents' understandings around abortion proved to be rather difficult initially, as some respondents were somewhat confounded

by the question. In the beginning, some providers responded in biomedical terms stating that abortion was “the termination of a pregnancy by surgical means” or “terminating an unplanned pregnancy”, and only later, as the interviews progressed, spoke about their understandings in relation to women seeking an abortion and their work experiences, and expanded on their perceptions of abortion, ascribing more personal feelings to their views about abortion.

Moral views towards abortion

The ways in which moral views or beliefs influenced participation or non-participation in abortion services was explored, as abortion was possibly a contentious moral issue for many providers.

Abortion as a moral choice, and how it influenced health care providers’ degree of involvement in services, was framed in different ways. Morality in relation to abortion emerged around three broad issues; notions around the sanctity and preservation of life; childbearing and motherhood and the midwives role in facilitating this process; and making the “right” choices with regards to an unplanned pregnancy. Moral beliefs differed from religious beliefs in that they were not constructed within a religious framework.

Preservation of life

Providers’ opposition to abortion was motivated by the belief that the procedure was concerned more with the taking of human life than with the preservation of life as it related to the unborn child.

An abortion provider explored differing meanings around the preservation of life and suggested that preserving life needed to take into account both the life of the unborn child and the woman seeking an abortion. From her perspective, ultimately, choice lay with the woman seeking an abortion and the consideration of her well-being. She further suggested that those providers who adopted an anti-choice position tended “to

look at the end product”, without acknowledging women’s social realities and the long term implications of an unplanned pregnancy, and what it would mean to both the mother and the baby’s current and future life:

When I speak to anybody about preserving life, I am thinking of the life of this woman. I always bring them back to the fact that abortion – being pregnant – has many options. Some providers who do not really believe in choice will say, “what about the life of the unborn?” But they tend to look at the end product, the unborn. Now what would the quality of life be if the unborn was born, and it was not born into happy circumstances and where it could be provided with the basic needs, plus everything else that it needs. Then what? And I think it’s where I’m coming from being a single mom, and battling to keep my head above water. I am preserving the life of this woman, and providing her with a safe abortion ... and once again, it’s not for me to choose. It is her life. It isn’t my life. It’s a huge responsibility, and a very challenging one in the 21st century to have children. That’s how I feel about it. I’m still preserving life ...

Later gestational age pregnancies invoked added moral dilemmas around the sanctity and preservation of life. Providers suggested that notions around the morality of abortion were more significant in cases involving women who booked for abortions in late stages of the second trimester, because “at 17 to 20 weeks you are sitting with a fetus that is fully formed”. Conceptions around advanced gestational age pregnancies will be explored in depth in the chapter (Chapter 8) on second trimester abortions, where the focus will be on the emotively complex issues surrounding second trimester abortions.

Childbearing and midwifery

Notions of motherhood and childbearing were further underscored by some providers’ prior experiences as midwives. Midwives who are used to caring for mothers and delivering babies may find it difficult to reconcile their training with caring for women undergoing abortions. Within this context, perceptions regarding the reconciliation of midwifery with abortion provision were explored.

Nurse providers were asked to describe how they perceived the intersection between midwifery and first trimester abortion provision. Some perceived a mental shift in the philosophy of pregnancy care, while others felt that their midwifery training provided an integral set of skills needed in providing first trimester abortions. One provider involved in pre abortion counseling commented that the two specialties were “like white and black” polar opposites, as on the one hand one was bringing life into the world and on the other hand one was removing it.

A midwife, who was also an abortion provider, recalled and contrasted the “joyful situation” of maternity ward work, where she had delivered healthy babies to “doting parents”, with the “distraught situation” of caring for women with an unwanted pregnancy who “didn’t want to be pregnant”. In the former setting pregnancy was viewed as something to be protected, supported and celebrated, whereas with abortions “one had to shut all those things off so as to help women in need”. Discussing the relationship between midwifery and abortion care she elaborated further:

If you’re a midwife in a maternity hospital, you’re obviously delivering live babies and it’s a joyful situation with two parents standing there wanting this beautiful baby. However, I’m in the situation now where I’m working with women that don’t want to be pregnant and so it’s a whole different mind-set compared to working in a maternity hospital, where you’ve got two doting parents waiting for an arrival. Here we’ve got women coming in, in a distraught situation. However, being a midwife gives one skills and the knowledge to be able to do the procedure easier than somebody that hasn’t done midwifery.

As mentioned above, several providers who had midwifery training commented that their skills and experience assisted them in the abortion procedure. It was suggested that they felt more confident, particularly in cases where complications arose in the preparation of women for abortions, where the delivery techniques were required, and there was no doctor on hand to assist. One provider described a situation of early fetal

expulsion where her midwifery experience and expertise facilitated the delivery process:

It does have some implications in a sense that, now, when the doctor is not here. I'm waiting for the doctor to come and do the second trimesters, and while I was waiting for the doctor and then the next thing you know the head is hanging out, then we had to deliver the fetus before the doctor arrived. If you are not a midwife, what are you going to do?

Making the “right” choices

In relation to making the right choices, some providers believed that the CTOP Act had inversely restricted women's reproductive choices. In their view, giving women the right to choose, pressurized them into not considering continuing with the pregnancy and experiencing motherhood. For example, a nurse provider stated that by invoking their reproductive right to choose, she felt women were ‘forced’ into not making the “right choices”. In addition she believed that upholding the legal rights of women came into conflict with what she perceived to be the legal rights of the unborn child:

A lot of our women have even less of a choice now because a lot of them would like to keep their babies ... I get quite irritated when I see these women saying, that it is a right of everybody ... I think that that's just a small portion of it. Those women go ahead with abortions, because they seriously don't, in many ways have a choice, and they now sit with even bigger problems of having had an abortion that they really particularly didn't want ... Before the laws came out, that woman would not have had an abortion and what about the babies that they are carrying, what about their rights? ... A child is a blessing to a mother and her family.

In this view the right to abortion was not without its consequences, and by seeking an abortion women were negating the importance of motherhood and the family.

Religious beliefs

A complex picture emerged with regards to providers' relations between religious beliefs and decision-making around abortion provision. For some providers, who were practicing Christians, religious precepts required strong sanction against abortion, with abortion viewed as "murder and a sin". In contrast, other providers, who similarly identified as practicing Christians, found ways to reconcile religious beliefs with abortion practices. In these instances religious beliefs co-existed with views around the public health importance of access to safe abortions and women's need for reproductive autonomy and choice.

A counselor involved in pre abortion counseling and referral illustrated the ways in which religious beliefs intersected with daily practice, and how discomfort around abortion care was supported by religious ritual such as praying before going to work. For her preventing an unplanned pregnancy was paramount:

As a Christian, I think this is not what I would preach, I'm more for prevention. Because for me it's much more important to prevent a pregnancy. As a Christian, I pray before I come to work and it helps me, at the end of the day I leave everything here in this room and I go home to be a mother, a grandmother and a wife.

However for some providers, religious beliefs came into conflict with abortion care, and they restricted their involvements to certain aspects of care such as contraceptive provision. A provider who identified as a practicing Catholic explained that she would only allow herself to be involved in the family planning aspect of abortion care and not abortions, even though both were contrary to religious doctrine:

I'm Catholic, but I'm also doing family planning, so it doesn't seem to make sense. But I thought I have to take a stand somewhere on something, so that's why when I went into this position I told them I didn't want to do terminations – take part in any of that [referring to abortions], I will only do family planning.

This was in contrast to an abortion provider who similarly defined herself as a practicing Catholic but approached abortion provision differently. The following vignette highlights the complex and differing positions adopted by her as an abortion provider, mother and woman located within a religious community. She asserted that she had put her religious feelings aside, and justified her position by the fact that she offered a far more comprehensive service than just termination, because her work involved nurturing women, through education, counseling and family planning services, and contributing to women's overall sexual and reproductive health:

I'm glad you're saying my personal background, because maybe I must add that I'm a single mom and that I am raising two sons on my own ... initially, it was stressful telling my immediate family where I was working. I think I still find it difficult. I'm a practicing Catholic, by the way. So I've had to be strong and decide what is it that I want to do for me and for my children. And I've had to decide what I can do for these women, except for just providing TOPs. Inspire and educate them, inform them about family planning, and at least put something back into the community ... So that's where I'm coming from and I guess I've made peace with that ... I've come to terms with where I'm working. If I should die and I stand before God, I will tell him "I've had to raise my children on my own", and yes, if he's going to give me the punishment, I will take the punishment for it. But I can't turn back because somebody doesn't want me to work here. I feel it's the right thing for me now at this moment in time ... Obviously I'm being asked the question is there not anywhere else where you can work? As a nurse, I could work anywhere. It's true, I could work anywhere, but I guess I've made a choice.

Her narrative further identified church leaders and religious communities as a source of disapproval. Despite such pressures she found value and meaning in her work, and found a way to reconcile the disparity between her working and private life, without undermining her religious beliefs and practices or compromising her sense of self worth:

I think there's some animosity from my congregation, one can sense it. There is nothing I can do about that. I can only do what's best for me. But of course, it takes a lot of courage to adopt this attitude, and it's not always nice to be like this, but if it is protecting me than that is what works for me. I continue to practice my religion and attend church and pray to God and reflect on the kinds of work I do.

Despite some providers being able to reconcile religious beliefs with abortion care delivery, most health care providers had experienced colleagues' opposition to abortion on a mix of religious and moral grounds in the work environment. When reflecting on the impact of religious views on service provision, it was common for providers to associate the abortion with sin, quoting the sixth Biblical Commandment, "Thou shall not kill", and described that in some health care facilities other staff would align the work of abortion providers to that of murder, as reflected in the following commentary by a facility manager:

I don't have a problem with abortion, but I know that there are lots of religious people and they have strong moral beliefs that it's wrong and that you're a murderer and that these women are killing their babies, so religious beliefs obviously does play a huge role in how abortion is viewed.

Some felt that these beliefs did not solely emanate from religious viewpoints, but were also linked to the perception that nurses were expected to preserve life. Conflicts were thus intensified, given the special role of health care professionals in caring for and treating patients.

However for some providers the public health importance of providing access to safe abortion services related to prior experiences of morbidity and mortality associated with unsafe abortions, as discussed in Chapter 5, motivated them to balance religious beliefs with providing women with choices.

In relation to reconciling religious beliefs with the public health imperatives of ensuring access to safe abortions, one provider described her dual and opposing

views, arising from the different sides to her life, asserting that even though it was against her religion she was prepared to be involved due to the acute need for abortion services:

According to my feelings I can say I'm biased because according to my religion a TOP is against my religion, but because I've worked here and have seen the necessity of it, I'm also going with it. So I have got two sides to me, whilst it is against my religion the side that is the most is seeing the need. So now the most one is because I'm working with these women and I see the need for TOPs especially when one thinks of threats of illegal, unsafe abortions that I work with women who need TOPs.

It thus became clear that religious beliefs and practices influenced decisions in diverse and often contradictory ways, and providers' negotiated their own thresholds regarding abortion involvement.

Reproductive rights and choice

Understandings around reproductive rights and choice were framed in differing ways, and notions of choice were influenced by reproductive rights discourse circulating within the sexual and reproductive health care arena post 1994, and by the provisions of the new abortion legislation. However, providers also had their own ideas about reproductive choice and women's legal rights to abortion, which were informed by moral and religious ideology, notions around the preservation of life, and views around motherhood and childbearing as discussed previously. Related to notions around abortion and reproductive rights and choice, were ways of deflecting choice away from the provider and onto the woman seeking an abortion, as a way of dealing with conflicting views around abortion and choice.

Providers' perceptions around reproductive choice will be explored in relation to conflicting meanings and consequences of choice, and for some, the need to place limitations on choice. Furthermore, notions around reproductive rights and choice

cannot be viewed in isolation from the CTOP legislation, as reproductive rights and choice are an integral component of the CTOP legislation.

Conflicting meanings around choice

Providers' understandings and views towards reproductive rights and choice were explored in relation to attitudes towards abortion and knowledge of the current abortion legislation. Moral and religious beliefs intersected with the principles of the abortion legislation and providers' perceptions of the legislation. For those that were opposed to abortion the legislation was problematic, whereas for others it provided a framework with which to support the work they did.

Providers' responses were varied; those who identified themselves as pro-choice supported reproductive choice and highlighted the importance of a woman's reproductive autonomy with respect to access to safe abortion services. In contrast, providers who stated they were less comfortable with reproductive rights and choice focused on what they perceived to be the negative implications and consequences of unrestricted choice. On this basis, they argued for limitations to be placed on reproductive choice and questioned the principal aspects of the CTOP legislation.

Consequences of choice

Providers who were opposed to abortion and a woman's right to choose, believed that the CTOP Act did not adequately provide for the psychological and emotional consequences of abortion. A provider involved in pre abortion counseling believed the promotion and growth of abortion services as a result of the CTOP legislation had led to an over-emphasis on reproductive rights, which "negate the woman's right to her emotional issues" related to abortion. Limited restrictions on choice and hence accessing an abortion had in her opinion resulted in hasty decisions without taking into consideration subsequent poor mental health outcomes. She explained that:

The woman is not given the right to be sad after she's made the decision, because of how they promote the fact that it's okay for you to have that right [to choose].

A similar sentiment was expressed by a social worker involved in pre abortion counseling, who believed that while every woman had the right to choose, one needed to take into account the social, emotional and psychological consequences of choice. She alluded to the important role of child bearing in sustaining marriage, and anticipated that the long term consequences of abortion would include poor mental health outcomes. In her view, though legally permissible, abortion was not without its negative effects on women:

To me it's like if you do abortion, it's something that's going to haunt you I am not comfortable with this, because it's like they encourage people not to use family planning, but at the end of the day, it will come back to haunt you. Because they are still young ... there will be a time when you will reject this. One day, you will marry and not have children. There will be problems with the marriage. We try and give them options. It's for them to choose. So I cannot say they must not [abort], because they are legally entitled to it, but I am just trying to create an atmosphere where they can choose.

Devolving choice

Some providers were initially hesitant to discuss their personal views around reproductive rights and choice, and suggested that ultimately the issue of choice was not so much about what they believed in, but instead a decision that many women had already made prior to seeking assistance. Their role was to provide objective, value-free counseling where decisions around choice ultimately resided with women seeking abortions.

A nurse involved in pre abortion counseling emphasized the importance of setting aside one's own values, so as to provide objective counseling. In so doing she devolved choice onto the client:

Abortion to me it's to end a pregnancy and really I am a service provider, I think of it that way, when somebody comes in here and requests an abortion and, I make very sure that they, that is what they want, so I don't say you can do this or you can do that, I ask how can I help you, because it's a choice and I'm okay with this choice as long as they don't come back and say - I said you must go - so for me we all have choices and at that time, it may be right for that person, it doesn't mean I am for abortions. But it's very important for me not to put my values in front of this client and say what I think, or the way I feel personally.

Assigning choice to a client was further discussed by a nurse who emphasized the importance of enabling women to make informed choices and to provide non-directive counseling, and suggested that women often had already made a decision prior to seeking an abortion. She offered her thoughts on the matter:

I feel that everybody has a right to their own thoughts and choices, so I'm not going to force an abortion onto anybody. I think people must be given the correct information, and they must make an informed choice. We don't take people off the road and just give them abortions, that's not done. As I've said to you before, when they get to our door, they've normally made a choice. If they haven't, we are skilled enough to note that.

In contrast to notions of informed choice discussed above, four counselors from a Christian based pregnancy crisis center for “women in crisis” adopted a different approach to issues around informed choice, for them “crisis counseling” replaced informed choice.

These counselors described their role in providing pregnant women with “options and choices in a crisis situation”, and elaborated on how their counseling differed from public sector abortion facilities by providing a far more “nurturing environment to women in crisis”. Their discourse emphasized the importance of motherhood and the centrality of the family, realized by providing options and choices to women who were unable to exercise choices when it came to unplanned pregnancies. Reproductive rights and choice were inverted and pregnant women were constructed as not having

the choice not to have an abortion. This apparent incongruous situation was explained by a counselor as:

I want to see people being helped in a balanced way and not just being pushed in one direction. It's interesting because the Act is called a choice for termination of pregnancy, but most people say they don't have a choice, they've got to have an abortion, so well where has the choice gone?

The following excerpts from their discussion provide contextual information about the particular kinds of counseling provided to women with “crisis pregnancies”. Similar to other providers, they too alluded to what they believed to be the negative mental health effects of abortion:

I think number one when the client comes in, we treat them with dignity and respect. There's also the understanding of the crisis that the person is in, because it's a real crisis for a lot of mums. They are important, so there's a value on the person, that's very much what we like to create. So immediately there's a feeling of, exactly unlike to what we said earlier on, that confidentiality, that security and that trust isn't there in some of the other places. There's time spent here, there's no rush, you know there's no time constraints on how long we counsel a client. In any crisis there's chaos so it enables them to follow through on their thought processes that's going to be better for them in the long term.

My heart aches for women who have to make that choice, where they don't have to, where they don't have any other way to go, you know, because of pressures and anxiety and all the stuff that's going on in their lives. Because I feel that whatever researchers or psychologists might say, that abortions do damage women, and abortion upon abortion is a trauma onto another trauma.

She further elaborated as to why they do not refer women to abortion facilities, underscoring her pro-life stance:

We don't refer, you know, so when a client comes in here and she says that [referring to an abortion] is what I want, can you tell me where to go? We don't give names and telephone numbers. We don't give any direct information. Because, our policy is to speak the truth in love, so we tell them the truth about what the abortion will look like ...

From the above discussions around reproductive rights and choice, it emerged that providers viewed reproductive choice not only as an abstract concept supported by the CTOP Act, but more importantly as it translated in concrete terms in their day to day practice as health care providers. Choice had diverse meanings and implications for those requesting an abortion and those expected to provide or enable choice, yet for many providers choice ultimately belonged to the woman seeking an abortion. However, for a few providers who absented themselves from abortion provision, choice had little to do with reproductive autonomy and was more about having the “choice to continue with an unintended pregnancy”.

Abortion legislation

Providers' knowledge of the abortion legislation was varied and related to their levels of involvement in abortion care. However, what appeared to have more impact on service provision than levels of knowledge around the abortion legislation was the manner in which conscientious objection was understood and put into practice. The practice of conscientious objection and its impact on service provision will be discussed in detail in the next chapter (Chapter 7).

Providers who were performing abortions were familiar with the details of the CTOP Act of 1996, whereas some providers who were opposed to abortion were unclear about the conditions under which a woman could request an abortion. Misinformation about who could perform an abortion and the time restrictions with regards to gestational age were evident in the response of a provider who absented herself from abortion provision:

I'm not too familiar with the Act at all, just the little snippets that I picked up from the previous Sister. She used to quote the Act. I do know vaguely, I think, that they do have to still see a doctor, and decide whether that person is entitled to have the abortion. But I am not sure actually. I also think that you can only get a TOP until 14 weeks.

A group of counselors from a pregnancy crisis center vocalized their opposition to the abortion legislation, and employed their knowledge of the abortion legislation to critique the CTOP Act, including the CTOP Amendment Act of 2004. Important aspects of the legislation that they were opposed to were expanding first trimester abortions to registered nurses, that parental consent is not required for minors, and that pre and post abortion counseling should be non-mandatory and non- directive:

We found that there's one definite area where we feel there needs to be a change to the legislation and that is that the counseling should be mandatory and not just promoted, because there are many areas in which the counseling is just not happening, and we would like to see our type, or good quality counseling happening everywhere. Of course that's probably a pipe dream, but the first step would be that it's actually written in the law. The other one is this total anomaly of the teenagers that have the right to chose for what could be almost a major medical procedure, without the consent of their parents, and yet there are so many other things put in place for the protection of the child and yet this is a huge hole. I think we have a good understanding of the law and the changes that we would like to see, if the law doesn't fall away entirely.

Also the desire to extend it,[referring to the Amendment Act of 2004] it's already happening, I don't know to what extent, where it was extended to the fact that registered nurses should be providing terminations and not just the midwives and the doctors. We feel strongly about that because we feel that it's unfair to expect registered nurses to cope with things that midwives are struggling with, and I think that extending a service that's not being done in a caring way, is just adding to the problem rather than improving the situation.

The CTOP legislation thus provided a useful framework for some providers in relation to women's reproductive rights and choice; however, for those who were opposed to abortion, the legislation was either seen as too permissive or, in the case of a few, needed to be overturned or limited. Furthermore, for those providers who were opposed to abortion on moral or religious grounds, the right to freedom of conscience enshrined in the South African Constitution afforded them the opportunity to invoke their right to conscientious objection.

Conscientious objection

As discussed in Chapter 2 the conscientious objection of providers who do not wish to perform abortions on moral or religious grounds is supported by the constitutional rights of all South Africans to freedom of thought, belief and opinion. A health care provider may refuse to perform an abortion. However, they are obliged to inform a woman of her reproductive right to choose an abortion according to the Act, and to refer her to another provider or facility.

The ways in which religious and moral beliefs around abortion intersected with health care workers' right to conscientious objection was problematic, and on initial analysis difficult to understand. A complex interplay of factors in relation to understandings and implementation of conscientious objection was evident. Some providers spoke about absenting themselves from abortion provision, but did not relate their refusal to provide services to invoking their right to conscientious objection, nor did they use the term conscientious objection; and if it was used, it was in response to our questions around understandings of conscientious objection. However, managers and some stakeholders spoke about how providers refused to be involved in abortion provision due to conscientious objection, but there was no formal record or formalized conscientious objection process recorded.

Confusion and uncertainty with regards to understandings around conscientious objection and its implementation were similarly reported by some providers. There was a general lack of understanding concerning the circumstances in which health care providers were entitled to invoke their right to refuse to provide, or even assist in

abortion services. While in other situations, despite being aware of the circumstances and limitations placed on conscientious objection, providers refused to provide services, and the policies and procedures for managing conscientious objection were not standardized or formalized in terms of record keeping.

Respondents viewed the health services as lacking the necessary regulatory structures, or not having contingency plans in place to deal with conscientious objection among health care providers. Furthermore, there seemed to be very little recognition or support from health service managers regarding the impact of conscientious objection on the ability to render abortion services. Providers seemed to have poor understandings of how conscientious objection was to be implemented, but were also constrained in that there were few guidelines in place to guide them in the process. There were draft policies available at most facilities, but it appeared as if providers were either unaware of their presence or did not engage with their contents. The fact that a few providers were aware of the limitation on conscientious objection and the requirements regarding patient care would suggest that those who had attended training or other information sharing workshops were aware of the CTOP Act as it related to conscientious objection. However, this did not necessarily mean that in all situations the law was appropriately applied or regulated.

In some situations it appeared as if conscientious objection was being used as a lever to oppose abortion on very broad grounds, and conscientious objection became an all encompassing opportunity for non-participation in abortion services. Some managers and providers related to this phenomenon with a certain amount of skepticism, whereby they felt religious and moral objections to abortion were at times about being conveniently able to refuse to provide services. They saw this as evidenced in the fact that these objections would sometimes be abandoned for financial remuneration. The impact of conscientious objection on service provision will be discussed in greater detail in the next chapter.

Separating the personal from the professional

Providers were asked to reflect on their professional roles and responsibilities in relation to abortion provision, and how professional practices impacted on personal beliefs.

