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What health-care providers say on providing abortion care in Cape Town, South Africa: findings from a qualitative study

Introduction

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. These barriers include, but are not limited to, provider opposition, stigma, poor knowledge of abortion legislation, a lack of providers trained to perform abortions, and a lack of facilities designated to provide abortion services, particularly in the rural areas. The dearth of abortion health-care providers undermines the availability of safe, legal abortion, and has serious implications for women's access to abortion services and for health-service planning.

There has been little research to date on health-care providers' attitudes towards abortion in South Africa. Studies elsewhere, including countries where abortion is highly restricted, have found that various factors shape health professionals' attitudes towards induced abortion. Religious beliefs, the reasons for seeking an abortion, such as rape or incest, and gestational age were all found to affect attitudes and willingness in relation to abortion provision. In South Africa, little has been known about the personal and professional attitudes of individuals who are currently working in abortion-service provision. Exploring the factors that determine health-care providers' involvement or disengagement in abortion services may facilitate improvement in the planning and provision of future services.

This policy brief reports on results from a qualitative study that explored knowledge, 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.

Methods

The study was conducted across three public-sector primary health-care facilities; eight public-sector hospitals; four nongovernmental organization (NGO) facilities, three of which provided abortions; and two health services linked to secondary and tertiary educational institutions. Study sites were based within the greater Cape Town area and three outlying periurban areas within the Western Cape Province, South Africa. Facilities studied provided a range of reproductive health-care services, from pre-abortion counselling and referral, to the provision of first- and second-trimester abortions, postabortion counselling and contraceptive services.

A total of 34 qualitative in-depth interviews and one focus group discussion (on request by participants) were conducted with health-care providers and health-care managers who were involved in a range of aspects of abortion-service provision in the public and NGO sectors (see Table 1). Participants were selected through purposive sampling, and both providers and non-providers were included in the study.

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The sample represented a range of health-care providers who varied by professional category and type of provider. These included providers who were trained to perform abortions and were providing abortions; providers trained in abortion services but who were not providing abortions; and providers who were not trained in abortion procedures. Other respondents included nurses and counsellors who were involved in pre- and postabortion referral and counselling, and health-care managers in facilities providing either abortion or reproductive health-care services.

The majority of respondents were female (89%) and the median duration of experience in abortion services was 7 years (range 0–30 years). Interview guides were semistructured and open-ended, and made use of probes. Interviewers, who had experience in qualitative research methods and were comfortable with the subject matter, conducted the face-to-face interviews, using the interview guide.

Interviews were digitally recorded and transcribed verbatim. All participants provided written informed consent, and confidentiality and anonymity were ensured. Ethical approval was obtained from the Research Ethics Committee, University of Cape Town and the World Health Organization Research Ethics Review Committee.

Data were analysed using a thematic analysis approach. Initial categories for analysing data were drawn from the interview guide and themes and patterns emerged after reviewing the data. Key themes to emerge were: reasons providers were not willing to provide abortions, including individual and health-service-related barriers; how providers defined or conceptualized abortion; knowledge and understanding of the termination-of-pregnancy (TOP) legislation; and how reasons for seeking an abortion impacted on providers' decisions to be involved in abortion provision.

Results

Complex patterns of service delivery were prevalent throughout many of the health-care facilities, and fragmented levels of service provision seemed to operate in order to accommodate health-care providers' willingness to be involved in different aspects of abortion provision. Some provided abortions and some assisted with the procedure and/or provided pre- and postabortion counselling. Others restricted their involvement to tasks solely relating to pre-abortion care, such as performing ultrasound scans to determine gestational age, and referral to a designated abortion facility.

Table 1. Background characteristics of abortion providers included in the study

Characteristic	Number
Number of providers	38
Sites of providers	
Primary health-care facility	3
Hospital (tertiary and secondary level)	8
Nongovernmental organization	4
Educational institution	2
Total	**17**
Training status	
Providing service	
Trained	16
Health-care manager	1
Total	**17**
Not providing service	
Trained	1
Not trained	17
Health-care manager	3
Total	**21**
Service-provider category	
Counsellor	7
Enrolled nurse	2
Registered nurse	3
Nurse-midwife	17
Doctor	6
Management	3
Median number of years worked in TOP services (range)	7 (0–30)
Sex and religion of providers	
Sex of provider	
Male	4
Female	34
Religious affiliation	
Christian	19
Other	1
Not specified	18

Factors influencing the decision to provide abortion care

Personal reasons

Reasons for involvement in abortion provision were often tempered by indirect or direct personal experiences. For some, provision was part of a natural career trajectory, whereas for others involvement was linked to prior exposure to mortality and morbidity associated with illegal "backstreet" abortions and the recognition of a dearth of providers willing to provide abortion services.