When talking about factors which influenced their ability to separate personal values from professional conduct in relation to abortion, providers' responses were varied. Several providers stated that they did not experience any difficulty in separating their thoughts and feelings from required codes of professional conduct and practice. Some providers suggested that there was "nothing personal around abortion", and that a TOP should be approached in biomedical or clinical terms. Similarly, another provider who identified as "pro-choice", took a more clinical than emotional view of abortion, and described her attitude as follows:

I keep going back to the right of the person ... I can look at it clinically and say that I am just taking care of something, or terminating something that shouldn't be able to grow... I think the way I deal with it is very clinical. In terms of my attitude towards the abortion, I am entirely pro-choice, and I manage the woman, I hope, clinically and professionally. Personally, my position is thoroughly pro-choice. I don't have a moral issue.

A nurse provider highlighted the importance of maintaining a professional attitude, and suggested that one's personal and professional stance with regards to abortion should remain consistent, and that it was artificial to separate the two:

I think that if you're a nurse, you're a nurse, whether you're on duty or off duty, and I don't think your attitude can change from professional to personal, as far as pro-choice is concerned. You can't be pro-choice here and be pro-life outside, I mean really, that would be - you'd go absolutely mad. My personal and my professional choices are exactly the same.

However some providers did relate to more personal views towards abortion in relation to themselves or a family member. Even in cases when providers expressed

their support for the service, and the need to be non-judgmental of women seeking abortions, it was common for them to suggest that if they themselves or any family member were to have an unplanned pregnancy, abortion would not be an option they would necessarily choose. Providers grappled with differing reactions to abortion, especially when relating to their everyday lives, and the recognition of the highly contested nature of abortion in the workplace and within their wider social environment.

Whilst some providers were forthright in their ability to separate the personal from the professional, others were ambivalent, as these comments by a nurse provider suggested:

I have never been particularly pro-abortion and I haven't been anti-abortion, but it wouldn't be something that I choose for myself or for a family member seeking help. Especially a daughter or close family member, but for a patient that might be different.

An abortion provider reflecting on his son's possible future sexual relationships voiced similar sentiments, yet at the same time acknowledged the importance of access to safe abortion services:

I see young people because I have a young son, and I see this young person coming with his girlfriend, and that sort of touches on me, and hoping in my heart that my son will also be good to his girlfriend if that happens. You know, in my personal life if you ask me if I will have an abortion done on my girlfriend or my wife or my child's girlfriend I can't really in all honesty answer you that before I've reached that point. I think probably I will, depending on the circumstances, but I think it will be difficult for me like it is for anybody else. However, it will be slightly easier but because I know the person will be safe, and it is a safe procedure, so, that will make it easier for me but it will still be a difficult, emotional and maybe ethical problem for me.

Some providers managed ideological conflicts around abortion by making a conscious separation between their personal beliefs and professional medical practice, and for

some, emotionally removing themselves from the process and ascribing the consequences of choice to the woman seeking an abortion was an important means of mediating internal conflicts. A nurse provider described how she had removed herself from the abortion process and literally left what she did at work, thus preventing any slippages into her home life. An impenetrable barrier was constructed between her clinical practice and social world:

I don't make it my problem as, it's not my problem, she decided to come here, she knows why she's coming here and it's her choice. It has got nothing to do with me ... other people they always threaten us, they say - you are going to have bad dreams and see pieces of babies and all this in your dream. I never had anything like that because I leave what I do here in this place. I am working as a nurse and I leave what I do here.

In relation to creating barriers between work and private space, another provider spoke about the importance of maintaining boundaries and an emotional distance when providing counseling, so as not to get too closely involved with the client:

I need to stay level headed and practical when counseling and give information and give support, and not give permission for an abortion. That's very important. Because there are some women who would ask what do you think I should do? I would just bounce it back and say, well what is it that you think you should do? Let's look at your circumstances, let's look at what the most suitable options are. So I need to be very clear on that. I also need to be clear about the distance emotionally between us – not to become involved, not to give permission but rather to give support, information and guidance. Sounding it back to the client is very important. It is a challenge because, well there are some clients with whom you get a little bit too closely involved. But I think I became aware of it very quickly. I'm saying to myself, you are over your boundary, get back to your boundary.

Providers at all levels of provision experienced emotional distancing and separation in the work they carried out, and it was common for those whose personal views were less clear cut, to talk about distancing themselves or emotionally disengaging from

their work. A provider involved in abortion work talked about “shutting off” her mind to what was going on around her:

You are there to help people get better and to have a better quality of life. Now you totally shut off all those things, just to help the one in need ... At times one needs to maintain one’s distance so as not to get too involved.

The need to maintain thresholds or boundaries when engaging with abortion provision was evident in providers’ discourse recounting how they managed these conflicts, with the use of metaphors such as maintaining “boundaries” and “putting on different masks” with different jobs performed, underscored by attempts to separate their personal views from their professional practice.

Reasons for seeking an abortion

Rape, incest and fetal abnormality

The reasons why women sought abortions were explored as possibly influencing providers’ attitudes towards providing care. Almost all providers perceived an unplanned pregnancy due to rape or incest as different, and a legitimate reason to obtain an abortion. For many, it appeared a given that those who were pregnant through rape or incest would deserve more compassion and support than those who were pregnant through consensual sex. Abortion providers perceived pregnancy due to rape as totally different, and in one case deserving of “*standing in the theatre holding their hand*” during an abortion. As a nurse provider explained:

I imagine incest or rape would be very different from a consensual loving relationship, where the condom broke, you would perhaps think a little bit harder about that situation. It might be a more difficult decision to make than if the woman had been raped.

Some of the abortion services appeared to see large numbers of pregnant women due to rape, while at others this appeared a rare occurrence. This difference could partly be due to health care providers' perceptions of what constituted a rape. For instance, a provider who was not directly involved in abortion provision and who described herself as quite harsh questioned the many claims of being pregnant due to being raped. Similarly, other respondents appeared to look to contentious notions of responsibility to justify a judgmental response toward women who were raped and seeking an abortion:

Of course for some people they would ask, why were you raped, what time were you raped, you know, and if it's three o'clock in the morning on the main streets, in the middle of the night then they would be less inclined to be non-judgmental. Often we get this feedback from health care providers that people are irresponsible sexually and it's their own fault ... which is nonsense of course.

The few providers who commented on fetal abnormality suggested that staff generally were more understanding and supportive towards a woman seeking an abortion for what they perceived as a legitimate medical reason. It seemed to be a given that a woman would be more traumatized about giving birth to a baby with a fetal abnormality, and therefore deserving of more support, and that this would be forthcoming from staff whatever their stance on abortion might be.

Socio-economic reasons

Most respondents appeared to be in agreement that many women who sought abortions were motivated by socio-economic hardship. Whether this was due to being too young, having to defer studies, or just being too poor and overwhelmed to have another child, respondents responded with sympathy and understanding. Reflecting on a possibly miserable life for a woman and her child, many providers were clear that women should not have an "unaffordable baby". It was thus viewed as critical not to delay an abortion in these circumstances, as any delay could result in women changing their minds. Comparing their own relatively better circumstances to those of many abortion seekers seemed to elicit a sympathetic response from some providers,

including those who personally would have not opted for an abortion. Furthermore, there were very few patronizing or judgmental responses to unplanned pregnancies and women's compromised socio-economic circumstances.

Contraception: relation between contraception and abortion

It was felt by some providers that women were using abortion as a means of contraception. One provider suggested that the availability of abortion services “encourages people not to use family planning”, while another provider attributed the rise in “repeat abortions” to the failure of contraceptive services to address women's diverse needs. The perceived poor state of contraceptive provision, and the relationship between abortion and failed contraception was to become a dominant narrative throughout the study, and will be explored further in the next chapter (Chapter 7).

The possibility that women were using abortion as a contraceptive method appeared to be a major concern for providers, underscored by perceptions that abortion was often a substitute for responsible family planning. Furthermore, a woman who came back to the services for a second or third time was identified as coming for a “repeat abortion”, and seeking an abortion more than once was indicative of using abortion as a contraceptive method, of being sexually irresponsible and seeing abortion as an easy option:

For some people it's just becomes too easy an option to choose, because I've seen people coming in for second and third abortions and it's, I mean I see that it's becoming a contraceptive and so that doesn't sit well with me at all.

Other providers were less homogenizing in their responses to an unplanned pregnancy, and recognized the differing circumstances for requesting an abortion, acknowledging that they were not always able to fully understand the reasons and complex decision making around seeking an abortion:

I just help them as they come in. Listen to them, as I say, I don't make it my procedure or my story or my value. I just help them, listen to them and I know they all have different reasons. ... every single person is different and the reason why they're here is different ... I could never understand anyone wanting to have an abortion, but yet, some of them who come here and you want to cry with them You don't know where they're coming from, you know the background and everything.

Whereas for another provider, not knowing why a woman was having an abortion could be frustrating but would not ultimately influence her decisions around providing abortions:

I only see the patient when I do the procedure. But of course it would make no difference for me, whatever the reason was. But there are many moments that I think I hope there is a good reason and that it's not just – I don't use anything and I'm being irresponsible and now I'm pregnant again and there's this stupid woman who will help me out again ... There are perhaps very few like that, the majority have very good reasons, but that is exactly the frustration. I haven't been in that process of why they are seeking a termination.

The multiple and varied reasons why women sought abortions did impact on providers' approach to women seeking an abortion. In circumstances such as rape or for fetal anomalies providers were more empathetic and supportive, whereas for perceived inappropriate use of the services, and returning more than once for an abortion, they were less supportive.

Conclusions and discussion

Providers' perceptions around abortion were often mediated by shifting social identities as mothers, health care professionals, and as women within their wider social community. The impact of the changing political landscape in South Africa post 1994, and the new human rights discourse including reproductive rights, resonated in many providers' discussions.

Providers, with the exception of a few, did not overtly align themselves with either a pro-choice or an anti-choice stance, but rather provided a set of reasons for their varied levels of involvement in abortion care. This was largely dependent on differing social realities, such as recognition of the public health implications of unsafe abortion, the notion of reproductive rights and choice supported by the South African Constitution and the CTOP Act, and their role as health care professionals tasked with supporting women's reproductive rights including their right to reproductive choice. However, as has been argued elsewhere, whilst the legal rights to abortion might have been won, the moral right to abortion is still contested (Løkeland, 2004).

What emerged is that for many providers, pragmatic personal boundary making assisted them in dealing with the difficulties associated with abortion provision. Whether it was setting personal gestational age limits, being involved in pre or post abortion counseling or being supportive of women in cases of rape or fetal abnormality, all were linked to creating differing thresholds of care.

The processes by which providers interpreted, rationalized and managed their understandings of abortion and hence abortion provision were diverse.

What became apparent was that many providers balanced personal, moral and religious beliefs around abortion with their professional responsibilities as health care providers. Some providers were pragmatic in their approach to abortion and managed personal and religious beliefs in unexpected ways, whereas others, particularly those working in settings that were openly "pro-life", such as the pregnancy crisis center, were more forthright in their views around abortion and how it impacted on women's roles as mothers and carers. As has been found in other studies, women who seek an abortion may be perceived as challenging the inescapability of maternity and disregarding reproductive physiology (Cox, 2005; Kumar et al., 2009; Rylko-Bauer, 1996).

Abortion is a contested domain, as previously discussed in Chapter 3, and like issues such as stem cell research, euthanasia and capital punishment, has to do with notions around the sanctity of life. Providers did not necessarily engage with the ontological debates around conception and when life begins. Rather for them, the visual and

emotional responses to an aborted fetus were lived experiences, not necessarily located in ideological or philosophical arguments.

The notion of devolving reproductive choice onto the woman seeking an abortion, and in so doing creating a metaphorical boundary and removing oneself from the decision-making process, is somewhat unusual in the standard medical domain, where the health care provider is in control of the diagnosis and treatment plan (Sheriff, 2009). A woman in South Africa who seeks an abortion is in a somewhat unique position in that she is able to make the decision to have an abortion on her own (other social barriers aside), and in that sense the provider is somewhat removed from the decision-making process and has a more technical role, but one nevertheless still vested with power in being able to refuse to provide the service and hence hinder women's abortion access.

Abortion is unique as an area of medical practice in that health care providers are unlikely to separate their own attitudes from the care that they deliver. Therefore it could be argued that attitudes held by health care professionals whether positive or negative will have a profound impact on the quality of care that women undergoing an abortion will receive (Lipp, 2007, p. 1683).

The reasons for women undergoing an abortion were also found to influence attitudes toward abortion to a greater or lesser extent. Similar to other studies elsewhere, providers' attitudes appeared to alter depending upon the circumstances of the woman seeking an abortion, such as weeks of gestation and reasons for the abortion. Abortion in circumstances of rape, fetal anomalies, or if the pregnancy threatened the woman's life were supported more so than pregnancies as a result of non-contraceptive use (Buga, 2002; Engelbrecht, 2005; Harrison et al., 2000; Marek, 2004; Marshall et al., 1994; Silva, Billings, Garcia & Lara, 2009).

As will be discussed in greater detail in Chapter 7 and Chapter 8, the notion that women were using abortion as a form of contraception has been reported elsewhere in South Africa including the Western Cape (Cox, 2005; Engelbrecht, 2005), and is an overall concern in developing countries, where post abortion counseling including

contraceptive initiation is inadequate (Ceylan, Ertem, Saka & Akdeniz, 2009; Rasch Yambesi & Massawe, 2008).

Moral conflict around abortion is unique in relation to other medical practices in South Africa, and is the only instance where health care professionals can invoke their right to conscientious objection. Despite this, conscientious objection was either poorly understood, or in many cases incorrectly implemented in health care facilities, and hampered access to abortion care. Harrison et al. (2000), in research conducted two years after the implementation of the CTOP Act, noted that conscientious objection was poorly understood by health care providers in KwaZulu-Natal (Harrison et al., 2000). Similarly, Engelbrecht (2005), Ngwena, van Rensburg and Engelbrecht (2005) and Varkey (2000) reported parallel situations in other areas of South Africa. Similar to the findings of this study, Engelbrecht (2005) also found that no policy documents or service guidelines were in existence in health care facilities, and a lack of clear operating procedures for abortion services added to the confusion with regards to conscientious objection (Engelbrecht, 2005).

Providers took a more pragmatic as opposed to moral approach to conscientious objection. Some were aware of the importance of providing clients with the necessary information or referring them to another facility, whereas others refused to be involved in providing these services, yet did not formally document their conscientious objection. The application of conscientious objection and its impact on abortion service delivery will be explored in greater detail in the next chapter (Chapter 7).

CHAPTER 7: HEALTH SYSTEMS CONTEXT

Introduction

Following on from the previous chapter, which explored health care providers' conceptions around abortion, this chapter will have a broader focus by locating health care providers within their work environment, and exploring ways in which the health system context and institutional environment impacted on abortion service provision.

Salient issues to emerge in this chapter were largely related to barriers to service provision, which included both structural and individual level barriers:

i) abortion and values clarification training opportunities; ii) the ways in which opposition to abortion and/or conscientious objection impacted on abortion provision and care, resulting in differing thresholds and boundaries with respect to abortion provision; iii) individual level experiences of abortion provision such as stigma and burn- out, quality of care as it relates to abortion services including location of services; and iv) failed or poor contraceptive uptake and services associated with increasing abortion demand.

Description of abortion services

A description of the different abortion services and staff components at health care facilities provides context to the differing work experiences of a diverse group of health care providers working in the public sector. Organization of the services varied between facilities and was contingent on staff's willingness and training, the type of health care facility, and impetus from hospital management to support and provide abortion services.

In many of the designated abortion facilities, first trimester abortions were performed by trained nurse midwives or by a doctor if there was no one trained or available to perform first trimester abortions. Second trimester abortions were performed by doctors who formed part of a roving team of doctors employed by the Provincial Department of Health to provide services, as few doctors within the public health sector were willing to perform second trimester abortions. Nurse providers were responsible for the day to day running of the services often with little support from management.

The staff component at the different facilities varied according to type of hospital. Tertiary (academic) and secondary level hospitals had a stronger physician component including obstetricians/gynecologists and registrars. However their role in abortion services was limited, as their training and responsibilities included all aspects of obstetrics and gynecology, and abortion care formed only a small part of their duties. In larger facilities, abortion services did not take precedence over what was perceived as more important gynecological services. As a registrar explained:

Placing TOPs within general obstetrics and gynecological services was not the most efficient use of scarce resources and personnel, and where the main priority was on more routine gynecological procedures and surgeries.

In other designated abortion facilities, staff complements ranged from nurse midwives trained to perform first trimester abortions, roving doctors performing second trimester abortions, registered nurses not trained in abortion but providing other abortion related services such as referrals, pre and post abortion counseling, and social workers providing pre abortion counseling.

A diagrammatic representation of the clinical pathways to abortion provision illustrates the different roles and responsibilities of health personnel in the process (see Box 1 below).

Box 1: Clinical pathway through health care system

Pre abortion

- Referral to a designated abortion facility
- Making a booking
- Ultrasound to determine gestational age
- Pre abortion counseling
- Appointment date and facility
- Misoprostol prescribed for cervical priming

Abortion procedure

- Administration of further misoprostol or other medications
- Assistance in operating room if surgical procedure
- Monitoring vital signs

Post abortion

- Post abortion counseling including contraceptive counseling and provision
- No formal follow-up

Note: These different activities were often performed by different health care providers

Nurse providers were responsible for:

- Making appointments, largely based on gestational age - both first and second trimester abortions were not provided on a daily basis and depended on providers' availability and facility capacity.
- Pre abortion counseling was either undertaken by a social worker or by a nurse, and the content and time spent with the client varied.
- Ultrasounds to determine gestational age were performed either by a doctor or in some cases by a nurse provider. Not all facilities had ultrasound equipment, and clients were consequently referred to a facility that performed ultrasounds. Similarly, not all facilities provided abortions, and medical staff were required to refer clients to a designated facility.

- Post abortion counseling, including contraceptive counseling and provision, was either undertaken by a nurse or the person performing the abortion or delegated to another provider. However, as will be discussed later, this did not appear to be happening in a consistent or comprehensive manner.
- No follow-up visit was required for abortion clients.

The above portrayal of abortion services underscores the disjointed and fragmented nature of service provision. All the above roles and responsibilities required suitably qualified health personnel, coupled with willingness on the part of providers to perform these varied tasks integral to comprehensive abortion care.

By way of introduction to this chapter and to provide some background to providers' experiences with health service provision, two narratives highlighting key issues to emerge will be presented. These personal narratives reveal the multiple barriers to effective service provision, including provider opposition, stigma associated with abortion provision, poor infrastructure, and a lack of training opportunities, and support. Issues associated with the service provision underscore the improvised way in which abortion services were implemented and organized, supported by a dedicated cadre of abortion providers, and is an overarching theme of this chapter.

Furthermore, these two narratives, one of an abortion doctor and another of a nurse manager responsible for abortion services at a secondary level hospital, underscore the complex and contested nature of abortion work in public sector facilities. While their professional responsibilities might differ, a common thread is visible through their accounts of the difficulties faced while providing a range of abortion services. Both individual and structural constraints served to create barriers to effective service delivery, and included quality of care issues, resistance to abortion provision and a dearth of abortion providers. Despite this, they both sought ways to overcome these barriers in a climate of resistance. To maintain anonymity all identifying information has been altered or removed from these narratives.

Day in the life sketch of abortion provider: Dr C

The following vignette describing a day in the life of an abortion doctor reflects the complex and contested nature of abortion work in a public sector abortion facility, and is based on extensive time spent with the provider both formally and informally at meetings, conferences and at various facilities. I draw on our numerous interactions and my journal recordings:

Today Dr C is replacing the regular “roving team” doctor as she is on leave. We arrive at the facility early in the morning, there are already 20 women waiting in a small room with little ventilation, there is one wooden bench, and the rest of the women are either sitting on the floor or standing. The nurse informs the doctor that the patients have been given misoprostol for cervical priming prior to the D&E procedure. There is a lengthy discussion about the misoprostol dosage and times given. The doctor informs me that there is a tendency to give too much misoprostol and too early, and consequently women expel the fetus at home, in transit to the hospital or in the waiting room. She explains that administering high doses of misoprostol for cervical priming has become a practice by a particular provider as a way of dealing with large volumes of women, and is a traumatic experience for not only the women but also for the providers caring for the women.

Dr C comments: “I could complain about this [referring to misoprostol dosage], but since we have no other providers willing to do second trimester procedures I let her do it this way, even though I am not happy with this situation, but it is her way of dealing with the large volume of patients”. If the women abort the fetus prior to the D&E procedure, the procedure is modified and becomes shorter and less difficult to perform. The women appear to be in considerable discomfort, and only have access to one toilet situated a distance from the waiting room. The nurses comment about the lack of toilet facilities for patients, a problem reported at many of the other public sector facilities.

Overcrowded working conditions coupled with poor equipment and infrastructure is a common complaint. Today, the light used to visualize the vagina and cervix is not working; apparently the globe has been missing for a few weeks now. The doctor in desperation has brought her own light bulb and inserts it into the lamp. She can now proceed. The doctor performs the abortion, and there is virtually no discussion with the patient apart from asking why she has waited so long to seek assistance. The doctor is puzzled, as the patient has three children, and one would assume knowledge of the signs and symptoms of pregnancy. The woman informs the doctor that she did not realize that she was pregnant until after 12 weeks, she is now 19 weeks pregnant. A source of frustration to providers is that many of these women on their ultrasounds were less than 12 weeks gestation but are now more than 14 weeks gestation. The doctor explains that it is due to the booking systems, where women present in their first trimester but due to long waiting times are only seen when they are already in their second trimester. This is largely the result of a dearth of second trimester abortion providers, resulting in women having to wait up to three weeks before they obtain an abortion. This also has health consequences, as a second trimester abortion is medically more difficult to perform and has more procedure related complications compared to the MVA procedure which is a simpler, safer and quicker procedure.

During the procedure the nurse is mostly absent from the procedure room. She has ensured that the surgical tray is ready but, apart from this, her assistance is minimal. She does not make eye contact with the patient nor does she reassure her during a visibly uncomfortable procedure. Apart from a cervical block, women are not routinely given any analgesia. There appears to be no recuperation area. Later in the tea- room I overhear some of the nurses' comments. Women are seen as "irresponsible", and using abortion as a form of contraception. Yet ironically, the women are not given any post abortion contraceptive counseling, instead they are told to go to the family planning clinic in the adjacent building. There appears to be no follow up to ensure that women have accessed contraceptives after the procedure.

The second narrative highlights the difficulties in establishing abortion services shortly after the advent of the CTOP legislation. Unlike the other narratives presented so far, this narrative reflects the experiences of a provider involved in pre and post abortion counseling and not abortion provision per se. However, her narrative provides important insights and captures some key problems with implementation.

Nursing manager responsible for abortion services at a secondary level hospital: Sister R

As with the other narratives previously presented, this second narrative provides historical context to the implementation of the CTOP Act in the Western Cape. These extracts from Sister R's interview underscore the innovative responses to dealing with medical staff's refusal to be involved in abortion services, by enlisting the help of older, retired friends and colleagues in order to sustain the services, with little support from medical or hospital management. Dealing with differing levels of opposition to abortion services resonated with other providers' accounts of their working environments:

I started off working here by establishing the Rape Center and many of the women needed to terminate as a result of rape and we then had to also assist with the TOPs. There was an area within the Rape Center that was not utilized, and we realized we can fit the TOPs there, so it was in my department, so I had to then write up the protocol. There were four female doctors that were pro woman's choice and myself, and we only started off with seeing two patients a week, then we went up to four patients, then we went to ten patients. However, we then encountered problems with the counseling. The counseling that the women received at the other facilities prior to seeing us was always sub-standard and we then had to expand our pre termination counseling sessions.

Sister R described the lack of planning and foresight into what was required to establish abortion services. Another key insight provided is the effects of implementing liberal abortion legislation within a conservative hospital and wider

community environment, without adequate preparation or recognition of the need to prepare and support health care providers in the process:

The problem was that the province didn't say "well this is what we need to do in order to give this service". They said: "this is the service that must be done". What was actually upsetting and I think that everything would have worked out fine if there was just more foundation put into the structure before the law was implemented and to make sure that everything was in place.

Now you must remember that this is also a very, very conservative environment especially this hospital, and there's a big difference between this area (located a distance outside of Cape Town) and other areas in Cape Town, I mean if you don't know, it's a very different mentality. This is a conservative community and also a religious community.

The CTOP Act came out in 1998 and we were instructed to do TOPs, but I had not undergone any TOP training apart from two days of values clarification. It was very basic and how can you teach somebody counseling in two days? I have not done the actual TOP provider training because there has always been the gynecological department doing it. The doctors do the actual procedure, because we were a secondary level hospital, therefore it was stated that the department of gynecology must do the first trimesters. They agreed to do two per week, then they said they would do four per week so then now it's ten per week, but that's all they will do, but the sad thing about it, if the woman is not bleeding, then they won't touch her. The women are given misoprostol to take at home, we don't do it on site, and so they come back bleeding. If they are not bleeding, we repeat the tablets, because at the moment there isn't one doctor that is pro termination. They'll only do a post evacuation ... although the medical superintendent said that they must do it if it is a gynecological emergency. By that I mean per vagina (PV) bleeding, they have to treat that as they cannot ignore a PV bleeding. That's how they get around the situation with the pro-life doctors, they said that a woman that is bleeding is still your responsibility, the same with the nursing staff, that's how they dealt with the nursing staff that did not want to do it or help the women. In fact there were

some doctors that refused entirely, that's why the responsibility became more upon us, because the doctors wouldn't even refer them to another facility that did terminations.

The above scenario depicts the complex situation whereby providers created their own personal thresholds for abortion provision. Creating limits and boundaries around abortion provision, as mentioned in the previous chapter (Chapter 6), now is extended to the actual abortion procedure, where providers created their own limits such as only treating medical emergencies or modifying the abortion procedure to performing a post evacuation surgical procedure once the products of conception had been expelled:

I could not cope with the demand and with other nursing staff refusing to help me. I then enlisted help from my nursing friends. I said; "no but this is not good enough", we need to re look at it, so I decided to enlist the help of friends, one is a retired Professor of Education. Because now we were getting between 37 to 47 women per week, so we couldn't cope. I always maintained from the three of us, and we are all older women aged 53, 63 and 45 that the three of us helped each other.

The three of us were very happy to be doing this. I do the basic organization of the services, for example if they need extra theatre [operating room] space and things like that. I also organize staff members to go and work in the TOP services that I know are basically decent and will treat the women decently. These staff members were paid extra for that day, so it's on their off days in theatre that they will come and assist. Because at the moment the person in charge is totally anti TOP and the second in charge is also totally anti TOP, and the manager as well, so all are anti TOP.

And later in the interview she discussed how exhausted she was:

I cannot keep it up because I'm burning out from the TOPs. There's nobody else to do the pre and post procedure counseling. I have written a letter to the province to say that there are only three individuals that are willing to do it. We

tried to get other people on board, they lasted a few weeks, and it was too much and they didn't come back, because it's a lot of work and then you have the managers saying it's not cost-effective having three of you working, and so we have written a letter now and we've told them that I've given them until the end of this year, it is not my responsibility to look for somebody to replace me, if I am not cost-effective, then they should actually be looking for somebody else.

Later during the study period I met this provider in another setting and she informed me that she has left to work elsewhere, due to overall fatigue and burn-out, and how the facility has subsequently stopped doing abortions due to staff unwillingness to provide abortions.

Abortion and values clarification training opportunities

Another barrier to abortion service provision was a shortage of trained and/or willing abortion care providers. Abortion training as discussed in Chapter 2 is an important component towards increasing the pool of abortion care providers. Opportunities and access to training is crucial in both abortion provision and in sustaining services. Furthermore, attending values clarification workshops provides opportunities to engage with and reflect on the complex and contested issues around abortion. With this in mind, issues around abortion training including values clarification (VC) were explored.

Two types of training will be discussed in this section: abortion care training for midwives and more recently registered nurses who are legally allowed to perform first trimester abortions; and VC workshops which are either run in conjunction with abortion care training programs or separately for a range of stakeholders involved in various aspects of abortion provision.

Values clarification workshops

Values clarification, as discussed in Chapter 2, is considered an integral part of abortion training for health care providers who are involved in all aspects of abortion provision, including pre and post abortion counseling and referral (WHO, 2004a). The focus in this section will be on how providers viewed VC and their experiences of VC workshops, as either part of abortion training programs or as a separate program.

Abortion VC workshops are considered useful for addressing barriers to access stemming from misinformation, stigmatization of women and providers, and negative attitudes and obstructionist behaviors. They engage health care providers and other stakeholders in a process of self-examination, with the goal of transforming or shifting abortion related attitudes and behaviors in a direction supportive of women seeking abortions (Turner et al., 2008, p.108). Furthermore, abortion values clarification workshops allow health care providers to engage with and reflect on their feelings and views about abortion.

VC workshops were initially provided prior to the implementation of the CTOP Act, as a way to promote understanding around abortion, and were later included in The Midwifery Abortion Care Training Programs. They were also provided as stand alone workshops, in order to address barriers to provision, and provide those involved in abortion services with opportunities to engage and reflect on abortion related issues on both a personal and professional level.

Content of VC workshops includes, amongst others, reviewing in detail the CTOP Act, sexual and reproductive rights and choice as it applies to women in South Africa, and explanation and demonstration of the MVA abortion procedure, the latter to dispel misconceptions about the abortion procedure.

In the years following the implementation of the CTOP Act, VC training workshops have been provided on a sporadic basis, and largely supported by international reproductive health NGOs such as Ipas, and in some instances initiated by Provincial

Departments of Health (Mitchell, Trueman, Gabriel, Fine & Manentsa, 2005). Despite positive feedback and favorable evaluations from participants, VC workshop opportunities have not been sustained or provided on a regular basis, which has been attributed to few local trainers to facilitate workshops, reliance on NGOs for provision, and few participants volunteering to attend, as well as overall problems with access to training present throughout sexual and reproductive healthcare services.

On the whole most providers and managers viewed VC workshops as an important part of facilitating abortion provision, both for those performing abortions and those involved in other aspects of abortion care. However, despite recognizing their importance, opportunities to attend workshops or continue providing workshops were thwarted, largely due to poor planning, obtaining staff replacements or overall staff shortages.

Providers who had attended VC workshops were positive about the content and outcome, and had found them extremely “useful” and “helpful”, as they had provided them with opportunities to reflect on their personal belief systems. Some mid-level providers, who had undergone abortion training, mentioned that they had attended a two day course in values clarification and counseling during their training, whereas others had attended VC workshops when the legislation was first introduced, and many acknowledged that opportunities to attend workshops had been beneficial to their own work experience, and had a positive spin-off on abortion seekers.

A nursing manager remarked that she was convinced that more providers would “let go of their negative attitudes towards abortion”, if there was a greater focus on the provision of such workshops, as staff from her facility who had attended these workshops had returned with positive outlooks, and lamented the fact that somehow these workshops were not sustained over longer periods of time. For some nurse providers, VC workshops had helped to shift their attitudes towards abortion. They recounted how VC workshops provided them with opportunities to gain insight and knowledge around various aspects of abortion provision, including details around the abortion legislation, the public health importance of access to safe abortion, and

reasons why women seek abortions. In addition, VC workshops also provided them with opportunities to engage with the issues in a non-threatening group environment.

Providers also suggested that VC helped them to define their role as facilitators who guided rather than directed a client. This alleviated the decision-making process. One provider remarked on the importance of tolerance and mutual respect when engaging with clients:

TOP is not a nice thing but values clarification helps to open up your mind. After that I don't have to judge that woman - I don't have a right to judge. She has got her own reasons why she's doing this and you have to respect that client as a patient.

Furthermore, although VC workshops were not designed to “force” staff to provide abortions, a health service manager maintained they played an important role in contributing to the understanding of the roles and responsibilities of health care providers involved in any aspect of a client’s care. This was achieved by reviewing the details of the CTOP Act, and also the importance of reproductive autonomy and of being tolerant of others views.

Whilst most providers found the experience of attending VC workshops beneficial, possible limitations included difficulties with getting time off work to attend workshops often due to staff shortages. In addition, the manner in which staff were selected was perceived as unfair and did not make logical sense, as often those who were not involved in abortion services attended, while those involved in abortion provision were excluded, which was attributed to poor management and planning.

Factors such as time constraints or professional position seemed to contribute to non-attendance. One provider suggested that lack of resources prevented her from attending, as management was unable to find someone to temporarily replace her. A nurse involved in assisting with the procedure mentioned that her request to attend a workshop was turned down. She was dissatisfied that management sent other staff who did not subsequently involve themselves in abortions:

I did ask them for [values] clarification, but they didn't send me, and I felt very unhappy because none of those Sisters and that nurse[referring to a nurse in her facility] is involved with the TOPs at the moment, so I don't know why they sent them, and they're not even doing the work now.

She further suggested that some health care workers attended the workshops for opportunistic reasons, either to get time off work, or for the sole purpose of obtaining a certificate.

Values clarification workshops can also assess potential trainees' willingness and motivation, and screen out those who are unsure or unlikely to want to provide services, ultimately saving resources, time and effort (Turner et al., 2008, p. 111).

Related to motivation to provide services, some providers suggested that values clarification did not help everyone involved in the services. One provider commented that while VC addressed issues on a professional level, "it doesn't make you feel better about yourself once you leave the workplace". A provider suggested that VC had not changed the attitudes of some staff working in the services, particularly operating room staff who did not want to be involved in the service, but were forced to because of staff constraints and their specific skills as operating room nurses. Despite this, she felt that perhaps their views and values had shifted a little, allowing them to be more empathetic toward women seeking an abortion.

When starting a new position in abortion service provision, attendance of VC workshops was not mandatory, and there seemed to be little done to regulate who attended when. Not all mid-level staff had the opportunity to attend workshops, and doctors tended not to have been offered VC workshops. None of the doctors reported having attended VC workshops, and this was possibly related to the fact that very few doctors had attended formal abortion training programs.

Key issues to emerge were that the importance of these workshops was not fully appreciated by most hospital managers and wider provincial structures, and that they were not provided on an ongoing basis similar to other training or career opportunities

within the public health system. Furthermore, there was a reliance on international NGOs such as Ipas to fund, initiate, facilitate and sustain VC training workshops.

Abortion training programs for nurses will be discussed separately as their main focus was on training midwives in first trimester abortion using the MVA procedure. Other aspects of the training included pre and post abortion counseling and values clarification.

Abortion training

A conflicting and complex picture of the state of abortion training opportunities and training barriers for health care workers arose during discussion. Training opportunities for some appeared to constitute training barriers for others. On the one hand, access to training was seemingly unproblematic for those who would seek it as “They just have to phone the college and they’ll get training, whenever there’s a training group.” On the other hand, even if accessible, training appeared infused with contradictions, with some providers who were trained still not providing abortions, and others who sought training being denied access while simultaneously witnessing “abuse” of training opportunities, as the following input by a nursing manager suggests:

I think training is readily available [but] I’ve seen so many midwives who have gone for TOP training, but when they come back, they don’t do TOPs ... I always think a person has a choice whether to go for training or not. I don’t know why they would go for training and then decide later that they’re not interested ... it doesn’t make sense ... but there is a need for midwives to be trained in first trimester TOPs.

Comments on training often suggested great frustration regarding training structures and expectations. The problem appeared to be twofold: firstly, difficulties in accessing the didactic component of abortion training; and then once completed, problems in completing the practical component due to a shortage of instructors able to assess trainees. This was further compounded by stigma associated with attending

abortion training, followed by difficulties in trying to get the services up and running in a particular facility, especially if dependent on one mid-level provider. This was reflected in the narratives presented in Chapter 5 on providers' career pathways and in Sister R's narrative in this chapter.

A nurse who had attended the theoretical component of the abortion training program experienced problems in getting adequate practical experience in abortion provision, as there was only one person available to assess competency levels with respect to the practical component of MVA provision:

The problem is there is no one to come to my facility to assess me and sign off that I have done the required number of TOPs. The doctor came once but it is far and she is also busy doing her own work. It is very frustrating as I have to wait for when she has time to come and assess me.

Stigma and fear associated with providing or even assisting with abortion services was reported as a further barrier to accessing training, even when it was on offer. A health care provider implied that rather than access to training being an issue, the real problem was that nobody wanted to do it. Attending abortion training could be fraught for some providers, as training could signify a pro-choice stance and consequently opening oneself up to "finger pointing and name calling".

Despite all the problems associated with access to abortion training and possible negative associations for those who underwent training, training was recognized as a critical component of service improvement by a senior nursing manager:

You see if we can have more training, more providers, the work load would be less and more support from our different institutions to people who are dealing with TOPs, then if we can get support from their management, that can also improve the services overall.

Opposition to abortion and conscientious objection

This section will attempt to unpack the ways in which conscientious objection was spoken about, interpreted and practiced, and its impact on service provision. As mentioned in the previous chapter, there appeared to be ambiguity around when and who was entitled to invoke their right to conscientious objection amongst most providers and managers. There also appeared to be some confusion about how the abortion law was being implemented and the limitations on conscientious objection, with selective application of the law with respects to health care providers' duties when invoking their right to conscientious objection.

Initially when analyzing providers' and managers' discourse around conscientious objection and non participation in abortion services and the impact this has on service provision, I had assumed that providers were invoking their right to conscientious objection. On closer examination and further analysis I realized that the situation was more complex, as in some instances managers and providers were aware of the requirements of conscientious objection and the duties as set out in the CTOP Act, yet did little to ensure that the process was duly followed. In some facilities, managers and providers appeared to accept the situation of colleagues and co-workers refusing to be involved in abortion services, and either provided limited services or enlisted the help of providers from the private sector.

Providers misinterpreted or incorrectly invoked their right to conscientious objection as it related to abortion and the CTOP Act in three key aspects of the legislation. Firstly, the right to conscientious objection serves to allow a health worker to choose not to participate in abortion procedures, and not to refuse to participate in other aspects of abortion provision. Secondly, providers were legally obliged to refer a woman seeking an abortion to another facility or provider. Thirdly, providers had the ethical and legal obligation to care for patients with abortion related complications or a medical emergency. All three of these requirements were not always applied in the correct manner and will be discussed below.

The situation was further confounded in that there were no clear guidelines or protocols guiding the process of conscientious objection, and no formal register or recording of staff's objection on grounds of conscience. I subsequently came to realize that respondents were using the term very broadly, and that opposition and discomfort towards abortion provision was conflated with conscientious objection. Moreover, non-participation in differing aspects of abortion provision tended to be viewed as conscientious objection by providers, managers and policy makers.

According to respondents, it was evident that health services lacked the necessary regulatory structures to deal with conscientious objection among health care providers. Furthermore, there seemed to be very little recognition or support from health service managers regarding effects of conscientious objection or non-participation on abortion service provision.

A nurse involved in abortion provision described the impact on service provision of providers refusing to assist in abortion services, and the difficulties she encountered working on her own with little assistance and support:

It is always a problem to get somebody to assist as we don't have a fully functioning clinic with permanent staff. I need a doctor who can prescribe misoprostol, and a doctor to help me, but then they say no, it's against my religion, and I'm not doing it". But it's not my position to say to them "where is your written excuse"? It is not part of my responsibility, so I then have to look around for somebody who will be able to assist me.

She later elaborated with a degree of skepticism the manner in which conscientious objection occurred in the work place. Similarly, other providers were skeptical about some providers' motivations with regards to conscientious objection:

You know people are very funny, people are strange - for instance, you'll find there are nurses in the hospital, they'll say, no I'm not working with those abortions. But just offer them some money, offer them some type of incentive and they'll all rush there, - so I think sometimes people object for the wrong reasons. They don't object because it's against their morals or principles or

religion or whatever, they object simply because they can - because it's there, they'll say, I don't want to do it. So for me that is double standards, you're either religiously against it, morally against it, your family doesn't want you involved in it and they mean more to you than your profession, or whatever. However, I feel that you, as a human, you make your own choices and you choose to either do it or you choose not to do it, but you can't have a grey area, and that is what's happening.

Another senior manager similarly relayed her skepticism and the ambiguous way in which providers objected to providing abortions:

I am bit skeptical about conscientious objection and the way in which it is occurring in many health facilities. Sometimes I think it might have more to do with - this is a way to get out of another responsibility, I'm mentioning that but I have no evidence of that, but I think that that can definitely play a role.

I'm also skeptical when they can always find somebody from the nursing services and we know that when we are paid extra we will go and do something that we claim we won't do if it's just part of our work process, so I don't know, I think a lot of people who do say - don't believe in it - and then they go out and moonlight for the nursing services and they're prepared to do things, because they're getting paid extra, makes one a little bit suspicious about motivation, maybe I'm being a bit cynical now.

Even if there were no clear guidelines with regards to how to register conscientious objection, it would not fully explain refusing or obstructing access to abortion services. It appeared as if some providers either had selective knowledge about the Act as it related to conscientious objection or applied the Act selectively.

Refusal or non participation in abortion services occurred in many ways and did not necessarily translate to invoking one's right to conscientious objection.

In one instance, a provider at a designated abortion facility, who was familiar with the details of conscientious objection and the duties of health care workers as they related to abortion provision, intimated that despite being aware of the limitations placed on

conscientious objection, management still permitted providers to refuse to render services. From her perspective this was evidenced by employing nurses from outside of the public health sector through a private nursing agency to provide abortion services.

I cannot remember much about conscientious objection, it was introduced about 10 years ago. It says you can refuse to do the procedure, but you cannot refuse to render services, like to counsel, pre-counsel or refer, even to go into the theatre (operating room) to clean up, or to stand there and hold her hand. You cannot refuse to do that, but the procedure itself, you can refuse, that is my understanding. But we have a lot of colleagues who refuse and so we have nursing staff from an agency coming in, because the staff refuse to go in theatre to work there. And I think somehow, although the law says you cannot refuse to go that far, somehow, our managers respect the staff's position otherwise they wouldn't have got in agency staff to assist.

In some health care facilities providers tended to conflate obstruction to services as conscientious objection. Many providers reported that staff, including non medical staff such as cleaners and administrative personnel, refused to assist or obstructed access to abortion services. By way of example, a nurse provider at a public sector designated abortion facility explained how access to care had been initially blocked by an admission's clerk. While in this instance the provider might have used the incorrect terminology or used the term loosely, the impact on service provision remained:

We do experience conscientious objection. We had a situation three years ago from the administrative officer who was working here and so I didn't have a clerk who was going to admit my clients for TOP. You'll see the way they'll treat patients who come with the letter because they must have a referral letter. Once they open that letter and find it's a TOP, they will just throw that letter away and if it's somebody who asked them to open a folder for my clients as if it's she who's actually doing the TOP. Or it just might happen, if they come early at half past 6 in the morning, they will only be admitted at 12 o'clock. The whole day they are sitting there in the corner, they didn't have somebody to take care

of them because they have come to do this obscene something that cannot be heard of, but now I've got a dedicated clerk, now everything is running smoothly again.

Many designated abortion public sector facilities did not have providers who were prepared to either perform abortions or to assist those performing abortions. The impact of refusing to provide services extended to all aspects of the abortion process. As previously discussed, health care workers are not according to the CTOP Act permitted to choose different levels of participation. They could object on grounds of conscience to perform an abortion but not to provide related care such as administering medications or other nursing duties.

Differing thresholds of care related to attitudes towards abortion extended to all aspects of abortion care. Providers who had chosen not to provide abortion services provided complex multi-layered levels of abortion provision. Some health care providers assisted with the procedure and/or provided pre and post abortion counseling including contraceptive counseling. Others restricted their involvement to tasks solely relating to pre abortion care, such as counseling or performing ultrasounds to determine gestational age and referral to a designated abortion facility. Related to this, some providers went further and absented themselves from the entire process, including refusing to administer cervical priming agents and other abortion related medications. These complex patterns of service delivery prevalent throughout many of the health care facilities resulted in fragmented levels of service provision to accommodate providers' willingness to be involved in different aspects of abortion provision.

A nurse explained how she was the only one prepared to do abortions in her facility, and how nursing staff were not prepared to administer misoprostol required for cervical priming prior to the MVA procedure, or enter the operating room to assist the doctor, or deliver instruments or other medical equipment:

I'm the only one who's happy to do it [abortions], because the other nurses refused to give even the tablets [misoprostol] for the girls. I have someone who helps me in theatre, making the packs and assisting me with the book work but

she refuses to give the tablets. She said she's not going to involve herself with this ... Some will make up the theatre packs for the procedure but will not even go into the theatre to deliver the packs. They leave them outside of the theatre.

An Obstetrics and Gynecology registrar at a tertiary teaching hospital commented that she was the only registrar who was willing to provide abortions, and that other registrars had the choice not to be involved in abortion services. This was confirmed by the Head of Obstetrics and Gynecology at the same hospital. He commented on the disjuncture between the ideal and what was happening in his facility:

So there's the ideal then there's reality and you have to live with the reality. Not every registrar who gets to rotate in the gynecology rotation wants to do or treat TOP clients. They are asked during the interview if they mind doing the TOPs. So registrars have a choice whether to be involved in TOP provision or not. Those who choose not to be involved don't prescribe misoprostol [part of medical induction regimen], they only get to manage the TOP patients if they are bleeding, if it's an emergency situation.

This choice not to be involved in any aspect of abortion provision including pre-abortion work-up was further compounded by operating room nursing staff refusing to assist doctors with surgical procedures related to abortion complications, even though their refusal to assist in abortion related complications was not legally and ethically permissible:

The whole TOP is a very emotion raising subject. It's not everybody who actually agrees to termination of pregnancy and it's their right to do that. So also getting staff to participate in termination of pregnancy services, it has to be staff that do not have any objections. There are nursing staff that won't assist the doctors because they conscientiously object to participating in a TOP where you have to do a hysterotomy when all methods have failed and that's an emergency situation yet they still object. That's the reality. [Head of Obstetrics & Gynecology]

It was not clear as to how exactly health care providers were conscientiously

objecting to providing abortion care services. Few referred to how the process was formally documented, but rather to how refusal to provide services impacted on working conditions and service provision. A doctor in charge of abortion services, in response to how he had experienced conscientious objection, explained how the process worked at “his hospital” and how he had resigned himself to doing the procedures:

I used to fight with doctors about this, because there was nobody that wants to do the TOPs ... I got a letter from the Health Professionals' Council that doctors can't actually refuse to do TOPs when the patient has bled [referring to abortion related complications], so I sort of forced the doctors and I got a lot of resistance, because there was nobody else. I couldn't do all the TOPs, and I said listen here I'll prescribe the misoprostol, I'll counsel the patient, but if it becomes an emergency situation, then you must do it. I must say I've changed, but if we get busy again then maybe I will go back to forcing people to doing MVA's but at the moment ... I've just learnt to respect their feelings, if they don't want to get involved, I'll do it ... I am also afraid that if they don't want to do it they may take it out on the patient by being rude, because unfortunately that is what happens most of the time ... so I'm the only person who's willing to do the TOPs.