A nurse-midwife underscored her need to be involved in services from their inception:

> I think having nursed patients in the past who came in with septic abortions, and who were quite ill and distressed, that was one of my motivating reasons. And also the fact that it was 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. ***(nurse-midwife working in NGO sector)***

Moral reasons

Abortion as a moral choice and how it influenced health-care providers' degree of involvement in services was framed in different ways. Some providers were vehement in their dislike of abortion care, whereas others were prepared to restrict their involvement to pre- and postabortion counselling or basic nursing duties, and were not willing to provide direct abortion care, including performing abortions. As a nurse stated:

> I don't want to come to do TOPs ...I would just hate it, hate it, hate it, it's not my choice ...I want to enjoy my work. ***(nurse working in reproductive health services public-sector hospital)***

Religious beliefs

When asked about the role of religion as an influential factor in service provision, most health-care providers had experienced colleagues' opposition to abortion on a mix of religious and moral grounds, in the working environment. Some abortion providers were quoted as "murderers" and "baby killers" who were expected to "preserve and not take life".

Religious beliefs played a role for some providers in deciding not to be involved in abortion services, whereas others approached the issue differently. A nurse provider explained that even though she was a practising Catholic, she had "made peace with" her decision to provide abortions despite being ostracized by her church.

Providers who described themselves as "pro-choice" preferred a "clinical" over an "emotional response" to abortion, viewing abortion care as part of their job, whereas those opposed to abortion found it difficult to separate their personal feelings from professional conduct.

Reasons for seeking an abortion

Providers were asked whether the reasons a woman gives for seeking an abortion would influence their decision to be involved in abortion provision. A nurse acknowledged her "biases", stating that the reasons for a woman seeking an abortion would influence the manner in which she counselled that woman.

> I first ask for a reason why they come for a TOP, then if it is not necessary at all I advise them to keep the baby because it's a sin to kill, but when I see there is a necessity for that [financial reasons or interrupting studies] then I support them. ***(nurse working at tertiary educational institution)***

Rape or incest

In general, providers and nonproviders emphasized that they did not want to be seen by clients to be discriminating openly about their reasons, but on a personal level they felt that there was a stronger case for TOP in pregnancies associated with rape or incest. A nurse mentioned that even though she precluded herself from TOP procedures on grounds of conscientious objection, she felt that rape and incest were sufficiently "different" motivating factors for TOP and, "I would be standing in the theatre holding their hand ...I would really try to support them through it, if that was the case".

Gestational age was another key indicator of acceptability. Providers found it more traumatic to deal with a termination performed around 17–20 weeks, than a termination at 14 weeks, because with the latter one was dealing with an embryonic sac rather than a "formed fetus".

Experiences: abortion services

The effective provision of abortion services seemed to be contingent on the willingness of staff to be involved in provision. Respondents suggested that those who were providing abortion services frequently felt stigmatized. Service providers experienced "burnout" and left the services as "they could not endure the comments or the attitudes of their colleagues". Another provider 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. Where you're supposed to be peers and working hand in hand, and you can become extremely unhappy. You'd often find midwives not providing abortions because they fear the victimization, being stigmatized, being isolated from their peers, and also within the community itself. ***(nurse working in public-sector facility***)

Another problem encountered was an ad hoc interpretation of the right to conscientious objection. Abortion legislation in South Africa makes allowance for a health-care provider's right to conscientious objection. A health-care provider may refuse to perform an abortion; however, they are obliged to inform the woman of her reproductive rights and to refer her to another provider or facility. Irrespective of conscientious objection, a nurse must provide nursing care including assistance with activities of daily living, emotional support, prescribed medications and comfort and pain-relief measures.

Many designated public-sector facilities did not have providers who were prepared to either perform abortions or assist those performing abortions. Abortion services were often not provided, due to "pro-life doctors not wanting to do anything about abortions", resulting in a roving team of providers from the private sector providing the services. The impact of conscientious objection on service provision included all aspects of the abortion process, from refusing to prescribe or administer necessary medications to refusing to assist in the operating room or provide abortions.

Contraceptive services

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 correctly and consistently. Often this was followed by reference to women preferring abortion as a means of contraception. A common perception among respondents was that contraceptive services in the public-health sector were not only preferable to abortion but were essential to the health of women. Yet, there were multiple barriers to this becoming the reality, including little or no contraceptive counselling, limited contraceptive choice, and judgemental attitudes particularly towards younger women. Comprehensive postabortion contraceptive counselling was difficult to initiate, as providers were often too rushed or had to talk to women "on the run".