A senior district manager commented on problems associated with unwillingness of medical personnel to perform abortions, and offered some suggestions for the future:

Each hospital should take ownership, but the problem is that the personnel in the hospital, some of them are not willing to do terminations and that's a problem with the managers, because when they advertise the post that should be one of the job descriptions and it should be written into the key performance areas with the person that applies, but at the moment we cannot afford to do that because we don't get enough people to apply for the jobs, so we have to take whatever we can or whoever we can, but once we're in the position that there's more applicants for the post then we can appoint people that are specifically interested in doing termination of pregnancy as part of the care. Then each hospital can take ownership and they can manage their patient load.

It thus became evident that there were gray areas regarding staff refusing to participate in certain aspects of abortion provision, including administering cervical priming agents and assisting a patient in a possible medical emergency.

Provider experiences in the workplace

For most providers, whether pro-abortion or anti-abortion, working in abortion services was a contested domain where they had to negotiate multiple barriers to effective service provision. These barriers ranged from individual level barriers, such as feelings of isolation and stigma often leading to burn-out and low morale and structural barriers, such as overcrowded working conditions with limited infrastructure and space which impacted on quality of care.

Stigma and burn-out

Many providers discussed feelings of isolation or being stigmatized by colleagues in the work place. Some were able to overcome the animosity, whereas others found it stressful and demoralizing, often resulting in “burn-out” and leaving the services, as “they could not endure the comments or the attitudes of their colleagues”. A hospital manager described feelings of isolation experienced by some nurse providers:

They make it difficult for you. They spread the word in the community ... and also isolate you from themselves in the hospital environment, where you're supposed to be peers, and working hand in hand, and you can become extremely unhappy. And you'd often find midwives who would often not be practicing doing abortions because they fear the victimization, being stigmatized, being isolated from their peers.

A nurse provider related on a more personal level how she was able to counter stigma and pejorative name-calling:

Frequently, when going to the pharmacy to collect the misoprostol one of the doctors from another department would say to me: “Oh here comes the murderer”. It has not been easy, but I would say I take it from whence it comes, because that’s how they have been brought up and I said: “Sorry, but I do object and if you call me that again I will take further action because you do know that it’s against the law”. And that’s it, they’ve never done it again, the shouting and abuse.

Furthermore abortions were often performed in difficult to find, stigmatized spaces in some health care facilities, where providers who worked there were viewed as “murderers or baby killers performing the devil’s work”.

Working in a contested environment seemed to contribute to the impression that working in abortion services was transitory. One provider believed that her colleagues who had not been involved in abortion provision failed to understand her rationale for doing so, and they were of the opinion that those who involved themselves in abortion did so on a temporary basis.

Despite feelings of isolation and being ostracized by colleagues in the work environment, some providers mediated ways to deal with negative attitudes displayed towards them and abortion seekers. For them, professional responsibility to help somebody in need outweighed personal judgmental feelings towards women requesting abortions, yet this was not without its challenges. A midwife related how she had dealt with the conflicting issues it threw up for her in a professional and diplomatic manner. While she expressed some discomfort at possibly being branded by colleagues as “the one” providing abortions, she had to maintain her professionalism, in order to sustain a sense of control and order amongst staff working under her, as well as being motivated by her personal values:

And if I’m not strong enough, I don’t think that they will also cope with it ... we support each other, and I think it’s necessary, because people look at us and they say, ‘Now, you are working behind that brown door ... where that happens,’ Not all people know that we are not just involved with TOPs, but ... irrespective if we were ... I think each of us must be respected for what we

decide to be involved with. We are here for the patients not for ourselves ... it's the patient who has a problem and we have to help her, to be there for her, irrespective of what her choice was.

Quality of care

Discussions around current service provision suggested a tremendous concern around quality of care. Providers' concerns centered on problems associated with a general lack of adequate pre and post abortion counseling, punitive staff attitudes towards women, overcrowded, overburdened and fragmented services, and difficulties with staff recruitment and retention, as highlighted in the two narratives presented in this chapter.

A nursing manager commented on the treatment and experiences of women seeking abortions in other public health facilities, using the metaphor of a "cattle ranch" symbolizing disorder, and called into question standards of care at these facilities. She further alluded to ways to protect women's privacy and judgmental attitudes displayed by providers, by monitoring what was recorded in their medical folders:

*I've always said I do not want a cattle ranch, okay, everything is done nicely here at this facility not like some other facilities. You need to understand I will **not** put my name down on anything that's crap. I think you have to put the stamp, if you don't, and then once you've set that benchmark, then it's there to stay. So, if you set your benchmark slightly higher, then maybe if it does fall down then it won't be so bad ... Women have all the information before they get the TOP, they've still got the choice now to change their mind if they want to. We even tell them to please let me know so that I can take out the information that they came for an abortion, because sometimes they might come to have the baby, or they might come for antenatal care and then the nurses will read in her folder that she wanted an abortion, and they will say, "So you wanted to kill your baby, so what are you crying for", so we try and not record a request for an abortion if she changes her mind, I mean that's people for you.*

Unsympathetic and judgmental attitudes displayed towards women requesting an abortion as described above were recounted by other providers. A provider who had chosen not to provide abortion services on religious grounds was equally concerned about the quality of care, describing punitive attitudes of other staff members who were opposed to abortion as “it’s kind of like you [referring to women seeking an abortion] have got to suffer. You wanted to do this and you got yourself into this situation, now you must suffer as you brought it on yourself”. Displaying punitive attitudes towards patients, and morally and physically disciplining them through medical practice was to emerge in second trimester abortion provision. Some providers spoke about withholding pain medication so as to dissuade women from returning for another abortion, and will be discussed further in Chapter 8 which focuses on second trimester abortion.

Faced with a medical superintendent who refused to involve herself in any way in abortion services, a health care provider was very concerned about the impact this attitude would have on the service. She recounted an incident where the medical superintendent refused to prescribe Valium for a 14-year old client experiencing acute anxiety before an abortion. In this instance the client was referred to another doctor who prescribed the medication. However, the thought of facing similar situations in future was distressing, and in her estimation an unnecessary and highly unprofessional approach to what she considered should be a caring profession. This was another example of punishing patients through medical practices such as withholding pain medication, or in this case anti-anxiety medication.

In addition, negative attitudes towards women seeking abortions extended to all levels of staff, including those not directly involved in abortions, and views held by ancillary workers seemed to be influential in hampering the quality of service provision. As a nursing manager explained:

Everybody had a problem, the tea girls had a problem making tea for the TOP patients, and the radiographers had a problem doing sonar’s for TOPs ... They have moral problems, and so it goes and even the porters have problems assisting patients.

In relation to women's experiences of the services, a nurse provider suggested that there was "very little concern about what it means for women to go through this whole process, a woman **can** have an abortion, but there is no quality of care". Whilst on a clinical level the abortion procedure was being performed in safe, aseptic conditions by trained providers, there was little supportive care and counseling and recognition of women's general well-being.

Inadequate pre and post abortion counseling, including contraceptive counseling and initiation, was an overwhelming concern amongst all providers. This was further underscored by lack of time to provide comprehensive counseling, and a private space in which to counsel women. Crowded working conditions with limited space compromised visual and auditory privacy when providing counseling. The subtext in many providers' narratives was that good contraceptive counseling could prevent unplanned pregnancies and hence abortions.

A manager from an NGO providing reproductive health care services drew attention to the problems related to patient care in public sector facilities, underscored by the need for clear policy guidelines with respect to abortion provision. She further highlighted the disjuncture between policy and practice:

I think the way in which TOPs are done in the government clinics at the moment is really not working because it's not integrated with other services, it is completely overloaded and there's no privacy and it's just not a quality service and they really should be reviewed in its complete sense, to really look again at policies of implementation and to make sure that this Act is implemented the way it should be.

Space and location of services

Related to issues around quality of care and a difficult work environment was the need expressed by many providers for "special or dedicated abortion clinics", so as to create a more supportive environment for both clients and providers. Many saw this as a way of dealing with negative staff attitudes and with providers who refuse to be

involved in abortion care and provision. A provider explored the complexities of providing abortion care in a climate of resistance to abortion, stating that:

People who work in this area must be committed and passionate about it. I think if they will just be placed in an environment and said, you have to go and do this, it's not going to be the same as if they are recruited to go and work in this area ... It's a relatively new environment and something people must adjust to. It's a whole shift in their mindset. There are some people who never have a shift in mindset and we must come to terms with that.

A hospital superintendent recommended establishing a separate dedicated facility to manage stigma and opposition associated with abortion provision, thereby creating an empathetic environment for both providers and patients. In this situation he advocated for a separate stand-alone facility, whereas in other instances providers recommended locating services on the same premises but with dedicated staff:

Let me tell you my personal views. This hospital is not pro TOP and I think it would be better to have a separate facility, not attached to the hospital with separate staff and that it's off-site. I don't know if it sounds as if I want to move my responsibilities off on other people, even if we have to supply the staff, but it's just that the history of TOPs in this hospital is and was difficult. It was a long and a very difficult road. So, I don't know if that's the answer to have it off site, because it seems that if you've got a dedicated system with people prepared to work there, that you give the full support, the social worker support, the psychological support, it might be better.

As discussed, in many designated facilities abortions were performed in hidden stigmatized spaces and were not integrated into the daily life of the hospital. Yet interestingly, even in other facilities where abortion services were physically located in the Obstetrics and Gynecology wards they were still somehow isolated and stigmatized and not considered part of legitimate obstetrics and gynecology care, but remained on the periphery, despite occupying the same physical space.

Often on entering a public health care facility it was a challenge to locate the space or place where abortions were provided. I recall an occasion where I had scheduled an interview with a health care provider at a large secondary hospital. I noted on arrival that there was no signage to point me in the right direction, and after repeated enquiries I was directed to a far out of reach corner of the hospital, where there was a small room with approximately 25 women crowded into a small waiting area. Negotiating my way through this small crowded waiting area I finally located the provider who I had come to interview. On relating my difficulty in accessing her office, she pointed out that it was best not to directly ask where the abortion clinic was located, but rather to ask where reproductive health services were located, “as staff don’t like to direct people to the abortion section as they pretend we don’t exist”. At a later stage I was informed by other staff members that many health personnel working at this hospital had no idea that both first and second trimester abortions were being performed at this facility.

Individual commitments

Contrasted with all the difficulties experienced, such as opposition, feelings of isolation, and generally disorganized services due to resistance on the part of many providers, there were some providers who related more positive experiences in their work environment, and were committed to providing abortions. Some health care providers talked about the personal rewards they associated with their involvement in abortion services. For some, abortion provision provided them with the opportunity to help women through a controversial situation which was different to other medical practices, while providers who were ambivalent towards abortion adopted a public health approach viewing their involvement as helping to prevent the consequences of unsafe abortions, and recognizing the importance of reproductive autonomy.

Providers at all levels of provision noted that their satisfaction stemmed from their ability to assist women who were “in need”, and the public health importance of preventing unsafe abortions. A health care provider involved in the counseling and referral of women for abortions described the daily experience of helping women in need as both a rewarding and useful means of using her counseling skills. Another

provider, who particularly derived satisfaction from working with youth, suggested that:

If you can just give somebody some hope at the end of the day, just one person, you know, then you've done a good day's work ... and you have prevented these young women who might be afraid to inform their mothers that they are pregnant from going to a back street abortionist. I have seen the consequences of many septic abortions in my time as a result of backstreet abortions.

Other health care providers suggested that involvement in abortion service provision was a vocation requiring dedication and commitment. Providers described that those involved in service provision needed to be committed and passionate, and could not merely be recruited. A nurse provider emphasized:

I think that people must choose to be in that situation, because some people are very anti-abortion, and you can't force somebody that is totally anti-abortion to go and work with somebody that's having an abortion.

Contraceptive services

Inevitably in discussions around abortion provision, unplanned pregnancies attributed to failed or absent contraceptive use took center stage in providers' narratives. Preventing an unplanned pregnancy through contraceptive use became the mainstay of most reproductive health care professional's ideology and practice. Providers expressed an overwhelming desire to assist in preventing not only unplanned pregnancies but also "repeat abortions". The notion of "repeat abortions" will be further explored in Chapter 9, as providers' responses were heightened with second trimester abortions, and key to their frustrations and often negative attitudes towards women seeking later term abortions.

Discussion on contraception was couched in terms of failure – failure of the public health sector to provide effective services, and failure on the part of clients to use contraceptives and take full responsibility for preventing unwanted pregnancies. Often

this was followed by reference to women preferring abortion as a means of contraception. A common perception amongst providers was that improving family planning services within the public health sector was preferable to abortion. Yet, there were multiple barriers to this becoming a reality, including little or no contraceptive counseling, limited contraceptive choice, and disapproving attitudes particularly towards younger women. Post abortion counseling was difficult to initiate, as providers often had to talk to women “on the run”, or they were too rushed to provide comprehensive post abortion contraceptive counseling. Access to family planning services was not always possible due to restricted clinic opening times and location. Difficulties in accessing contraceptives were further illustrated by a nursing manager, who indicated that contraceptive methods were not available at one of the sites where abortions were performed:

Where I do get complaints from the Sister, is that because the clinic [where abortions are performed] is here, ... but the family planning is 200 meters away from there, ... and sometimes they finish late and then the family planning clinic is closed, now she's [the client] stayed out of work today, so now she must stay out of work tomorrow again, or maybe two, three days after that - that's ridiculous, so with the result they don't come for the family planning.

Many providers felt that women were not taking responsibility for preventing unplanned pregnancies, and felt it was preferable to improve contraceptive services rather than expand TOP services, as “women need to take more responsibility to use contraception”.

Being confronted with a young woman seeking an abortion, a provider struggled to come to terms with trying to reconcile her role as a professional faced with apparent carelessness with regards to contraception. Pre-conceived assumptions about responsible sexual behavior and fertility intentions are highlighted in her narrative:

I must say sometimes it's hurting because one has to deal with this abortion and it is really not nice but because it is our job, we have to do it and we are there to help them. We're not there to judge them, but at the same time, they could have prevented that. Okay, for some it's an accident, but some I don't really want to

say that they're doing it deliberately - yes, because there are contraceptives which could have prevented having a TOP, I mean they could have prevented it by using contraceptives which are available for free.

Some providers remarked that due to separate or vertical family planning services having been replaced by comprehensive health care, often staff became generalist nurses, and were not adequately trained in family planning counseling and delivery. This meant that:

Everybody gets injections and then you ... fall pregnant and then you get it again. So it is injection, injection, injection and then the message everywhere is condoms. So when you ask the young girls, "What do you use for contraception?" you know they use condoms, but if you ask them, "Do you use them all the time?" it's invariably no ... I would like to see ... nurses going to schools and talking about family planning at school level.

Providers suggested that staff, who otherwise would have remained in abortion services, were discouraged by what they perceived as women using abortion as a form of contraception. It was particularly difficult to understand why older women who already had children would return for another termination. However, while it was clear that a number of providers felt it was unacceptable that clients would use abortion as a contraceptive method, others saw the shortcomings in family planning services themselves, and the problems women encountered there, to be primarily responsible for non or poor contraceptive use. For instance, they felt that adequate counseling on contraception was largely lacking. A few providers also cautioned that it was important to reflect on women's social context and on providers' own approach as to whether or not they could do more to help. It didn't help to "jump to conclusions", when realistically a person may have found it difficult to access services or was lacking adequate information about family planning:

Because you don't know what the situation is ... you don't know what the religion or the culture is behind this. ... You can't just shout at them and say, you are using it as a contraceptive method ... I'm not going to treat the person

... even if it is the second or third time, more bad no, no, she deserves the same treatment.

The perceived normalization of abortion was difficult for many providers, especially when contraceptive services, despite their shortcomings, were available free of charge in public sector facilities. However those providers who were more supportive of a woman's right to choose did recognize difficulties with contraceptive use in relation to women's personal and social circumstances and health systems shortcomings.

Contraceptive failure

Contraceptive failure was discussed both regarding a woman's own contraception failing and getting pregnant as a result, and in the broader sense of failure of family planning services as a whole. With regards to the former, contraceptive failure was not considered a main reason for women having unwanted pregnancies and therefore seeking an abortion. Providers maintained that family planning methods worked, that the problem was that people did not use them properly or consistently. Where the major concern amongst respondents seemed to lie was the perceived demise of family planning clinics; limitations on choice of contraceptives, where promoting condoms only was seen as insufficient; and not taking into consideration clients' concerns about side effects. This included not dealing adequately with young women's beliefs that the pill made them gain weight or could impact on future fertility.

A nurse provider strongly believed that women would prefer to prevent an unwanted pregnancy rather than have an abortion, but this required counseling clients on a range of methods, and integration of contraceptive services, which together would mitigate the need for an abortion. Providers struggled to understand why women who experienced problems with contraceptives did not change their method to one that was more suitable to them rather than "just stopping to take them". An underlying perception seemed to be that it was easier to have an abortion than to resolve a contraceptive problem, as suggested by a nurse provider:

Women might often just feel well now if I am pregnant maybe I can just go to Hospital X and get a TOP. So you see it becomes just too easy.

In the context of very high rates of HIV/AIDS, large family size, and inability to meet the basic needs of most people, it was considered more important for providers to promote family planning than abortion. A few providers explored the underlying reasons why women avoided using contraceptives and resorted to abortion instead:

Some people don't believe in family planning and they will always rather suffer the TOP than having to use a contraceptive method where the mom will find out that she's on the method ... And people also believe that family planning is messing your woman's parts up and can cause infertility.

According to providers, misconceptions about the possible side-effects of contraceptives abounded, and to counteract this, counseling on correct use was imperative. According to some providers, fewer women would fall pregnant if family planning methods were properly explained to them, and more effort was made to assist women who wanted to change methods. Furthermore, not only was contraceptive choice limited, but providers were not trained in providing a range of methods, including more long acting permanent methods such as the intrauterine device (IUD):

We try and get them to use loops [IUD], but they won't put the loops in at the clinic, they said they don't know how to insert them. The loops these days can stay in for 10 years ... One patient wanted one and I said to go to the clinic and then the clinic phoned me, 'Could I, or would we put it in?' I said 'Why?', no they don't know how to. I thought, well find out, you know.

Emergency contraception

Related to poor or inconsistent contraceptive use and limited choice, emergency contraception (EC) was considered an important additional method to prevent an unplanned pregnancy. However some providers were concerned that if one promoted

EC women would use them as a contraceptive method. Many who supported promotion and use of EC tended to feel more comfortable providing EC than providing or referring for an abortion: A nurse provider viewed EC as a further way of preventing unplanned pregnancies, and hence the need to seek an abortion. For her EC could replace the need for abortion:

Yes, I think emergency contraception is a very good thing, it must be available each and every where like condoms ... If people are so open to have a second and a third one [abortion], why not educate and boost the emergency contraceptives, it's much better. I would rather give that [emergency contraception] you see, because you prevent that pregnancy, so I'm okay with that ... I'd rather prevent that than to let them get pregnant and come for a TOP. So I'm for EC. It will cancel all the other hassles that you sit with, with TOPs.

This was in contrast to a health care provider who thought there was a fear amongst providers that if they promoted the use of EC, women would either use contraceptives inconsistently, or stop using other more longer term contraceptive methods such as the injectable contraceptive:

I've heard service providers say, well if we tell them about it, then they won't use the other methods like the injectable ... and so if they know that they've got an escape route on occasions when are not using contraception, then they're less likely to use the methods effectively, and I think that is the sort of thought process that makes them say well we'll keep it [EC] under the table instead of on top of the table.

There were also suggestions that stigma was attached to EC, because some providers believed that EC worked as an abortifacient. A nurse provider speculated as to why EC was not being promoted in many health care facilities:

The reason why emergency contraception hasn't taken off is that are some older nurses who believe that EC causes an abortion. They don't really understand how it works and that it doesn't cause an abortion like the medical abortion pill, because attitudes and misinformation are hard to change.

A complex picture around contraceptive services, use and practices emerged, and for most providers seeking an abortion was viewed as a direct result of failed or non contraceptive use by women. For them responsible and effective contraceptive use could ultimately reduce or eliminate the need for induced abortions.

Conclusions and discussion

This chapter set out to explore health care providers' experiences within the health systems environment, and the ways in which the health system context and institutional environment impacted on abortion service provision.

Medical institutions are traditionally characterized by structure and routine, and governed by protocols for different medical interventions and practices, yet this was not apparent in many of the health care facilities (Goffman, 1961). Rather, an unregulated and often ad hoc state of abortion provision existed, driven by a small group of dedicated individuals who were further supported by a roving team of abortion providers, which has long term implications for sustaining services (Alblas, 2008; Cox, 2005).

Providers' reluctance and refusal to be involved in different aspects of abortion provision led to complex and fragmented levels of service provision throughout many of the public sector health care facilities. Related to this was the need expressed by many providers for "special or dedicated abortion clinics", where providers felt committed to what they were doing, thus creating a more supportive environment for both women seeking abortions and those providing the services. Whilst not physically separate from other services, many abortion providers were in effect already operating in an independent stand-alone fashion.

In other settings, where freestanding clinics remain the dominant form of abortion delivery, concerns have been raised that creating stand-alone clinics can further isolate abortion providers from mainstream medicine and make them vulnerable to anti-abortion activities (Joffe & Weitz, 2003; Sheriff, 2009). Within the South African

context, establishing separate clinics could be perceived to be contrary to the current approach by the Department of Health of providing integrated reproductive healthcare services. However, benefits of separate clinics could include specialized dedicated staff and an environment conducive to all. Stand-alone NGO clinics providing abortions in South Africa have not thus far been subject to violent attack or harassment, suggesting that free-standing abortion clinics in South Africa would be less vulnerable to anti-abortion violence than has been reported elsewhere.

Quality of care in public sector health services is not an unexpected issue to emerge, and has been reported elsewhere in South Africa within the context of reproductive health services more generally, including in obstetric and maternal health services (Jewkes, Abrahams & Mvo, 1998; Jewkes et al., 2005; Wood & Jewkes, 2006). This situation underscores the need to destigmatize the issues around abortion, for clients and providers alike.

While an overburdened and overstretched work environment with limited resources is not necessarily peculiar to abortion and reproductive health services in the South African public health sector, what was different was provider resistance and refusal to participate in abortion services, and feelings of isolation experienced by those who were willing to provide abortion services.

Institutional and structural problems, including staff unwillingness to participate in abortion services or assist those providing services, have parallels elsewhere. Kade et al., 2004, in a study amongst nurses in Massachusetts, found that unwillingness to assist physicians providing abortions both hindered and delayed patient access to services, and resulted in a few dedicated providers being responsible for overall abortion provision. Providers were similarly constrained by the overall culture and environment surrounding abortion within health care facilities (Kade et al., 2004).

Metaphors of services being reminiscent of a “cattle ranch” or the “Wild West” (see Chapter 8) would suggest a cowboy-type of ad hoc delivering of medical care that departs from accepted medical practices. Although this did relate to the general state of abortion services such as long waiting times, poor infrastructure, inadequate pre

and post abortion counseling and generally overburdened services, it was also suggestive of a lack of clear protocols or guidance with regards to management of the services, ranging from cervical priming protocols to the manner in which conscientious objection or refusal to provide abortion services was enacted. Notwithstanding these difficulties, abortions were being provided in a clinically safe environment and by technically competent providers, with few reported serious complications (Smit et al., 2009; Warriner et al., 2006).

A poor understanding and implementation of conscientious objection was present throughout all study sites, and has been reported elsewhere in South Africa (Engelbrecht, 2005; Ngwena, 2003; Varkey, 2000). More recently, in October 2009, this was confirmed in a health service audit of designated public sector abortion facilities in the Western Cape. This audit was initiated by the Women's Health Sub-Directorate in the Provincial Department of Health, in response to complaints from staff about unmanageable workloads with increasing numbers of abortion clients, referral pathways not being followed, quality of care issues, and problems with conscientious objection (Personal communication Dr. Jennifer Moodley, June, 2010). Conscientious objection was an area identified where policy guidelines and protocols were not being followed, and recommendations were made to develop guidelines for the correct management of conscientious objection (Dearham et al., 2009).

Conscientious objection or refusal to participate in abortion services had the most significant impact on service provision. Not only was it unmanaged and unregulated, but it was often poorly understood and implemented. Developing clear guidelines could greatly assist in managing conscientious objection within medical and nursing educational institutions and in the work place. Delineating the obligations that come with conscientious objection is deemed important for overall patient care, and in respect of the cumulative impact on others in the health team when granting conscience-based exemptions (Wicclair, 2010). A clear and well communicated conscientious objection policy can facilitate informed choices and consistency, and minimize contention and disagreement due to ambiguity, confusion, and unrealistic expectations (Wicclair, 2010). Invoking one's right to conscientious objection opportunistically or as a means to avoid extra work, as stated earlier in this chapter by

a senior manager, has been reported elsewhere, making it even more important to have clear guidelines with regards to conscientious objection (Lazarus, 1997).

Although the right to conscientious objection is a basic human right, the case of refusal to provide abortion services on conscientious objection grounds should not be seen as absolute, especially in developing country contexts where referrals or access to another facility might be fraught with major obstacles, and could ultimately impact on patient care (Ngwena, 2003; van Bogaert, 2002).

Abortion training broke new ground for midwives in South Africa and around the world by providing an innovative model for expanding midwives' scope of practice to include abortion care services (Dickson-Tetteh & Billings, 2002, p. 149). Despite the establishment of the Midwifery Abortion Care Training program, no attempts have been made by tertiary institutions in the Western Cape to implement formal abortion care training for medical and nursing professionals (Smit et al., 2009). This was attributed to amongst others, a lack of interest amongst nurses in abortion training, a shortage of trainers and lecturers, and abortion training not being part of SANC regulations and directives (Smit et al., 2009).

Difficulties in accessing training might not be peculiar to abortion training per se, as poor planning, staff shortages and limited support from management are all issues and challenges that emerge with regards to training opportunities in the public health sector. Notwithstanding this, specific challenges to abortion providers were possible stigma associated with undergoing abortion training, along with difficulty in providing the services often with little support from managers or colleagues.

Boyle (1997) raises some interesting points with regards to contraception and abortion. When a woman requests an abortion she is indirectly saying something about contraception, that it was not used, that it was used inefficiently, or that the method failed, and in that sense the relationship between contraception and abortion is obvious (Boyle, 1997, p. 82). However, what is often overlooked is trying to establish contraceptive use before an abortion, as women often feel uncomfortable or judged, especially in the light of comments that women are negligent about contraception or use abortion as a form of contraception. This reticence to report accurately on

contraceptive use suggests that many figures for contraceptive use prior to abortion are likely to be underestimates. Furthermore, there has been little attempt to uncover why women, in settings where contraceptive services are not restricted in terms of access or cost, do not use contraceptives. Research has tended to focus on post abortion contraceptive counseling and initiation, and ways to avoid repeat abortions.

Concerns around repeat abortions have been reported in other research settings. However these studies focused on identifying risk factors to repeat abortions, and looked at ways of improving pre and post abortion counseling, including increasing post abortion contraceptive use with a focus on immediate contraceptive initiation, as well as more longer acting methods such as the IUD or injectable contraceptive (Collier, 2009; Heikinheimo, Gissler & Suhonen, 2008; Madden & Westhoff, 2009; Prager, Steinauer, Foster, Darney & Drey, 2007).

Contraceptive counseling, including post abortion contraceptive counseling and initiation, needs to be strengthened and integrated into post abortion care. Examples from other developing country settings, albeit in situations where abortions are restricted, have suggested that comprehensive post abortion contraceptive counseling and method choice increases post abortion contraceptive adherence. Women are likely to accept and use contraception when the service is offered as an integrated part of post abortion care (Billings, Crane, Benson, Solo & Fetters, 2007; Ceylan et al., 2009; Rasch et al., 2008).

While most providers were familiar with South Africa's CTOP Act and the conditions under which a woman can request an abortion, very few engaged with the complexities and difficulties in decision making surrounding an unplanned pregnancy, and the complex reasons why women seek an abortion. Unplanned pregnancies were largely attributed to failed contraception or irresponsible sexual behavior, yet sexual violence and non-consensual sex were rarely mentioned as possible causes of unplanned pregnancies. This is surprising given the high levels of gender-based violence in South Africa (Dunkle et al., 2004; Jewkes & Abrahams, 2002).

Opportunities for values clarification training, designed to promote more tolerant attitudes by service providers, should be expanded and extended to health care

providers working within all spheres of reproductive health care. Work undertaken by international NGOs and partners in the years after the implementation of the CTOP Act around values clarification should be continued and sustained. Such interventions have played an important role in improving the quality and continuity of care, as well as the long term health outcomes of women seeking an abortion (Mitchell et al., 2005; Turner & Chapman, 2008; Turner et al., 2008).

Boundary making and differing levels or thresholds of care was a thread to emerge throughout the study, and as discussed previously in Chapter 6, included personal boundaries such as gestational age limits, degree of involvement in different aspects of abortion provision, blurred boundaries between home (private space) and work (institutional space), to be discussed in Chapter 9, and between personal beliefs and professional practice.

CHAPTER 8: SECOND TRIMESTER ABORTION SERVICES

Introduction

This chapter will focus on second trimester abortion services, as this emerged as a major concern for health care providers, and was possibly the most contentious aspect of abortion provision. There was a noticeable shift in how providers thought about second trimester abortions as distinct from first trimester abortions. Furthermore, a dearth of trained and/or willing abortion providers was most prominent with respect to second trimester abortion provision, and this chapter will explore reasons why second trimester abortions were so contested. Returning to my central research question, these findings are framed by exploring the factors that influence or impact on decision making around second trimester abortion provision.

Key themes emerging from perceptions and insights expressed by providers illustrate the complexity of second trimester abortions, and included: i) gestational age as an important signifier in terms of decisions around abortion provision; ii) physical and iii) emotional responses to an aborted fetus; iv) second trimester abortion methods and their differing impact on providers; v) health systems related barriers; and vi) perceptions of why women delay seeking an abortion until the second trimester of pregnancy. Many of the issues explored in these themes overlap and are interlinked but will be discussed sequentially. However, an overarching concern and issue to emerge in most responses to second trimester abortion provision was providers' responses to an aborted more developed fetus inherent to second trimester abortions.

Gestational age

Gestational age was a key indicator of acceptability, and providers mentioned that they found it more traumatic to deal with a termination performed around 17-20 weeks, than a termination at 12 weeks, because with the latter, one was dealing with

an “embryonic sac or blood clot” rather than a “formed fetus”. Providers drew distinctions between early and later fetal development, ascribing more personhood and resemblance to an infant as the pregnancy progressed.

A nurse provider described the physiological distinctions between early and later fetal development, whereby the abortion process was made more real and hence more troubling with increasing gestational age:

With first trimesters it is not so difficult or real as the terminated pregnancy is more like a small blood clot or tissue but now with second trimesters, there are all these fetal parts ... they have a human shape, something that we recognize and that suddenly makes it an awful lot more real.

However in contrast, for some providers gestational age was not a key indicator of acceptability. They were opposed to abortion irrespective of gestational age and thus made no distinction between first and second trimester abortions. A nurse provider explained her position:

The end product of an unwanted pregnancy is a baby, regardless of gestational age, because abortion is abortion, whether it is at 1 week or at 19 weeks gestation.

Concerns and discomfort around increasing gestational age were also reported to extend to some designated abortion facilities, where providers and managers set their own gestational age limit by not providing second trimester abortions to women beyond 18 weeks, even though by law the gestational age limit is 20 weeks. A nurse provider described the situation at her place of work:

The doctors are only prepared to provide up to 18 weeks gestation, they are just not comfortable after 18 weeks. There is little commitment from doctors within the public sector to provide second trimester services, so it is easy for doctors and hospital managers to make these decisions but it just means these women have to be referred elsewhere and that increases the burden at the next facility.

Regarding gestational age restrictions present at some facilities, as discussed above, a second trimester abortion provider recounted the subsequent difficulties she faced, and explored the complexities associated with advancing gestational age pregnancies, especially when pregnancies were possibly over 20 weeks, the legal limit for second trimester abortions. Faced with a legal and ethical dilemma of when to exceed the gestational age limit, her decisions were often informed by women's personal and socio-economic circumstances. She likened this to a form of "playing God":

Well we don't do after 19 weeks gestation at this facility ... This woman was already 20 weeks and then I did the D&E procedure. Then the next patient was also 20 weeks, I even measured 20 and a half, but she was so desperate she told me she had three children already and it looked like this pregnancy might have been twins and in the end I couldn't see it very accurately and so, I just thought let me do it. But that I find difficult sometimes because then I've sent the one before home and she was also that far and I had said no it is not possible anymore, and in this case, I have decided I will do it. How does one decide? A person at the hospital one time accused me, and said that I'm playing for God, then I get the feeling maybe I am playing for God.

Physical responses

This next section will highlight the visual and visceral dimensions of second trimester abortions, and the concomitant personal and psychological impact on second trimester abortion providers.

Providers' embodied experience of later term abortions, shaped by the visual encounter with a more developed fetus, was a focal point in discourse around second trimester abortions. Decisions around at what stage to provide or abstain from providing care were not only linked to notions around conception and the sanctity of life, as previously discussed, but also related to the embodied experience of seeing and physically engaging with a more identifiable fetus.

A nurse provider, in relation to second trimester abortion experiences, recounted how she was adversely affected when a woman prematurely aborted an intact fetus prior to the doctor arriving at the facility:

I must say that it is especially difficult when it comes out in total, like last week I was assisting with one that was at 20 weeks. The doctor hadn't arrived yet and while I was assisting the woman onto the table I saw that it was coming out already, so I told her, push, push, and pop, the water comes out and the fetus is still hanging on the umbilical cord and it's moving, I must say, that is very difficult to have to see that to see a formed fetus and it subsequently took a long time for me to recover from seeing that.

Related to physical responses to viewing an aborted fetus providers similarly related to the psychological and emotional impact of viewing and dealing with a more formed fetus inherent in second trimester abortion provision. Physical and emotional responses were integrally linked, and providers developed various coping mechanisms to deal with these responses.

Emotional responses

Providers who performed second trimester abortions acknowledged that the work could be emotionally challenging, and employed coping mechanisms to deal with the day to day impact on their personal well-being. A second trimester abortion provider reflected on how she had reconciled the initial unease of being confronted with fetal body parts by reminding herself of the public health importance of providing the service to women:

In the beginning it was strange and it takes a while getting used to. I still remember an incident, this occurred after I had done several abortions. I recall I was eating chicken and the chicken had all these bones and then I somehow just made a connection, I don't know, I didn't really have big problems with it because I've trained doctors to do surgical second trimester abortions and I

must say some of them had much bigger problems than I ever had. But still it's not a nice thing to see.

You know after a while I could really look at it, and think about what this is. It's a miracle really, you see those little lungs and see the kidneys and you can see the trachea and that's beautiful, you can also look at it like that, and that's what I did. Yes, it is a difficult procedure and we're really drained emotionally and physically, we're tired at the end of the day but it is a procedure we need to provide for women.

A nurse provider described her experiences of dealing with women who aborted medically with second trimester pregnancies as frightening and emotionally draining:

Because this little thing is breathing ... it's just emotional ... and then you've got to walk back into the Day Ward and pretend like nothing has happened. In the meantime, you are thinking a little life is sitting in the bin. Your mind can't stop thinking about that.

Dealing with bodily fluids and products is part of general medical practice, however in the case of abortions, and especially second trimester abortions, providers actively sought ways to remove themselves from the abortion process. For example, some providers restricted their practice to less invasive measures, such as preparing surgical trays, monitoring the patients' vital signs, administering medications, and providing pre and post abortion counseling. A senior hospital manager who was responsible for second trimester services at a district level explored the precarious shifting nature of second trimester abortion provision in his health district:

The nursing staff have a problem physically being in the theatre (operating room) and having to sort out products afterwards, because they don't like it, so we try just to get them to talk to the patient and other routine activities such as preparing surgical instruments and the doctor does the rest. I think the moment you start doing things that they're not happy with, then the whole thing might collapse and we will have no service.

Second trimester abortion methods

Related to physical and associated emotional responses to dealing with an aborted fetus were providers' interactions and views towards the two different abortion methods employed at public sector health facilities. Providers' perceptions around the two different second trimester abortion methods, namely D&E, a surgical procedure, and medical induction using misoprostol alone, were explored to assess whether providers felt differently about the two methods, and whether it would impact on their decisions around abortion provision.

A brief description of D&E and medical induction is presented to provide context to providers' discussions and concerns, and highlights the issues as they related to the two abortion techniques in relation providers' involvement in the process (see below).

| Dilatation and evacuation (D&E) | Medical abortion |
|--------------------------------------------|----------------------------------|
| Surgical procedure | Medical procedure |
| Outpatient procedure | Hospital admission |
| 15-20 minutes duration | 1-3 days hospital admission |
| More active provider involvement | Less active provider involvement |

Dilatation and evacuation (D&E) is a staged surgical procedure, first requiring cervical priming with misoprostol taken at home, and then followed by removal of fetal and placental tissue using grasping forceps. The procedure usually is of 15-20 minute's duration, and performed on an outpatient basis by a doctor trained in the D&E procedure. Whereas, for medical induction using misoprostol alone, repeated doses of misoprostol are administered at six hourly intervals until the fetus is expelled. This process requires a hospital admission of more than 24 hours, and in some cases up to three days (Grossman, Blanchard & Blumenthal, 2008). Provider involvement is restricted to administering the misoprostol tablets and ensuring that the

woman has aborted the products of conception. With the D&E method the fetus is removed in stages whereas, with the medical abortion method the fetus is expelled after administration of repeated doses of misoprostol which induces labor. In South Africa within the public health sector misoprostol alone is the standard regimen for second trimester medical abortion.

In relation to duration of the abortion process and provider involvement, D&E is a shorter procedure compared to medical induction, but requires active provider involvement with the abortion process, while medical induction which is a longer process requires less direct provider involvement in the abortion process.

As had been noted by Weitz and Yanow (2008, p. 100), with all abortion techniques broad classifications do not reflect distinct categories, as multiple techniques may be used in the performance of an individual abortion. For example, medication may be used to initiate the abortion but, if it is not completed in a certain time frame, instrumentation may be used to remove unexpelled tissue.

In response to different abortion techniques, providers exhibited a range of responses regarding the two abortion methods, and included their views around the different methods and ways in which they dealt with the physical and emotional dimensions of second trimester abortion provision.

Referring to second trimester abortions and differing abortion techniques, a midwife suggested that dealing with an intact fetus inherent in a medical abortion was less traumatic than dealing with dispersed fetal parts inherent in the D&E procedure. She recounted how she had managed her discomfort and unease by blocking out her emotions, and for her the medical procedure was more tenable for managing her distress:

What I will say is for me, I would prefer the medical abortion more than the surgical method. If you think about your second trimesters, of what product is taken out when you do a surgical abortion and if you don't block your mind when one is doing those surgical abortions, then I think one can go insane. Because if you think of how a person develops and you see that child coming out

you have to be very hard not to see it. Because for me, that is where I get a little bit, I'm not mad about it, or I won't say I will go insane, but what I'm saying is that I don't like that part. Where you have to see the product that's taken out, you see a little hand or another body part - you see the whole fetus, whereas the fetus is expelled wholly when you do a medical abortion. So that is for me better to handle emotionally than having to see the products that are taken out.

The following narrative of a hospital manager responsible for abortion services in a peri-urban hospital outside of Cape Town highlights the complex issues of providing second trimester abortion services, as well as many of the issues discussed in this chapter. Opposition to abortion, underscored by exposure to the aborted fetus, was central to the doctor's reluctance to support services. His account of abortion provision at this hospital features prominently the distinction between first and second trimester abortion, notably difficulties associated with the D&E procedure:

Second trimester services are not being provided here at this hospital. A roving doctor is providing the D&E procedure, as most of the staff including senior medical staff do not want to get involved with the D&E procedure. They're fine with the medical induction at the moment and with the first trimester MVA procedures, but the D&E procedure they don't want to get involved with. I think the reason is because they see the fetus and they see the products and they don't want to get involved with that because they can see what they are doing. The staff that I'm working with now, with the first trimester TOPs, they are okay with the procedure because they only see blood, they don't see fetal parts, once or twice they saw the products and they were very uncomfortable with that. So I think it's mainly with the products that they see so I think it's more the idea of seeing the human parts.

Concerns were also raised by some doctors about the more complex surgical procedure related to the D&E method with reported medical complications. A hospital manager reported on experiences with complications due to D&E procedures:

Unfortunately my medical staff, including medical specialists such as gynecologists, are against the D&E procedure. We had a few difficult surgical

ones and that unfortunately created some negativity around the second trimester TOPs.

Similar sentiments were echoed by a doctor at a tertiary hospital providing medical abortion, who after a lengthy discussion about different abortion techniques, intimated that they were not prepared to provide D&E services, even though they recognized their current difficulties in respect of bed space and duration of hospitalization associated with medical abortion. He spoke candidly about his discomfort with the D&E procedure:

I don't think that D&Es are appropriate for this facility as we don't want to have the wrong aura and be associated with D&Es or be seen as that place that does second trimester TOPs via the D&E method. I don't think it is a very safe method as we have had one or two bad experiences with D&E procedures so I don't foresee D&Es being introduced here as we do not want to get a bad reputation.

This was further compounded by medical staff not being prepared to provide medical support should complications occur while they were not on duty:

Personally I would prefer the medical route, the reasons being not only my personal opinion, but thinking of the backup system if complications occur and a doctor is required, it's difficult. I've got to contract a specialist in town to be the back up for the second trimester patients, my own gynecologists don't approve, so they don't provide back up. They will give medical back up for the first trimester complications even though they are very few. But for the surgical second trimester, they do not support it and they do not give back up so I've got to get a local gynecologist and that makes it very, very difficult. Again the full time gynecologists here will not assist. I've spoken to them previously about it and the head of the department is very, very outspoken against TOPs, so unfortunately the whole Obstetrics and Gynecology Department takes their lead from the Head of the Department and will not get involved in second trimester services.

The above vignette captures the tremendous resistance to second trimester abortion provision and senior medical staff's ability to unilaterally decide to not provide abortion services. No formal or documented conscientious objection had been registered, and lack of clear policy guidelines resulted in the services being supported and driven by a small cadre of dedicated providers.

Health service barriers

In this section health service related barriers pertinent to second trimester abortion provision will be discussed, as they were distinct from overall abortion service provision on several levels. Health service barriers to second trimester abortion provision related to barriers within the health care system and were also related to the woman seeking an abortion. Second trimester abortion procedures are medically more difficult to perform, are stigmatized, and are largely provided by doctors located outside of the public health system.

Infrastructural barriers

Providers alluded to numerous difficulties associated with the provision of second trimester abortion services. These included problems with an increasing demand for services and a concomitant lack of infrastructure, physical space and health personnel to respond to these demands. Staffing the service seemed to be the biggest challenge at all of the facilities, with a roving team of doctors providing the service as previously discussed. As a result, they acknowledged that levels of service provision were often fragmented and quality of care was compromised. A doctor illustrated the extent to which medical care was compromised while paradoxically stating that they were doing a "fantastic job": The general sentiment was that in the face of large numbers and demand, providers rendered the service with little consideration of overall quality of care:

I think we're doing a fantastic job, but unfortunately, it's a bit of Wild West every now and then. I think there are far too many patients, ... and they're all

sitting in one room and the Sister that's doing the first trimesters can't look after the second trimesters, so they all sit there bleeding with fetuses between their legs and I think it's terrible ... there's never blood pressure taken ... every now and then somebody almost bleeds to death and nobody has noticed and it's bad, it's terrible and there's of course no privacy, there's nothing, it's awful. It can improve a lot.

When asked to comment on women's experience of the service, providers asserted that women were grateful, and relieved to be able to obtain an abortion regardless of the type of care received. This is illustrated by a service manager at a facility providing D&E services:

Well, probably my perception will be, most feel grateful that they have finally accessed the service, to the point where they have actually not complained too much about the overcrowding, because they want the service and they realize this is the only place where they can get it. Imagine somebody who travels a long distance to come here and then they find it's a bit crowded, but they automatically get the service. The overcrowding is a big issue, we would do it better if we had the space, but most of the clients walk away happy that they have got the service.

Providers were faced with a conundrum in that on the one hand there was a distinct need for the service, yet due to staff shortages and resistance they provided a less than optimal service.

Stigma

The contentious nature of abortion provision resulted in many providers being stigmatized in their workplace, as discussed in Chapter 7. However, stigma was often heightened with second trimester abortion services. A nurse provider commented on her "exaggerated experience" of stigma in relation to second trimester abortion provision:

Now with second trimester abortions it becomes worse and other professionals call you “murderers and baby killers” and you get known as someone who is involved in that type of abortion. Somehow it is just much more exaggerated with second trimester abortions and somehow first trimesters are not such a big issue.

Furthermore, abortion services occupied not only a stigmatized but also a hidden, difficult to access space, where providers who worked there were viewed as performing the “devil’s work.” This was illustrated by a nursing manager’s comments, referring to lack of signage indicating where second trimester abortion services were located:

I would have liked it [the second trimester abortion services] more in the open. I actually asked them also for the signage ... I wanted a sign that says, this way is TOP but that wasn’t really met very well, so as a result we still don’t have a sign. When somebody comes here for assistance regarding TOP, it’s a nightmare, because how do you ask somebody, you know, knowing that maybe this person knows your family or knows you, you don’t know who you’re speaking to.

Another hospital manager recounted how a sign with an obtuse complicated acronym for gynecological services signified where abortion services were located, and despite repeated requests had not been successful in obtaining clearer signage. This focus on the lack of signage has symbolic significance. Abortion services are located on the margins of health care, both regarding physical location in facilities and the moral and ideological discourse surrounding second trimester abortion. Whilst most public health facilities had no clear signage indicating where abortion services were located, it was most evident with regards to second trimester abortions where opposition and stigma was heightened.

Perceptions why women delay seeking an abortion

Providers were asked why they thought women accessed abortion services in their second trimester, so as to explore how this would impact on attitudes towards abortion provision. Some providers focused on health systems limitations, whereas others held women responsible for late presentation, largely attributed to poor contraceptive uptake and usage.