Quality of services

An overwhelming concern about quality of care within public-sector health facilities emerged. Providers' concerns centred on problems associated with a general lack of adequate pre- and postabortion counselling; punitive staff attitudes; overcrowded, overburdened and fragmented services; and difficulties with staff recruitment and retention.

A nurse provider described how, often, large numbers of women were turned away due to staff shortages, and the potential consequences of this.

> ...There is often not enough staff to provide the services and we are only able to take a certain number of clients a day, women are often too scared to go elsewhere or can't afford [the] transport fare to attend another facility, resulting in them seeking a backstreet abortion. ***(nurse working in public-sector tertiary hospital)***

A respondent from an NGO providing reproductive health-care services summed up the situation in public-sector facilities.

> 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. It's just not a quality service that they are providing. ***(manager, sexual and reproductive health NGO)***

However, there were also positive comments about the services, particularly within the NGO sector where providers felt they had more time for counselling and appropriate infrastructure to provide optimal services, and where people who worked there chose to be involved in abortion provision. This was preferable to many public-sector facilities where TOP services had been introduced as part of sexual and reproductive health-care services and had not necessarily obtained the "buy-in" from health personnel working there.

Related to issues around quality of care and a difficult work environment was the need expressed by many providers for "special 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 attitudes of staff and with providers who refuse to be involved in abortion provision. A nurse 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 are just placed in an environment and [it is] 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 mindset. There are some people who never have a shift in mindset and we must come to terms with that. ***(nurse working in public sector hospital)***

Conclusions

Several factors seemed to be at play among service providers, in terms of influencing their decisions to become involved in some way with abortion-service provision. These included a combination of circumstance and personal interest. For nonproviders, religious and moral beliefs and fears of being ostracized played an important role in decisions not to be involved in abortion provision. However, despite misgivings about being involved in abortion provision, nonproviders were concerned about the numerous difficulties women in South Africa faced in seeking an abortion, and the need for improved contraceptive provision and counselling.

Providers' reluctance to be involved in different aspects of abortion provision led to complex and fragmented levels of service provision throughout many of the health-care facilities. Related to this was the need expressed by many providers for "special or dedicated abortion clinics" where people feel "committed and passionate" about what they do, thus creating a more supportive environment for both clients and providers, which could contribute to sustaining a pool of abortion-care 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. Health services seemed to lack standardized 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 the effects of conscientious objection on service provision.

Policy implications

The insights from this study indicate that:

- reproductive health counselling, including postabortion contraceptive counselling, needs to be strengthened and better integrated into postabortion care;
- an emphasis on quality of care is needed and would encompass all aspects of abortion provision, including improvements in allocated space and infrastructure;
- the psychosocial needs of providers must be addressed, as counselling and support is required for both providers and clients;
- knowledge and understandings of the 1996 abortion legislation, including conscientious objection, needs to be strengthened among all health-care providers, including health managers;
- values-clarification workshops need to be expanded;
- support programmes that attract prospective abortion-care providers, and retain existing providers, need to be developed. Financial compensation and a scarce skills allowance for abortion providers needs to be considered.

Further reading

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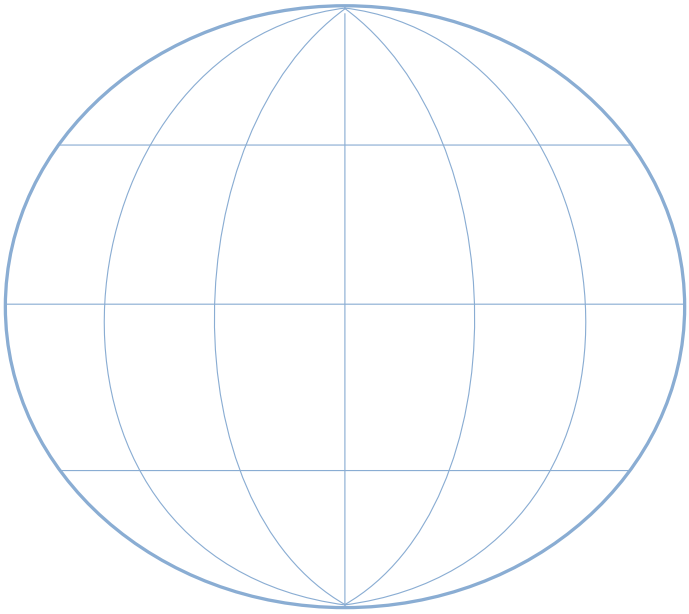

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