Health systems limitations

Health systems limitations included cumbersome booking systems, too few facilities to accommodate large patient numbers, and a shortage of willing, trained providers, which resulted in restrictions on the number of second trimester abortions performed per week in designated second trimester abortion facilities. These delays meant that some women presented at a facility in their first trimester, but due to the facility's limited capacity, they were not able to obtain an abortion until the second trimester. A hospital manager elaborated on the situation in the public sector and explained how delays were often attributed to health systems failures:

The late presentations are either because of the cumbersome booking systems where somebody who is first trimester, phones a clinic to book to be seen and then they are put in a book, they are given an appointment date, and depending on how long that appointment date is - some women would have phoned when they were one month, two months' pregnant, and then they get given an appointment in the next six weeks. So that pushes them from a simple first trimester which was going to be done very easily into the second trimester because of the booking systems ... the other reason which is still connected to the booking system is that there seems not to be enough of these clinics that provide services.

Some providers found it difficult to speculate as to why women delayed seeking an abortion; however many blamed women and their personal circumstances for their late presentation. Their opinions were that women were often scared, in denial and

uncertain as to whether to continue with the pregnancy. These comments were often expressed in such a way as to imply that women presented in the second trimester due to negligence or broader social reasons. As a nurse recounted:

There's actually not a reason for a woman to become a second trimester, because the service is available. I think they haven't got the responsibility and also, when you ask them - why did you wait so long - they haven't got an answer ... some of the young girls will tell you - 'I didn't think it will happen to me' ... I think many of them are afraid of their mothers and they postpone it every month, and then they become a second trimester.

The manifold reasons why women delay seeking an abortion were summed up by an obstetrician / gynecologist:

I think there are various reasons; I think it's indecision about whether they want to have a termination Maybe it also has something to do with access to contraceptive services, the general knowledge of education that the patients have - and for those when they come to access the service, the service can only accommodate so many at a given time, in fact they spill over into the second trimester. So I think it's multifactorial why patients come in the second trimester.

Contraception

The possibility that women were using abortion as a contraceptive method appeared to be a major concern for second trimester providers, underscored by perceptions that abortion was often a substitute for responsible family planning. The notion of “repeat abortions”, as previously discussed, was further intensified and key to providers’ frustrations and often negative attitudes towards women seeking later term abortions. This intensified reaction to “repeat abortions” was possibly linked to biomedical reasons, second trimester abortion provision as a more complex procedure requiring more physician involvement, underscored by institutional based shortcomings including a scarcity of second trimester abortion providers. Women returning more

than once not only heightened the failures within the health care services but also suggested women were normalizing abortion or viewing it as an accepted contraceptive practice, and at variance with an already fragile health care system.

Providers' responses to preventing repeat abortions included focusing on more permanent or long acting contraceptive methods and restricting pain medication during the abortion procedure. By way of illustration, a senior medical superintendent expressed an underlying discomfort with abortion, particularly second trimester procedures, suggesting an aggressive promotion of family planning, including more permanent methods such as female sterilization, as a feasible alternative:

My other concern with the second trimester TOPs is that I think a lot of them are repeat people coming in ... and it's a problem, I think that's not my idea of the TOP, it's not a family planning method, and it's something else. So I feel that there should be aggressive programs to look at family planning and other methods like sterilizations and that type of thing, rather than just going for a TOP. I'm not comfortable with second trimester TOPs.

Punitive attitudes toward women seeking an abortion were reflected in the medical management of pain control. Some providers raised concerns that, if they provided a "nice" abortion or alleviated pain during the abortion procedure, women might return for another or "repeat" abortion. It appeared as if some providers deliberately withheld pain medication so as to make the abortion experience painful akin to the birthing process. A nurse provided her reasoning with regards to monitoring pain control:

Once they are finished with the procedure they will say I will never come again. But you will find, some of them they come for the second or for the third time, so once you feel the pain, it's like when you give birth it's like I will never fall pregnant again, then you fall pregnant. But with them, some of them they come for the second, for the third time. So maybe if we improve the situation and they feel no pain they might not return. Some are really sincere that they will never come again, and they don't come. So then if we're going to maybe change this and make it pain free they will still keep returning. Those who fall pregnant for

the first time they will say, even if I fall pregnant again then I will come for the second time because I feel no pain, it's too easy, you see.

Conclusions and discussion

Second trimester abortions emerged as a major concern for most health care providers in this study, and was possibly the most contentious aspect of abortion provision. Providers exhibited an emotional and qualitative shift in their approach to second trimester abortions as distinct from first trimester abortions. This was particularly heightened in their embodied and emotional responses to a more developed fetus associated with advanced gestational age.

Discomfort and difficulties with second trimester abortion provision included moral and ethical conflicts with a more advanced pregnancy, in which gestational age became a key indicator of acceptability. Providers also grappled with the personal and psychological aspects of second trimester abortion provision underscored by the visual and visceral dimensions of second trimester abortions. Second trimester abortion methods and their differing impact on providers were further explored and included health systems related barriers. In addition their perceptions of why women delayed seeking an abortion until the second trimester of pregnancy were elicited, and were perceived in part as related to health systems shortcomings and partly attributed to women's individual behavior. Resistance to providing second trimester services was integrally linked to these difficulties and discomforts, resulting in the second trimester abortion services being largely run by a dedicated cadre of abortion providers employed outside of the public health system.

Gestational age as a key indicator of acceptability has been reported in the USA and United Kingdom, suggesting that providers' attitudes towards abortion changed depending on the length of the woman's gestation (Marek, 2004; Marshall et al., 1994). However these studies did not discuss in depth nurses' reasons for these responses or their relationship with the fetus in advanced gestational age pregnancies.

Central to providers' discourse around second trimester abortion was their relationship with the fetus and the particular abortion technique to initiate and complete the abortion process. Along this continuum of care, providers' roles and responsibilities were framed by their ability to engage on both a physical and emotional level with the abortion process.

Providers struggled with the visual and corporeal effects of witnessing, examining or removing an aborted fetus or fetal parts. This was particularly the case with the D&E method, and providers devised varying coping mechanisms to deal with these disturbing experiences in their professional practices. This was typified by differing levels of care, and related to their physical proximity to the client and contact with an aborted fetus.

Feminist scholars have written about the increasing public interest in fetuses, in part as a result of effective anti-abortion discourse, and in part as a result of developments in medicine and technology, notably prenatal ultrasound screening with the ability to visualize the fetus (Morgan & Michaels, 1999; Taylor, 2008). Feminist reluctance to engage in reflexive discussion of fetuses has been a prudential response to the politics of abortion. To talk about fetuses has been thought to cede to the pro-life movement its major premise, and so to foreclose the feminist insistence on women's right to reproductive freedom (Morgan & Michaels, 1999, p. 2). Similarly Harris (2008), in attempting to "break the silence" about second trimester abortions, highlights the physical and emotional aspects of second trimester abortions and their impact on providers. Providing a safe space for providers to engage with the disquieting aspects of second trimester abortions, including the emotionally disturbing aspects of dealing with fetuses, is considered integral towards continued support of second trimester abortion providers (Harris, 2008).

Despite feminist literature on the silence around the fetus in abortion politics, providers in this study were neither silent nor overtly concerned with the potential impact that anti-choice rhetoric would have on women's reproductive autonomy or the pro-choice movement, but rather provided candid, reflexive discussions about the emotional effects of dealing with an aborted fetus. Discussions related to the emotional and physical response to an aborted fetus

extended into broader discussions around second trimester abortions in general, including staff attitudes and resistance, an overburdened, overstretched health care system, structural barriers to abortion access underscored by increasing numbers of second trimester services, poor contraceptive uptake, and reasons why women delayed seeking an abortion until the second trimester.

Abortion advocates and clinicians have argued that second trimester abortion raises complex issues regarding abortion methods, values, stigma, the burden on providers and the often complicated reality of women's lives and decisions (Comendant & Berer, 2008; Harris, 2008). Both medical and surgical abortion is considered to have differing impacts on both the provider and the woman obtaining an abortion. These distinctions regarding involvement in the abortion process had resonance with providers in this study, so much so that no providers in the public health sector were willing to provide D&Es, and D&E services were provided by three "roving" private doctors employed by the Provincial Department of Health, which has clear implications for sustainability.

There were mixed feelings about ways to potentially expand the overall capacity of second trimester services in the Western Cape Province. Although hospital staff recognized that D&E services might better meet the large demand for second trimester abortion than current medical induction services, there was reluctance by respondents at medical induction sites to consider switching to a D&E service. They indicated that although a D&E service might be easier for women, it would likely be more difficult for providers who experience a visceral response to removing fetal parts. This perception of D&E services as emotionally and physically difficult for the provider has been reported previously in other contexts (Gammeltoft, 2008; Harris, 2008; Kaltreider, Goldsmith & Margolis, 1979).

Provision of D&E requires an investment in training of health professionals and ongoing support to maintain requisite surgical skills as well as psychosocial support. Many providers in this study were reluctant to undergo D&E training, especially with advanced pregnancies, yet equally some providers found it difficult to deal with a

fetus after medical abortion. Providing second trimester abortions was challenging for providers whatever the method.

Values clarification and other training that is designed to convey the abortion client's perspective could also improve health care providers' perceptions of the women who access abortion services. Many of the respondents in this study spontaneously offered opinions suggesting that women seeking abortions were irresponsible, leading to a delay in coming for services and repeat use of the services. Values clarification and client-centered training could also increase providers' likelihood of providing pain management and emotional support. In a recent study on second trimester services in the Western Cape, and which was conducted in parallel with the later stages of this study, around 50% of clients undergoing both abortion methods reported high or extreme pain, and 28% reported high or extreme emotional discomfort, with only 20% receiving any kind of pain medication (Grossman et al., 2010, forthcoming). The low use of pain medication is particularly concerning, given the findings of this study, indicating that some providers feel that the abortion experience must be unpleasant in order to prevent women seeking a "repeat abortion".

Comments about "repeat abortions" were widespread and seemed to indicate respondents' disproportionate concern with this phenomenon. Although women may underreport previous abortions, in a recent study on second trimester methods, only 4% of over 300 participants reported having had a previous abortion (Grossman et al., 2010, forthcoming). This issue requires further investigation, but suggests that providers thought that a much higher proportion of clients had had a previous abortion than was actually reported.

Medical hierarchies and power relations between different levels of medical practitioners came to the fore around decisions about second trimester abortion provision. This was analogous to the power relations reported between nurses and doctors with the introduction of the CTOP Act, where trained midwives were allowed to perform first trimester abortions, as discussed in Chapter 5. In most other countries where abortions are legal, second trimester abortion services are provided by Obstetrics and Gynecology departments. From the discussion above it became evident that second trimester abortions were not treated as a legitimate (despite being legal)

form of women's health care. Rather, a complex negotiated process whereby health care providers' response to a personally disturbing surgical technique and its consequences was integrally bound to moral and personal conceptions of abortion.

The next and final findings chapter (Chapter 9) will explore health care providers' relationships with wider community contexts, and the ways in which social and community contexts impact on abortion service provision.

CHAPTER 9: COMMUNITY AND WIDER CONTEXT

Introduction

In the previous four chapters, providers' individual and personal conceptualizations of abortion were explored, with a focus on personal trajectories into abortion provision and conceptualizations around abortion, followed by an examination of providers' relationship within the healthcare system, and how individual and institutional contexts impacted on decision making and experiences around abortion provision.

This chapter explores the ways in which health care providers' relationships with broader social and community contexts intersect with and impact on abortion service provision. Health care providers' perceptions of abortion and experiences of abortion provision within the work place are now extended to their experiences within their broader social environment.

The relationships between providers and their work environment and how these intersect with wider social relationships within community are explored, paying particular attention to the ways in which religious organizations, family networks, and political and ideological discourses in the public domain, including the ways in which sexual and reproductive health NGOs and anti-abortion opposition impact on providers' daily lives and influence decisions around abortion provision.

Salient issues to emerge from the research were: firstly, providers' close relationships with their church and religious community, and the difficulties associated with concealing their involvement in abortion provision from their congregation; secondly, their relationships with family, friends and other social networks, and fears of being recognized and exposed with respect to abortion involvement; and lastly, the less spoken about influence of international and local sexual and reproductive health NGOs and the wider public discourse around abortion politics including anti-abortion demonstrations.

This chapter will also highlight that abortion remained stigmatized, not only within the healthcare environment as discussed in Chapter 7, but also within the wider social environment in which providers resided. This was further problematized as many providers worked in health care facilities located in areas where they resided. Close geographical proximity between work and home and active social involvement within their community, predominantly through the church, influenced their ability to separate their professional and private social worlds, and maintain a level of anonymity within their communities. For many providers, being part of a church community was socially embedded in their daily lives, coupled with the fact that many providers came from the community in which they were working, and were bound to engage with congregants or their broader social networks in the healthcare facilities.

Providers mediated their position as abortion providers through silence or being circumspect about what they did, or, in some situations family members ‘sanctioning’ their work. Difficult relations between their work and wider social networks were most acutely experienced in their interaction with religious domains, and emerged as a central theme in this chapter. Their relationships with international NGOs were less talked about, however it will be argued that NGOs have played a significant role in abortion services in South Africa regarding training, provision, advocacy and support. Opposition in the form of anti-abortion demonstrations was discussed, but did not have a significant impact on decisions around abortion provision or on providers’ physical safety, as is the case in other global contexts such as the USA, described later in this chapter.

Church and religious communities

The most spoken about relationships between work and the wider community was in providers relationships with their religious community and religious precepts. Religious practices mentioned in discussions were exclusively Christian, and religious communities consisted of their priest or church minister, congregants and broader church structures such as parish councils or committees. Some providers were also

involved in reproductive health outreach work, covering issues such as family planning and teenage pregnancy.

The following vignettes highlight the often uneasy relationships between providers, their workplace and their religious community, underscored by the stigma and subsequent silence associated with abortion provision. Many providers described living in close-knit communities where they had to hide what they did, as the boundaries between health institutions and community environments were often blurred.

A nurse referred to close ties between community and church, recounting instances where she encountered members of her congregation as abortion clients. However, in order to keep her practice and those seeking an abortion hidden from the community, censoring each other by both keeping quiet enabled both provider and client to maintain a level of privacy within their community environment:

You know when you do work like this, you mustn't advertise outside, especially your friends and your community what you do. But funnily enough, you can not always exclude congregants from the church because they are coming for it [referring to an abortion] and many a time they get a fright because I'm there. What are they going to do because now I can tell their parents or anybody, you know, or I can go to the church minister and tell him, do you know this and that happened or whatever. They keep quiet, I keep quiet, because it's confidential on both sides.

The following narrative of a nurse working at a designated abortion facility in a peri-urban area outside of Cape Town illustrates her attempts at keeping her professional practice concealed from not only her church but also family and friends. Concerns included the disjuncture between being a parish leader and providing abortions, and anxiety about the impact on families, particularly, children. She recounts an awkward and troubling situation where as a member of her parish committee she was constantly afraid that other church members would discover where she works and attempted to keep her two worlds apart. Keeping her professional practice hidden from her church and family had taken its emotional toll on her psycho-social well-being:

It is very uncomfortable for me working in a facility that provides TOPs as I am a member of our parish council. I think in any religion, or most of the religions, religious people are against abortions, and for me it's uncomfortable, because I don't know what my priest and the others think about me on this matter and how they view what I'm doing. Well they don't really know what it is I am doing.

There is a nursing Sister working here with me who also previously worked in abortion. It touched her very much because she was very emotional and she says she is now on anti depression medication. Her daughter attended the local high school and she said that her school mates were yelling at her and saying that "your mother is a murderer", so I'm afraid someday that this might happen to my two daughters. One just doesn't know what people think or talk about outside. It does worry me that people might talk and as my priest doesn't know I'm busy with this and I'm afraid that he might find out. You know it really bothers me as even my daughters don't know about what I do and that really bothers me because I want to be honest with everyone. If I think of my spiritual beliefs and principles my mother wouldn't have approved and now I have to carry the burden of not being able to tell my family and church.

Furthermore, she explained how the situation was further compounded by residing in an area in close proximity to her workplace, making it difficult to maintain a level of anonymity between work, church and other social networks:

It would be much better if I didn't stay here, I don't think the feeling would be so heavy because I live here, I see them, the children here, around me. One of my friend's daughters was a patient and she got a fright when she saw me in the TOP section. And I wasn't able to inform my friend that her daughter came for an abortion nor did her daughter know that I work here. So if I don't know the people then it's okay. If you don't live and work in the same environment, then it's much better.

The notion of being afforded greater anonymity and privacy if one lived in larger more affluent urban areas in contrast to smaller, more rural communities is further

expanded by two doctors, one working in a large hospital located in Cape Town and another working in a hospital in a smaller peri-urban area outside of Cape Town.

The subtexts of race, class and professional hierarchies are detected in their narratives when discussing their visibility associated with abortion provision in communities outside of the hospital space. Abortion was highly stigmatized and providing abortions was considered akin to infanticide:

I remember attending a workshop on TOPs, where there were a lot of people from other provinces and then we sat and discussed various issues. Some of the people discussed how because they're involved in TOPs and the community knows they received very bad treatment within their communities because they are seen as baby killers. So in the community it does happen, let me put it this way, it will depend on where you stay. If you stay in the leafy suburbs, it's unlikely to affect you, because in the leafy suburbs, neighbors don't know each other, nobody knows who does what, so whether you do TOPs, nobody bothers, you don't know what other people do. But in the Cape Flats or Khayelitsha [townships created during apartheid for Coloured and African people respectively], everybody knows each other's business, so when they know that you do TOPs it becomes a moral issue and there are quite a lot of people who think like that - that you are killing babies and I'm sure even if I take myself as an example, back to the time that I did TOPs, I think none of my friends knew that I was doing TOPs.

A provider referring to a small town environment was equally concerned about being identified as a “termination doctor”, and alludes to the marginalization of abortion work, considered inferior to other obstetrics and gynecology procedures. Stigma associated with abortion work was twofold. First, abortion was stigmatized within the wider community including within religious domains; and second, abortion work was both stigmatized and considered inferior within the medical domain. As discussed in the previous chapter, abortion provision was materially, professionally and ideologically considered on the margins of medical practice.

This is a small town, if we as a group go out and eat lunch in one of the shopping centers, there's always a patient coming around and they greet you and they or friends have had an abortion and you get recognized as a doctor doing abortions in a smaller town, in a bigger town it isn't such a problem. So we don't want one doctor to do terminations exclusively because he would be labeled as being the termination doctor and Dr... [Referring to the doctor responsible for the oversight of abortion services] doesn't want that either, because he'd like to do the rest of obstetrics and gynecology as well and not only be responsible for abortions. As a specialist one is trained to do lots of other procedures and no one wants to be seen as only doing abortions.

Fear of recognition and being associated with abortion work was in contrast to one provider who had not experienced any negative reactions from within her community. Support from her family had facilitated an open approach towards abortion provision. It was not clear why her situation was different to other respondents, and perhaps could be that she did not have close relationships with religious groups and did not reside within the same area as her place of work:

It's out in the open that I work in TOP, my family know that I do it, and they don't have any problem with it. It is really about changing people's mindsets like nobody's throwing stones at me when I'm on the street or I meet them somewhere in town. Really, I have not experienced any problems.

A nurse recounted complex patterns of non-disclosure with regards to abortion work, outlining strategies to make things less uncomfortable with respect to her work. Occupation as a nurse working in an abortion facility, relations with family and friends, residential location and prayer group attendance intersected with each other, making it difficult to keep different parts of her life separate, as is highlighted in the following narrative. She was purposefully circumspect about her work, informing people that she worked more broadly in reproductive health:

You know, outside there to my family and my friends, I don't talk about TOPs, I just tell them that I'm coming to my special clinic, I don't talk about termination of pregnancy and all these things and they don't know what I am doing here and

especially the people that attend the church that I go to. I've got a feeling that, I don't know whether I'm right, they might judge me and look at me as a bad person. Comments like: "Do you know she's terminating the pregnancy?" "This is not right for a Christian woman", you know, comments like that. I'm avoiding those things that will discourage me, or make me unhappy about the work that I do. You know wrong ideas spread so easily, especially amongst the women's manyano (prayer group) that I attend. I don't know what would be the outcome if the prayer group found out, I don't want to make myself unhappy so I can't discuss termination of pregnancy with the people I go to church with. You never say anything about what you are doing, because I'm telling you people will turn against you. Family and friends know I'm a nurse working in reproductive health and this is how far it goes. They know I am a nurse and that's that, but they don't know particularly what I do as a nurse. That goes for my prayer group as well.

Providers, who were not part of a religious community, or identified as not subscribing to a particular religious doctrine, had less to say about interactions with religious communities. However as will be discussed later in this chapter, they did encounter religious communities in anti-abortion demonstrations outside their place of work, or in one instance outside a provider's home. Whilst some providers who identified as "practicing Christians" were able to reconcile religious beliefs with abortion practice, as discussed in Chapter 6, it did not necessarily mean that members of their religious or wider community endorsed their practices, and many providers were similarly affected by anti-choice ideology within their wider social environment.

Family and friends

Being associated with abortion work or working in a facility that provided abortions influenced providers' social relationships with family and friends. However, separating interpersonal relationships with family or friends from religious domains, as discussed in the previous section, was often not possible.

Providers repeatedly raised concerns around maintaining a low profile and concealing the details of their work from friends and family. Keeping their practices hidden was not always possible, as indicated in providers' relationships with their religious domains and their prominence in close knit communities. However, in some situations they were able to discuss the type of work they did with immediate kin, while simultaneously having to be circumspect with other family members or friends. This uneasy situation of partial disclosure to select family members resulted in some providers adopting various coping mechanisms in order to maintain their personal and professional integrity.

In the following narrative, multiple issues pertaining to relations between family, colleagues and church are raised. In discussions around relationships with wider community structures it became evident that it was often difficult to separate church and religious practices from family and friends:

I belong to a very strict church and our church also does not involve themselves with this, with TOPS, but I spoke to my husband and he said to me as long as I don't do it on me, or on the kids it is fine. I don't feel anything because I'm not doing it on me and it's just like I'm doing suturing or putting a catheter in and it's just something that I'm doing and that I must do because the other Sisters and nurses don't want to be involved with TOPs. I told them I'm not doing it on myself, I'm not doing it for somebody else, it's that person who's coming to me for a TOP, it's her decision. It's not my decision. I don't call somebody from the street and then ask her are you pregnant, come for a TOP. I'm not doing that, so why must I feel ashamed if somebody needs help? I mean that is somebody who really needs help, who's coming for this TOP. Like this 16 year old who came for help and no one knew about her situation and if there's nobody to help them, then they will go to seek a back street abortion.

In the above extract it became evident that the separation between the provider's personal (family relationships) and professional duties and responsibilities were not that clear-cut, and as discussed previously in Chapter 6, agency and responsibility was deflected from the provider onto the woman seeking an abortion. Perceptions of no direct encouragement on the part of the provider are underscored by not actively

soliciting pregnant women nor personally seeking an abortion, and in so doing transferring any decision making with respects to abortion onto the woman requesting an abortion. Furthermore she raises the possibility that her church would not sanction her involvement in abortion services, but that she had nevertheless reconciled her role as a health care provider providing a service to women and recognizing the public health implications of unsafe, back street abortions.

Political and ideological discourses in public domain

Reproductive health NGOs

While not regularly discussed by all providers, international and local sexual and reproductive health NGOs and other women's organizations have had a significant impact and influence on abortion politics and provision in South Africa since the liberalization of the abortion legislation in 1997. International NGOs and other organizations have played important roles in overall abortion provision in terms of advocacy, training, and legal, technical and financial support. As previously discussed, designing the abortion training curriculum and values clarification workshops were facilitated by Ipas and other international reproductive health NGOs, and thus content would have been influenced by both local and global abortion advocacy and politics. Providers' discussions around the role of international and local NGOs in their daily practice was sparse, and the few who did mention their impact related to the possibilities of attending further training workshops such as values clarification workshops which they found helpful.

Three key events highlighting the significant role and influence that international and local NGOs and abortion advocacy organizations have had on the history of abortion politics in South Africa post 1994 will be explored. These events will be discussed as they occurred during the study period and highlight some of the problems raised by providers, as discussed in Chapter 7, notably the problems encountered with interpretations of conscientious objection. All three events related to identified barriers to abortion provision and these problems persisted throughout the study

period. While these events did not appear to result in changes or resolve issues raised by providers, a few providers in this study were active participants in these events and I was able to be part of some of the processes in which they were similarly involved.

These three events were the Conscientious Objection workshops in 2005-2006; followed by a National Department of Health Policy Workshop in 2007, convened to finalize conscientious objection and Medical Termination of Pregnancy (MTO) guidelines with the view to implementation in the public health sector; and submissions to Parliament in August 2007 with regards to the CTOP Amendment Act 38 of 2004, where international and local NGOs collaborated with abortion providers amongst others to present their submissions to Parliament. Abortion care providers in this study were involved in all three of these events, including submissions to Parliament related to the CTOP Amendment Act of 2004.

Throughout these processes mentioned above, the role of NGOs and other advocacy groups was crucial in driving the process, in providing technical and financial support and in keeping the momentum going.

Conscientious Objection Workshops 2005-2006

The Women's Legal Centre and Ipas, South Africa convened a set of workshops throughout South Africa which set out to assist health care managers and providers in designated abortion facilities to deal with the issue of health professionals who conscientiously object to performing abortion services. At the Western Cape workshops (which I attended along with five study respondents), participants engaged with various training materials aimed at clarifying difficulties and confusion surrounding conscientious objection in relation to the CTOP Act. The workshop was facilitated by women's legal advocates and lawyers, and was useful in that it explored the relationship between the right to conscientious objection, as set out in the CTOP Act and the South African Constitution, as it relates to women's right to exercise reproductive autonomy. A manual was produced by the Women's Legal Centre to deal with the complex issues of conscientious objection, and was a comprehensive

resource for researchers, women's rights advocates and health care managers and providers working in the area of abortion (Naylor & O' Sullivan, 2005).

The manual provided practical examples of how to apply the principles of conscientious objection and set out, in a user-friendly manner following a question and answer format, the relationship between the SA Constitution and women's right to exercise reproductive autonomy. The purpose of the manual was to indicate how the right to equality, reproductive autonomy, freedom of religion and expression, and the right to healthcare all interact with each other, and the limitations on these various rights within the context of access to abortion services. Furthermore the manual drew attention to the constitutional values that inform the CTOP Act and how this interfaces with the right to conscientious objection, but also what is required should a health care provider refuse to perform an abortion (Naylor & O' Sullivan, 2005).

However, as discussed in the previous chapters, health care providers' right to conscientious objection was not applied in a regulated manner nor did it appear that the information presented in the conscientious objection manual, with the exception of a few instances, was being adopted at designated health care facilities. No formal conscientious objection guidelines or protocols were available at most designated facilities, nor was there any formal recording of staff who conscientiously objected to providing abortions. This situation resulted in confusion and staff not applying their right to conscientious objection in the correct manner.

Few hospital managers or providers in the study referred to the manual during discussions around conscientious objection. Possible reasons being that they were not aware of the manual, the language was too legalistic, or in many instances were resolute in their decision not to provide abortions and thus saw no reason to engage with materials that explored the issues further.

It was also suggested at this workshop that a policy should be developed setting out the position of staff not involved in abortion provision, and strict adherence should be adopted in relation to such a policy. Suggestions with regards to specific content of the guidelines were not developed at these workshops and would have provided some

practical solutions to the problem of conscientious objection experienced in many facilities as discussed previously.

National Department of Health Policy Workshop 2007: Conscientious objection and medical abortion

A year later, in May 2007 a further attempt was made by the National Department of Health (NDOH) in collaboration with Ipas to address problems associated with conscientious objection. “Increasingly negative attitudes and hostility toward abortion by health care providers and managers who use conscientious objection as a reason for not fulfilling their duties in relation to TOP services” was cited as an ongoing concern. A policy workshop was held over a two day period. Two key objectives of this workshop were to finalize the guidelines for Medical TOP and the National Policy for Conscientious Objection. Participants included a diverse group of stakeholders from all over South Africa, including health care providers, policy makers and managers from the Provincial and National Departments of Health and Sexual and Reproductive Health NGOs.

Along with three study respondents I attended the workshop, and was able to observe the important role that international and local NGOs played in providing technical support and training around the issues of both conscientious objection and medical abortion. The development of evidence based guidelines for first trimester medical abortion introduction in the public sector is another example of continued support by international NGOs such as the National Abortion Federation, Gynuity Health Projects, Ipas and the Women’s Health Research Unit (WHRU) in assisting and guiding the process. This has taken many years of continued support and considerable delays on the part of the Department of Health, and at the time of writing, conscientious objection guidelines have not been finalized nor implemented in designated abortion facilities in the Western Cape. The conscientious objection manual discussed above was used as a guiding document in drafting the National Draft Policy on Conscientious Objection

Following the above workshop, the Maternal, Child and Women's Health (MCWH) cluster in the National Department of Health undertook to advance the policy development process through the legal unit of the National Department of Health, before the policies were finalized for implementation.

Finalizing the conscientious objection guidelines and MTOP guidelines has been a lengthy and protracted process, and it has taken many years before some of the recommendations have been approved and implemented. Recently, in March 2010, the MTOP guidelines were approved by the MEC for Health in the Western Cape Province, although the services are not yet available in the public health sector. The latter is attributed to problems with medical abortion drug procurement and bureaucratic delays. Similarly, as of June 2010, the National Policy guidelines on conscientious objection have not been finalized (personal communication, Deputy Director, Women's Health Sub-directorate, Provincial Department of Health, Western Cape, June, 2010).

The lack of finalization of guidelines hinders further additions to abortion services that may facilitate abortion access and provision. Furthermore, the absence of ongoing training and support as a continuous process by both NGOs and government hampers effective continued provision of services.

Legal challenges and submissions to Parliament 2007

A legal challenge to the CTOP Amendment Act 38 of 2004 was another situation in which international and local sexual and reproductive health NGOs rallied together to ensure that women's right to access safe abortion services was upheld. Some providers in this study provided submissions to parliament, and in their submissions outlined the public health implications of unsafe abortions and the need for access to safe, legal abortions for all South African women. Furthermore, these submissions in the public domain suggested providers' commitment to abortion provision and supporting women's reproductive right to access safe abortion services.

As previously discussed in Chapter 2, the amended CTOP Act aimed to make abortion services more accessible, by removing cumbersome procedures to designate abortion facilities, and by increasing the pool of trained providers through extending abortion training to registered nurses. In the main, the amendments were geared towards increasing women's access to safe abortion services and better governance of those services.

Almost eight years later, in their application to the Constitutional Court, "Doctors for Life" and the Christian Lawyers Association (CLA) declared that Parliament had erred by not facilitating public involvement prior to passing the Amendment Act. In response, the Constitutional Court mandated Parliament to rectify this by consulting with the public with regard to the Amendment Act.

The challenge was directed at the parliamentary procedure that was followed prior to the passing of the Amendment Act, rather than at the Act's substance. The court ruled that parliament had failed to adequately consult with the public and the Amendment Act was rendered invalid. The court's judgment was suspended for 18 months to enable parliament to facilitate public involvement. It was at these hearings that providers in this study and other advocates gave submissions to Parliament.

In concluding this section, collaborations between international and local NGOs and other organizations have been discussed, with a particular focus on three events which have highlighted the significant roles that wider local and global contexts have played in public discourse and ideology around ensuring safe, accessible abortion services for South African women. A small group of providers in this study participated in these processes, and actively engaged with political discourse and abortion politics within the wider political and policy domain. Whilst many other respondents did not overtly relate to the differing ways in which local and international sexual and reproductive health NGOs have impacted on abortion provision, they nevertheless have played an important role in training of abortion providers especially nurses, providing support in convening VC workshops, and assisting in the finalization of guidelines and protocols.

Anti-abortion demonstrations

The impact of political and ideological discourse circulating in the wider community and outside of the health care institutional environment was further explored. Experiences of outside anti-abortion demonstrations were rarely discussed by providers, and would suggest that resistance and opposition was more evident from within the health care environment than outside of their work place.

A provider working at a sexual and reproductive health NGO clinic recounted instances of pro-life Christian based demonstrators picketing outside their clinic, suggesting how religious ideology had permeated into this situation:

The demonstrators stand almost on top of our front door, and I think it can become very upsetting for the clients. It distresses them, they will phone and say, "is the clinic open, because I see these people standing with placards and they're protesting" And I say, yes, it's open, come through the side door. A few people including a priest stand outside the clinic on Saturdays. They are not violent they just stand outside with placards and sometimes a doll that looks like a baby which they hold. I have on one occasion confronted the priest; I said to him, "you know if God was here, He wouldn't judge his people". And he said that he was not judging them. So I said to him what is he doing, and he went on about how wrong it was. And I said: "what about all these children on the street, who have no homes, no parents, no nothing"? And he asked me ... I actually volunteered and I said, "You know I am a Catholic". And he said, "Where do you go to mass"? And I said to him [mentions the suburb] and he asked "and who is your priest"? And I said, "You know that really isn't any of your business". But my point is women have a right to choose. Two weeks ago on a Saturday I got out of my car. I wasn't supposed to be on duty, but there was somebody off sick so I came in to do the ultrasound scans. Now my car has a rosary, and the demonstrators were standing there. As I got out of the car, I saw this gentleman taking out a little bottle. I knew that it was Holy water that he was sprinkling. And I said, "What was that that you just did?" And he said, "I was just sprinkling Holy water". He then asked me, "Is that a rosary in your

car”? I said, “Yes, it’s a rosary in my car”. He asked me, “Are you a Catholic”? I said, “Yes, I’m a Catholic”. But I waited for further confrontation or discussion which he did not pursue, and I then walked into the clinic. We know have come to accept and have got used to these few demonstrators outside our doors on most Saturdays and they are not here during the week.

An abortion provider recounted an instance where her “cover had been blown” by a local community newspaper article identifying her as an abortion doctor, and her experiences of a small gathering of demonstrators outside her home. She described her apparent moral neutrality towards abortion, yet acknowledged incongruities between her different levels of comfort. In the work environment she was quite comfortable with what she was doing, yet outside of her professional domain was not comfortable telling others what she did:

I’m quite comfortable with what I’m doing but I don’t feel comfortable telling other people what I do, because it’s such a huge emotional issue, so if somebody actually asks me what I do, I will not tell them. Instead I say I’m a general practitioner. I suppose there’s some conflict there, you know, which is saying that I actually do not feel comfortable about what I do as you never know how they will react to you.

I had a problem about two months ago when a Christian Action campaign came and stood outside my house, I don’t know if you heard about it, it was in the local community newspaper and it was very traumatic for me. Nothing’s come out of it, it’s just dormant at the moment. So they’re still busy liaising about whether it was an illegal gathering and that sort of thing and that they mustn’t come back - so nothing’s actually happened, but they pitched up here while I was out. I came home when they were packing up, so that wasn’t great. It was very traumatic and also everyone at my child’s school read in the local newspaper that her mother does abortions, because I specifically did not put my surname when I enrolled her at school, I only gave my husband’s surname. So unfortunately the article mentioned his name as well, so there was a connection. But I haven’t had any problems from the school except when her report came back instead of them using my husband’s surname which they always have, they

used my surname even though I have never given them my surname as I have always gone under my husband's surname.

Moving from experiences at her child's school she discussed her experiences with neighbors:

The neighbors had no idea that I provided abortions and they were obviously not pleased. But other than that, everyone seems to be the same. Nobody's been rude or said anything. But they basically did blow my cover because I didn't want the school or the neighbors to know that I provide abortions.

The above discussions around anti-abortion picketing suggest that anti-abortion demonstrations were not as widespread or dangerous as reported in other contexts. No other anti-abortion demonstration apart from outside one of the NGO clinics was reported by providers. These demonstrations which I witnessed on a few occasions occurred usually on a Saturday morning and consisted of a few people standing with placards outside on the street opposite and alongside the clinic. Whilst opposition to abortion is strong in South Africa, similar to elsewhere (such as the USA), protest and conflict takes different social forms.

Conclusions and discussion

This chapter set out to explore health care providers' interactions with wider social environments including relationships with family, social networks and religious domains, and the ways in which these wider community contexts intersected with and impacted on abortion service provision. Interdependent relations between providers' place of work, residential location, family networks and religious community made separation between work and home in some instances difficult. For many providers, creating distance between work and community including religious domains was problematic as many providers lived in close-knit communities with close ties to their workplace, and feared being identified or associated with abortion provision. Their concerns were not based on physical threats or violent attacks in their place of work or their home environment as reported elsewhere, but rather related to maintaining

their reputation and integrity within their church communities and wider social networks.

The impact of political and ideological discourse around abortion in the public domain was less spoken about by providers. This would suggest that close ties to family and church, underscored by the need to keep their involvement in abortion work hidden, had more impact regarding their daily practices as abortion providers. This could be linked to the fact that abortion in South Africa is less contested in terms of physical violence leveled against abortion providers, coupled with a fairly stable environment with regards to reproductive rights and choice. Furthermore, South Africa, unlike many other countries where abortion is restricted, has liberal abortion legislation, with a constitution that explicitly supports and upholds a woman's reproductive autonomy and right to choose.

Discussions around anti-abortion protest suggested that anti-abortion demonstrations were not as widespread or dangerous as reported elsewhere, such as in the US, where abortion providers are subject to death threats, violent attacks, assassination attempts and murder, as in the recent case in May 2009 of Dr. George Tiller who was murdered while attending church in Wichita, Kansas. Violent backlash against abortion providers and facilities providing abortions has not occurred in South Africa, despite the fact that South Africa is an extremely violent society especially regarding gender based violence and homicide, with South Africa having the third-highest homicide rate in the world (Abrahams, Jewkes & Mathews, 2010).

Although not physically violent as discussed above, there is an ongoing 'assault' on the CTOP Act by anti-choice advocates in South Africa, financially supported by anti-abortion groups based in the United States, similar to other settings globally, for example Ireland (Oaks, 1999). Christian organizations such as Doctors for Life and the CLA have made attempts to overturn the CTOP Act and to legally challenge abortion laws and proposed amendments, as in 1998 when the CLA, Christians for Truth in South Africa and United Christian Action attempted to declare the CTOP Act void *in toto* under the 1996 Constitution, and in 2000 when the CLA brought another legal challenge to the CTOP Act regarding the rights of minors to exercise their choice to have an abortion (Engelbrecht, 2005). However to date, these Christian-

based organizations have not been successful in overturning any aspects of the legislation.

Challenges to the law through proposed amendments and opposing amendments continue. This would suggest that pro-choice groupings and government need to remain active in their support of the law and its implementation, and means found to provide greater support to providers in rendering of abortion services.

Providers mediated differing ways of dealing with the stigmatized nature of abortion work by ensuring a level of anonymity in their wider social environment. For some providers however, church attendance did not necessarily translate into non-abortion involvement or activism, as has been suggested elsewhere where women on both sides of the abortion divide have similarly been active members in the church and mediated their relationship with Christianity and abortion in complex and differing ways (Ginsburg, 1987). Furthermore, Sheriff (2009), in her interviews with abortion doctors in the USA, found that providers negotiated their abortion work with their personal lives in ways that were more nuanced than most political debate around abortion has presented (Sheriff, 2009).

As previously discussed, the role that international and local sexual and reproductive health NGOs and women's advocacy organizations have had in abortion advocacy, training and support has been significant. However, in the day to day experiences of abortion providers, social relationships with religious groups were more spoken about and had more resonance than relationships or interactions with outside organizations.

Abortion remained stigmatized in many of their communities, resulting in many providers' silence and concealment of the kinds of health care they provided, and led to some providers choosing to disclose to those they trusted or felt supported by, which is not too dissimilar to selective disclosure reported by clients in the HIV arena (personal communication Dr. Diane Cooper, September 2010). Ironically, providers appeared to experience less stigma and isolation within the wider environment than in the health care setting where they often felt unsupported and alienated, as discussed in Chapter 7.

A dearth of scholarly work on abortion care providers' experiences outside of the medical domain persists locally and globally. This is possibly due to abortion being highly restricted in many settings where providers operate under clandestine conditions (Silva et al., 2009). The little research that has been conducted has emanated from the USA, possibly because of the contested nature of abortion politics and the ongoing threat to the abortion legislation, in contrast to a relatively strong feminist movement and highly organized abortion rights groups within organized medicine, such as the National Abortion Federation (NAF) and Physicians for Reproductive Health and Choice (Joffe & Weitz, 2003, p.2363; Sheriff, 2009).

It is not clear why the finalization and implementation of medical abortion in the public sector and the finalization of conscientious objection guidelines as discussed at these workshops have not been concluded over the past five years. This could be attributed to a multiplicity of factors, including poor management and stewardship within local and national health structures, competing priorities within the women's health directorates, and general inertia, but also as Joffe and Weitz (2003, p. 2353) have argued could be due to the fact that "abortion remains divisive within society generally but also more specifically within medical culture". Whilst they were referring specifically to the situation in the USA, it similarly has resonance in South Africa.

CHAPTER 10: CONCLUDING DISCUSSION AND RECOMMENDATIONS

This final concluding chapter will discuss the key issues to emerge throughout the research study, linking them back to the central research question: What are the factors that enable or constrain health service providers from delivering safe, accessible abortion care services?

Summary

Health care providers' views and experiences of abortion services were explored from within three domains of enquiry: firstly, individual level conceptualizations of abortion and the ways in which understandings around abortion influenced decisions with regards to abortion provision; secondly, the ways in which the institutional environment and health systems context impacted on abortion provision; and thirdly, providers' relationship to their wider social environment and the ways in which community contexts intersected with abortion provision.

Analyses of personal and professional pathways into abortion provision were explored through the narratives of three providers who had decided to become involved in abortion provision with the implementation of the CTOP Act. Decisions in relation to abortion provision suggested a complex interplay between personal and social circumstances, and past experiences with abortion-related mortality and morbidity associated with illegal back-street abortions.

Analysis of pathways into abortion provision was followed by a closer examination of health care providers' broader understandings of abortion and how this impacted on abortion provision. Health care providers' conceptualizations of abortion were influenced by a multiplicity of factors, including personal, moral and religious views, in which abortion was perceived by some as akin to murder or as a sin; whereas others viewed access to safe, legal abortions as an important component of a woman's right to reproductive autonomy and choice, enabled by the new abortion legislation.

Conflicts between personal beliefs and professional practice were often mediated by establishing differing thresholds and boundaries in relation to abortion provision.

Following on from providers' conceptions around abortion, the focus of enquiry was broadened to exploring the ways in which the health systems context and institutional environment impacted on abortion service provision. Barriers to service provision involved both structural and individual level barriers, and included limited and infrequent abortion and values clarification training opportunities, ambiguity and confusion regarding interpretation and implementation of conscientious objection and its subsequent impact on service provision, and experiences of isolation and stigma in the work place. Failed or poor contraceptive uptake and services were of great concern to providers, underscored by the perception that abortion had in many instances replaced responsible family planning by women requesting abortions. This perception was especially heightened by their experiences of some women returning for repeat or frequent abortions. Fragmented services, functioning and supported by a small dedicated group of abortion providers, who received little professional or emotional support from management or wider health structures, had serious implications for sustaining abortion services. A lack of clear policy guidelines and protocols to guide abortion service delivery further constrained adequate delivery of abortion services.

Second trimester abortion services were explored, as the contested domain of abortion was the most heightened with second trimester abortions. Many providers struggled to cope with the emotional and visual impact of encountering an aborted fetus. Gestational age emerged as a key indicator of acceptability, and providers drew distinctions between differing stages of fetal development, and attributed more personhood and likeness to an infant with the growing physiological development of the fetus, increasing their unwillingness to perform abortions during the second trimester of pregnancy. Differing medical techniques relating to second trimester abortion also influenced providers' approach to second trimester abortion provision, with a noticeable resistance to the D&E procedure, as this required more active involvement on the part of the person performing the abortion procedure. Medical abortion was preferred as it was considered to require less provider involvement in the abortion process. A dearth of providers willing to perform second trimester abortions

resulted in most second trimester services in the public sector being outsourced to a roving team of doctors from within the private sector. This in turn has serious implications for the ongoing sustainability of second trimester abortion provision, particularly in view of the relatively high proportion of second trimester abortions in South Africa, and increased medical complications associated with second trimester abortions.

The final findings chapter explored the ways in which health care providers' relationships with broader social and community contexts intersected with and impacted on abortion provision. Abortion remained stigmatized, not only within the healthcare environment, but also within the communities in which providers resided. This was further problematized as many providers worked and resided in communities in close proximity to each other. Active involvement with the church made it difficult for many providers to maintain a level of anonymity within their communities.

The important roles that international and local sexual and reproductive health NGOs played in abortion advocacy, training and technical and financial support were highlighted. Anti-abortion opposition within the wider community was not as pronounced or violent as reported elsewhere such as the USA, and emerged as having had less influence on decisions around abortion provision than has been reported elsewhere.

Emerging issues and implications

Overall this study suggested that a broad range of complex interrelated factors both facilitated and constrained access to safe abortion services. With this in mind emerging issues and implications for abortion access and provision in South Africa will be discussed, highlighting some of the salient and unexpected issues to emerge.

Abortion as a contested domain

Abortion, more than most other medical procedures and practices, has entered the public domain with vigorous, highly contested debates, and elicits emotive responses involving a range of powerful stakeholders including politicians, religious organizations, the medical and legal fraternity, civil society organizations, sexual and reproductive rights organizations, feminist activists and public health advocates. Of all legal and professionally accepted medical procedures, abortion is considered the most divisive and controversial. Disagreements about abortion reflect differences in core beliefs about moral standing, the value and meaning of human life, personhood, autonomy and sex (Wicclair, 2010, p. 45).

It is against this contested background that major reform to women's reproductive rights and access to abortion services in South Africa should be located. One of the most progressive abortion legislations worldwide was passed within a particular historical and political juncture in the South African democratic process. However, this law was passed and expected to be implemented by historically conservative health care professionals, who had their own beliefs and views around abortion, childbearing, motherhood, and sexuality. Despite the progressive ideology of the CTOP Act, many South Africans remain somewhat conservative on the issue of abortion. Hence while constitutional rights and progressive abortion legislation are important starting points, they are not in themselves sufficient to ensure women's access to safe abortion services (Engelbrecht, 2005; Harrison et al., 2000). Whilst the South African population is generally politically progressive and supportive of a Constitution that is grounded in human rights language, there is still ambivalence around contentious issues such as abortion and capital punishment.

Additionally and more broadly, inadequate stewardship, leadership and management within the public health system have led to inadequate implementation, monitoring and assessment of what are often good policies (Coovadia et al., 2009). This is further compounded by a human resources crisis facing the health sector, which has contributed to increased challenges in implementation and in ongoing functioning of public sector health care services including abortion services.

Notwithstanding the impediments to the operation of the CTOP Act, there have been significant gains, notably in the marked increase in the number of abortions conducted since 1997 when 26,401 abortions were performed, compared with 2003 when 70,391 abortions were provided (Department of Health, 2004). Furthermore, abortion related morbidity and mortality has decreased dramatically by 91.1% since the implementation of the CTOP Act (Jewkes & Rees, 2005, p.250).

Whilst the more abstract or theoretical debates around abortion have been extensively researched and discussed, very little attention has been paid to the everyday experiences of abortion providers. Lisa Harris' seminal article on second trimester abortion provision opens up the space to engage with the complexities of abortion provision especially, as it relates to abortion providers (Harris, 2008). This is one of the few scholarly writings that confront the unsettling visual and visceral aspects of being exposed to an aborted fetus inherent in second trimester abortion provision. She raises a number of important, yet less spoken about issues, which provided further insight and meaning to respondents' discussions around abortion, particularly responses to an aborted fetus. By recognizing the disquieting aspects of abortion provision she provides opportunities, despite the risks of reinforcing anti-choice discourse and imagery, to reflect the full extent of providers' experiences of abortion care (Harris, 2008). Whilst providers in this study were candid about their experiences, opportunities for support and a safe space in which to engage with these issues were largely absent. Exploring ways of dealing with these difficulties such as providing on-going team support and openly engaging with the issues in workshops or staff support groups facilitated by an independent skilled facilitator could strengthen and support service provision. Debriefing sessions or other non-threatening and supportive spaces where providers can engage with these issues either on an individual one on one basis with a trained empathetic mental health professional or in a group could contribute to preventing further possible burn-out and fatigue.

Values clarification workshops whilst infrequent have been offered to some providers, and could also be an entry point to address the emotional and physical difficulties encountered with abortion procedures which are not always addressed in VC workshops. Whilst emotional and embodied responses to certain aspects of abortion

provision is only one aspect of the abortion process, other experiences such as feelings of isolation and being stigmatized in both the workplace and wider community need to be recognized. Performing work often considered on the margins of mainstream medical practice has implications for long term sustainability. Ongoing health service-based support and recognition is crucial, as currently most abortion services are provided by an older group of dedicated abortion providers and has implications for long terms plans and sustainability. The chronic shortage of abortion providers in South Africa has resonance elsewhere, where concerns have been raised about the “thinning ranks” of abortion care providers, with few younger abortion providers replacing an older cohort. This is underscored by the relatively few abortion education and training programs in existence in medical schools and residency programs (Grimes, 1992; Lazarus, 1997; Sheriff, 2009). Additional barriers for those attempting to integrate abortion provision into obstetrics and gynecology practices have further hampered the normalization of abortion practice (Freedman, Landy, Darney & Steinauer, 2010).

Empowerment

Paradoxically, within this new and highly contested environment and despite the obstacles encountered, being an abortion provider and being able to perform first trimester abortions was seen by some providers as “empowering”, in affording them a degree of clinical autonomy and professional status, especially for nurse providers. The new abortion legislation permitting suitably trained nurses to provide first trimester abortions was viewed by some nurse providers as an opportunity to expand their skills base and professional status, and to support women’s reproductive rights and choice. Assisting women in a controversial situation coupled with prior experiences on a personal or professional level of the consequences of illegal, unsafe abortions was a motivating factor for some providers to undergo abortion training and subsequently provide abortions.

Religious beliefs

However, for other providers the issues related to abortion provision were more complex, and religious and moral beliefs were the determining factors in their decisions not to be involved in abortion provision or training. This finding is in keeping with reports from other studies both in South Africa and elsewhere (Buga, 2002; Djohan, Indrawasih, Adenan, Yudomustopo & Tan, 1999; Harrison et al., 2000, Lazurus, 1997; Marshall et al., 1994). Notwithstanding this, religious beliefs and practices did not prevent some providers from being strong supporters of a woman's reproductive right to choose, and from being involved in abortion provision. These providers were able to reconcile religious beliefs with their professional practice, and mediated ways to make this possible. In these instances religious beliefs co-existed with views around the public health importance of access to safe abortions and women's need for reproductive autonomy and choice. Similarly, in two other studies undertaken at similar research sites, women, including HIV positive women, seeking abortions related similar conflicts between their religious beliefs and need to terminate an unplanned pregnancy (Harries et al., 2007; Orner, de Bruyn, Harries & Cooper, 2010). Fear of being ostracized by the church, family and wider community, and difficulties reconciling religious beliefs around the sanctity of life with "taking a life", were underscored by the realities of women's daily lives and personal circumstances.

Reconciling religious precepts and practices with abortion provision was an unexpected finding in this study, and highlights the complex and differing ways in which health care professionals managed and mediated their professional and personal identities in the health care environment. Pragmatism, public health considerations, support of women's reproductive autonomy and other factors contributed towards decision making around abortion provision, despite being inconsistent with religious (in this case) Christian doctrine.

Anthropologists have shown how in other settings such as Vietnam and Japan, abortion and religious beliefs similarly co-exist (Gammeltoft, 2003; Hardacre, 1997). Gammeltoft (2003) investigates how young, unmarried women in Vietnam seek to cope with experiences of abortion by appeasing fetal spirits through ritual practice,

and explores how in a context where induced abortion is considered a routine medical procedure and where the apparent moral acceptance of induced abortion corresponds with efforts made in Socialist Vietnam to advance an atheistic and scientific understanding of human life, women still seek resolution by praying or providing offerings to fetal spirits. This ritual practice appears contradictory to the Vietnamese social and political order. However she suggests that ritual practice and prayer produces a social space where personal experiences of abortion can be expressed and recognized. Similarly in Japan, where abortion is readily available, the practice of performing religious rituals for aborted fetuses termed *mizuko kuyo* has received much attention since the 1970s, especially as the practice relates to the commercialization of these religious rituals including targeting younger women (Hardacre, 1997). While the focus in these studies is somewhat different, they provide insights into the complex ways in which religion and abortion are mediated and how abortion and religious beliefs surface in unexpected ways.

Contraception and abortion

One of the central narratives in this study was an overriding concern that contraceptive use was being replaced by abortion. This was underscored by perceptions that abortion was often a substitute for responsible contraceptive practices. Whilst shortcomings in contraceptive services were recognized, including a lack of pre and post abortion contraceptive counseling and initiation, little insight was provided by respondents as to why, despite the widespread availability of free hormonal contraceptives in public sector facilities and a relatively high contraceptive prevalence (65%) in South Africa, abortion rates continued to increase (Department of Health, 2004). The relationship between induced abortion and contraceptive use, whilst widely discussed and commented on, remains for the most part unexplored in reproductive health research (Mundigo & Indriso, 1999, p. 26).

In contrast to this, research conducted in Cuba, where abortion continues to play a major role in fertility regulation despite high contraceptive use (75%) and extensive free health services for all, suggested that whilst women were aware of contraceptive methods, their understanding and knowledge around contraceptives was scant, and

relied mainly on informal networks such as women friends for information (Vasquez, Garcia, Catusus, Benitez & Martinez, 1999). Poor levels of knowledge and understandings around contraceptive methods was attributed to inadequate counseling and limited method choice, and often led to inconsistent use, method failure and discontinuation. Reasons for inconsistent or non-contraceptive use were linked to the provider-client interchange or a lack thereof (Vasquez et al., 1999). Similar to these findings, providers in this setting alluded to shortcomings in both pre and post abortion counseling including post abortion contraceptive initiation and method choice. Strengthening the provider-client interchange and providing comprehensive information, also on method choice, thereby empowering women around contraceptive decision making, could further contribute to contraceptive uptake (Wood & Jewkes, 2006; Stephenson, Beke & Tshibangu, 2008).

The potential for improvements in contraceptive service provision to impact positively on various aspects of health and welfare, both from society's and the health system's perspective, cannot be overstated. However, it is critical to recognize that even with complete family planning coverage, abortion, including second trimester abortion, will always be a necessary health care service.

Conscientious objection

Perhaps one of the most complex issues to emerge in this study was the interpretation and subsequent implementation of health care workers' right to freedom of conscience, as enshrined in the South African Constitution, but not clearly addressed in the CTOP Act.

Exploring the ways in which conscientious objection was being interpreted and applied by differing levels of health care workers in relation to abortion provision raised multiple and contradictory issues. Whilst the ambiguity or "silence" around conscientious objection as it relates to the CTOP Act has been recognized by both legal scholars and women's legal advocates, the manner in which it occurs within public sector health facilities has not been fully interrogated or reported on in scholarly works.

From providers' accounts it was often difficult to distinguish what constituted misinformation with regards to understandings around the Act as it related to conscientious objection, and what was opposition to abortion provision, exacerbated by the limited guidance provided on how to manage the process, including registering an objection in a formalized manner. Instead an ad hoc, unregulated and at times incorrect application of conscientious objection occurred at many facilities, and often extended to other levels of abortion care.

Interestingly, very few providers alluded to the lack of policy guidelines in relation to abortion provision and conscientious objection, highlighting the improvised nature of many abortion services. Guidelines from other settings exist, and appropriate guidelines need to be adapted for the South African context (Wicclair, 2010).

An area of importance that has been overlooked is the way in which ambiguity around the Act and conscientious objection can exacerbate the problem of access to safe abortion services. In order to disentangle what is resistance to abortion provision in general, and what is conscientious objection on religious or moral grounds, clear guidelines and protocols need to be provided as to what constitutes conscientious objection, and under what conditions they can be applied, including what measures need to be undertaken in order to lodge one's right to conscientious objection, accompanied by careful record keeping. This would facilitate long term contingency plans for abortion service provision.

The relationship between personal convictions and professional and ethical obligations should be an important component of ethics training in medical and nursing schools, so that providers are able to engage with the issues when they emerge.

Even if clear, comprehensive guidelines and protocols were in place, the question of whether health care providers would continue to use conscientious objection as a means to resist abortion provision remains. Conscience based objections are likely to persist and it is crucial that they are managed in a transparent, coherent and comprehensive way. Recently (2010) attempts have been made by the Western Cape

Provincial Department of Health to address identified problems with conscientious objection, and guidelines are currently being drawn up. However, as was the case with the conscientious objection manual as discussed in Chapter 9, a policy will be effective only if health care providers are familiar with it, or, at least if they know how to access it and are fully informed of its contents, application and importance for overall service provision.

Abortion training

Abortion training emerged as a key area needing further exploration and intervention, as the shortage of trained and clinically competent abortion providers is contingent on sustained comprehensive abortion training. This study identified limited opportunities for providers to attend abortion training programs, and the training that was provided was sporadic and problematic regarding its ability to allow providers to complete the practical component necessary to be certified as technically competent. Training of trainers programs and other mentorship programs should be fostered in relation to abortion care training, and as a means of increasing the number of fully trained, competent providers capable of providing ongoing effective abortion services.

One way to ensure on going abortion training is to integrate abortion education into medical and nursing school curricula, and should form part of reproductive and women's health. South Africa is well placed to undertake this for two reasons: firstly, it is one of the few countries where both nurses and doctors are allowed to perform abortions; and secondly, it has one of the most liberal laws in the world, with currently few legal impediments to abortion provision. However, abortion education has thus far not been incorporated into medical and nursing school curricula. Medical and nursing school education and training is heavily state subsidized, and as such guidance and support with regards to including abortion education in medical and nursing programs needs to be advocated for and supported. Despite the establishment of the Midwifery Abortion Care Training program in 1998, no attempts have been made to date by nursing colleges and/or universities in the Western Cape to implement guidelines and/or formal abortion care training for nurses or doctors (Smit et al., 2009).

In order to engage with some of the issues surrounding conscientious objection as discussed above, all aspects of abortion provision should be included in abortion training. This should include not only the clinical aspects of abortion provision, but also the ethical and legal requirements and obligations of health care professionals towards women requesting an abortion. Related to this, conscience based objections to abortion and how they can be instituted and regulated, and other broader aspects of abortion related care such as pre and post abortion counseling including contraceptive counseling, and values clarification, and the individual level and public health implications of unsafe abortion on women's lives, should to be included in abortion education.

Support and recognition

Support and recognition should be provided for those who choose to undergo training and continue to be involved in abortion provision. Research has indicated that in the Western Cape nurses providing abortions receive no professional or financial recognition for their services, with little or no psycho-social support from management or other stakeholders (Smit et al., 2009). Currently, abortion provision for nurse providers is not recognized as a specialized or scarce skill, and recognition in monetary terms for abortion provision as a specialized skill should be considered. This in turn may encourage more staff to volunteer to provide abortion services. Support programs which attract prospective abortion care providers, and retain existing providers, need to be developed.

Mentorship should also be encouraged along the lines of the recently established Global Doctors for Choice (GDC), an international group of doctors committed to advocacy for reproductive health and choice that has initiated advocacy training models in South Africa, with the view to extending abortion advocacy amongst doctors in South Africa.

Perhaps one of the major problems with the process of abortion reform in South Africa and the subsequent implementation of the CTOP Act was that there was no

sense of ownership, overwhelming support or ‘buy-in’ when the legislation was passed. Preparing key stakeholders prior to the introduction or establishment of services, as has been the case with the introduction of new reproductive technologies in other settings (Simmons et al., 1997) might have avoided some of the difficulties and opposition to implementation and continued provision of services.

The insights and findings from this study point to the following recommendations, and are summarized from the above discussion.

Recommendations

- The psychosocial needs of providers must be addressed, as counseling and support is required for both providers and clients. Psychological support in the form of support groups or individual counseling for abortion providers needs to be established. For example, appropriate partnerships, involving collaboration with counseling units at the three universities in the Western Cape should be explored.
- Support programs which attract prospective abortion care providers, and retain existing providers, need to be developed. Financial compensation and a scarce skills allowance for abortion providers need to be considered.
- Knowledge and understanding of the 1996 abortion legislation, including conscientious objection, needs to be strengthened amongst all health care providers including health managers. A suggested way to impart knowledge of the CTOP Act and what is expected of health care workers with regards to abortion provision would be through values clarification workshops, which received a positive response from most participants in this study.
- Abortion values clarification workshops need to be expanded and regularly scheduled throughout the Western Cape Province. It is important that the workshops be scheduled well in advance and that all facilities are notified, so

that facility managers can make the necessary arrangements for staff to attend these workshops.

- Abortion care training needs to be incorporated into both medical and nursing school curricula, and into Obstetrics and Gynecology residency programs, and is crucial to ensuring the ongoing provision of abortion services.
- Contraceptive counseling, including post abortion contraceptive counseling, needs to be strengthened and better integrated into post abortion care.
- Suggestions for future research would include more emphasis on applied social science research, with a closer examination of the interactions and interchanges between clients and providers in the abortion setting. An area that warrants further research is the investigation of pre and post abortion counseling, including post abortion contraceptive counseling. Counseling should have a particular emphasis on informed contraceptive choice, but in order for this to be achieved, health care providers' knowledge and understandings of contraception, including post abortion contraception, needs to be strengthened.

The CTOP Act was a ground breaking piece of legislation for both women's rights and health, and for overall public health in South Africa, with the country having taken the lead in Africa and elsewhere in abortion reform and rights. However, the momentum for realizing the full extent of the legislation regarding service implementation seems to have been lost since 1996. In order for this momentum to continue there is a pressing need to address the provider shortage, and abortion education and training needs to be formalized and initiated in medical and nursing schools. This should include ongoing training and support for those health care providers who become involved in abortion provision and care.

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APPENDICES

Appendix 1: Table 1: Socio demographic data of respondents

Includes FGD and IDI participants

(N= 52)

| Study characteristics | N |
|----------------------------------------------|--------------|
| Study sites | |
| Primary Health Care Facility | 3 |
| Hospital Level (1,2 or3) | 9 |
| Non-governmental organizations | 4 |
| Other | 2 |
| Total | 18 |
| Abortion provision | |
| Providing abortions | 16 |
| <i>Registered nurse or midwife</i> | 11 |
| <i>Doctor</i> | 5 |
| Not providing abortions | 36 |
| Total | 52 |
| Service provider category | |
| Registered nurses | 26 |
| Doctors | 10 |
| Hospital managers | 7 |
| Policy influentials | 3 |
| Counselors | 4 |
| Social workers | 2 |
| Total | 52 |
| Number of years working as a provider | |
| Median (range) | 23.7 (9-40) |
| Age of provider (years) | |
| Median (range) | 45.1 (39-65) |
| Sex of provider | |
| Female | 45 |
| Male | 7 |
| Total | 52 |
| Religious affiliation | |
| Christian | 41 |
| Not specified | 11 |
| Total | 52 |

Appendix 2

In-depth interview guide for service providers/health managers

Introduction

As I have mentioned, we are conducting a research study on health care providers' understandings of termination of pregnancy services in South Africa. The information that you provide will help inform future reproductive health care services and programs. I would like to ask you some questions to find out what your thoughts and experiences are with regards to TOP services. Please note that there are no right or wrong answers, we are interested in your thoughts and opinions on the subject matter. We can discontinue the interview at any time should you so require.

1. Could you tell me a little about your working life and the work that you do?
2. Could you describe the kinds of training you have undergone?
3. Could you describe your understandings around abortion/TOP?

Probe:

- How do you think personal or professional attitudes towards TOP might differ?
- Have you attended any values clarification workshops, if so how did you find these workshops?

If respondent does not know what values clarification is, please say:

“Values clarification aims to separate the personal from the professional.”

- What are your thoughts about different abortion methods?
- What are your thoughts about first and second trimester abortions?
- What are your thoughts about emergency contraception?
- Could you describe your understanding around reproductive rights and choice?

4. What are your general feelings about working in a facility that provides / refers women for TOPs?
5. I would now like to ask you broadly how you feel about TOPs and what factors might have influenced your decision to provide or not provide TOP services?

Probe:

- What or who was an important influence in deciding to provide TOPs / refer to TOP services?

Or

- What or who was an important influence in deciding not to provide TOPs / refer to TOP services?
- What role do you think religious or moral beliefs, or other personal reasons could play towards decisions to be involved in abortion services?
- If explicit about refusal, probe reasons for refusal.
- Referrals: Would you feel comfortable or willing to refer a woman to a facility that provides TOPs: if yes, why, if no, why not?
- If a midwife: How do you think being trained as a midwife relates to decisions to be involved in TOP services?

6. I would now like to ask you a few questions concerning your thoughts or views about women seeking a TOP.

There might be different reasons why women seek a TOP. In what ways would you be or have been influenced by a woman's particular reason or reasons for seeking a TOP?

Probe:

- Contraceptive failure
- Partner or gender relations, such as relationships between men and women and their impact on a woman's ability to make decisions.

- Rape or incest
- Fetal abnormality
- Socio-economic reasons
- Other

7. Women have now been legally eligible for TOPs for just over 10 years. I would like to ask you about your understandings around the TOP legislation?

Probe:

The idea here is to explore the provider's knowledge of the legislation and generally how they view the legislation.

- What is understood by "conscientious objection"?
- How does conscientious objection impact on other providers' ability to decide to become involved in abortion services?

8. What have your experiences been with others' attitudes towards TOPs?

Note: This could be in both the professional (work colleagues) and personal (family and community) spheres. If the participant has had experience, ask: What issues have been raised?

Probe:

- Are providers being ostracized or stigmatized by other colleagues / health care workers in the work place, and if so, how does this influence their decision to become involved in abortion services?
- Are providers being ostracized or stigmatized in their wider community, and if so, how does this influence their decision to become involved in abortion services?
- If this has occurred in either the workplace or wider community or both, how have you responded to these situations?

9. Sometimes health service managers or administrators influence opportunities to become involved in TOP services? What has your experience been in this regard?

Probe:

If respondent has not had any experience, ask: Do you know of anyone else who has experienced this?

10. Have you or do you know of anyone who has experienced difficulties in accessing abortion training, if so, what have they been?
11. What are your thoughts on the way TOP services are currently provided for women?
12. Do you have any other comments, suggestions or questions that you would like to ask?

We have come to the end of the interview. I would like to thank you for your time and participation.

Appendix 3: Certificates of Consent in English

UNIVERSITY OF CAPE TOWN



Information sheet for providers and policy makers participating in the research project: **Health care providers attitudes towards termination of pregnancy: A qualitative study in South Africa**

Explanation of the study and the purpose of this interview.

Hello, my name is..... I work at the University of Cape Town's Women's Health Research Unit. We are talking to health care providers, health managers and policy makers about termination of pregnancy services. We would like to improve our understanding of providers' opinions and experiences of abortion services and what issues are important to you in your work environment.

Procedures

To find answers to some of these questions, we invite you to take part in this research project. If you accept, you will be required to participate in an interview with myself. You are being invited to participate in this study. Your experience in this area of women's health can contribute to our understandings of abortion services in the Western Cape. Your participation in this interview is completely voluntary. To help us to remember what you say here today, I will be taking notes and, if you agree, would also like to record today's session on tape.

If you do not wish to answer any of the questions posed during the interview, you may say so and I will move on to the next question. The interview will take place in an agreed upon place and no one else but myself will be present. The information recorded is considered confidential, and no one else except our research team will have

access to the information documented during the interview. I will not record your name, and nothing that can identify you will be recorded as part of this study. The expected duration of the interview is about an hour.

Risks and Discomforts

There is a slight risk that you may share some personal or confidential information by chance or that you may feel uncomfortable about talking about some of the topics. However, we do not wish this to happen, and you may refuse to answer any question or not take part in a portion of the interview if you feel the question(s) are personal or if talking about them makes you uncomfortable.

Benefits

There will be no direct benefit to you, but your participation is likely to help us find out more the needs of health care providers and managers working in the area of reproductive health and more specifically abortion. Your participation in this study will not involve any risks to you.

Incentives

You will not be provided any incentive to take part in the research.

Confidentiality

The information that we collect from this research project will be kept confidential. Information about you that will be collected from the study will be stored in a file that will not have your name on it, but a number assigned to it instead. The name associated with the number assigned to each file will be kept under lock and key and will not be divulged to anyone. Tape recordings of the interview will be destroyed soon after use.

No names of persons or of their workplace will be mentioned in any dissemination of the study results, results will be summarized by main themes and categories.

Right to refuse or withdraw

You do not have to take part in this research if you do not wish to do so. You may stop participating in the interview at any time that you wish without any prejudice or negative impact on your job.

Who to contact

If you have any questions you may ask these now or later. If there is anything that is unclear or you need further information; we shall be pleased to provide it. If you wish to ask questions later, you may contact any of the following: Ms Jane Harries (PI), Women's Health Research Unit, School of Public Health and Family Medicine, University of Cape Town, Tel: 021- 406-6798.

This proposal has been reviewed and approved by the University of Cape Town's Research Ethics Committee, whose task it is to make sure that research participants are protected from harm.

Certificate of Consent for study

I have been invited to take part in the research on **Health care providers' attitudes towards termination of pregnancy services in South Africa**. I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this research study and understand that I have the right to withdraw from the discussion at any time without any prejudice.

Participant signature

Interviewer

Date

Date
