

# **Nurses' experiences of an abortion counselling training course and their understandings of quality abortion services**

A thesis in fulfilment of the requirements of a Masters in Psychology

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## **Abstract**

This research study focuses on nurses' experiences of participating in an abortion counselling training programme in the Eastern Cape Province (E.C), using a grounded theory and symbolic interactionism framework. The study aims to investigate how participating in a women-centred abortion counselling training course offered through the Critical Studies in Sexualities and Reproduction research unit may modify or improve nurses' practice of abortion counselling and understanding of quality abortion services. Through purposive sampling, nine research participants working as abortion providers in EC health care facilities were recruited. Research data were produced using discussions around prior abortion counselling experiences, a reflective activity, power point case presentations conducted within the counselling training, and semi-structured interviews conducted two months after the training with five of the providers. A grounded theory analysis was used to generate themes that highlighted different aspects that enabled or hindered access to quality abortion services. In accordance with prior research, it was revealed that nurses undergo abortion training but there is limited content on abortion counselling training. Findings from this study reveal the modifications of practice and understanding of quality abortion services of nurses who participated in the client-centred abortion counselling training course. Themes of change that emerged from the nurses' experiences were rendering counselling services in a non- judgemental, non-directive way, being acknowledged and recognized for the services they offer as abortion providers, and accepting that abortion is a reproductive legal right that can be accessed whenever a woman in need of the service requests it. The findings of this research also indicate that, despite the controversy and stigma attached to providing abortion services, the participants were motivated to continue offering abortion services because they felt equipped since undergoing abortion counselling training. The training course improved reported abortion counselling practices, but systematic issues such as lack of managerial support, space for individual counselling and procedure equipment continue to undermine services.

Keywords: abortion, abortion counselling, abortion training, grounded theory, client-centred approach

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## Glossary of terms

Word	Meaning
Ehh	Refers to a long thinking pause
Neh	Is it, isn't it so; Afrikaans but used ubiquitously in South Africa
i (in front of a word)	Referring to something; can be an abstract (an/the)
Ke	Means then/that when translated to English
Yena	Referring to a person (she/him)
Ukuba	Xhosa word that refers to that
Ukuthi	Xhosa word that refers to that depending on the context
Uhm	Indicates a thinking pause
Mna	Xhosa word referring to self (me) in English

## List of acronyms

CTOP Act	Choice on termination of pregnancy Act (no. 92 of 1996)
TOP	Termination of pregnancy
SI	Symbolic interactionism
RUESC	Rhodes University Ethical Standards Committee
S.A	South Africa
RJ	Reproductive Justice

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## **Chapter One: Introduction & Context**

### **1. Introduction**

Abortion is a common and simple medical procedure that should be a fundamental part of any comprehensive reproductive health programme (Varga, 2002). It is a time-restricted health service that should ideally take place within the first trimester (Harries et al, 2012). However, given the prevalent lack of knowledge about basic reproductive biology such as timing of the fertile period, early signs of pregnancy, and the long travelling distances women must travel to obtain an abortion, this reproductive service remains inaccessible (Varkey, 2000).

Research conducted on women who undergo an abortion, has revealed that they often experience a sense of isolation (Birdsey, Crankshaw, Mould & Ramklaas, 2016). In addition, the procedure may cause women to experience a range of emotions that include regret, guilt, sadness and relief (Baron, Cameron & Johnstone, 2015). Thus, the provision of quality abortion services, including counselling, in such an anxiety-invoking environment is seen as essential to women's health. It is, therefore, crucial for research that specifically focuses on the provision of abortion counselling to be conducted in order to understand what is meant by quality abortion services.

South Africa's democratic constitution affirms the right of individuals to make their own choices regarding reproduction and to have security in, and control over, their own bodies (Vincent, 2011). However, abortion counselling can be anti-abortion in deploying the conjecture that abortion causes psychological or other harm in order to gain support for political programmes aimed at restricting recourse to abortion in practice. This assumption acts as an extension of surveillance and control over women's bodies rather than as means to enable women to practice and make meaningful choices regarding their bodies (Vincent, 2011). This is problematic because in several contexts, abortion counselling practices have positioned women who seek abortion services as being in crisis (Vincent, 2011).

In this chapter, I provide context regarding abortion in South Africa (SA). I highlight the abortion legislation in South Africa, the concept of conscientious objection, abortion stigma, and global challenges of abortion provision, second trimester pregnancies and referrals. These contexts

illuminate the factors that may or may not influence nurses' understandings or practices in abortion counselling and services.

## **2. Abortion legislation**

Experiences around the world show that restrictive abortion laws lead women to have unsafe abortions, which in turn contributes to the high rate of maternal deaths particularly in the global South (Morroni, Myer & Tibazarwa, 2006). Abortion is a legal reproductive right in South Africa. South Africa reformed the abortion law in order to improve the health of women and to prevent deaths among women, and it is arguably one of the most significant steps in acknowledging the rights of women to choice and bodily integrity (Mhlanga, 2003)

The Abortion and Sterilisation Act of 1975, allowed for termination of pregnancy only under limited circumstances, resulting in large numbers of illegal abortions taking place each year, and often in unsafe environments (Vincent, 2011). It was constituted in a manner that seemed to offer greater access to women seeking abortions compared to before it was put in place. According to the Act, an abortion could be obtained if two physicians believed that the pregnancy would endanger a woman's life or her physical and mental health, or when two physicians believed that the pregnancy could cause severe handicap to the child, or if the pregnancy was a result of rape, incest or other discriminating intercourse such as with a mentally challenged woman (The Abortion and Sterilization Act No.2 of 1975). However, the Act's specifications made access to quality abortion services restrictive (Guttmacher, Kapadia, Naude & De Pinho, 1998), and the circumstances in which an abortion could be carried out were so stringent that only women in urban and well-resourced areas could access abortion under the conditions of the Act (Mhlanga, 2003).

The majority of women who could not benefit from the 1975 Act were black women from rural areas where there was limited reproductive health assistance with mostly one doctor in a hospital. This made access to abortion services restrictive, because the Act required as least two doctors (one of whom would be a psychiatrist in the case of mental health stipulations) to agree that a woman qualified for an abortion (Guttmacher et al., 1998). Thus, the Choice on Termination of Pregnancy Act (CTOP) of 1996 was passed by the government of the African Nation Congress as a result of high rates of maternal morbidity and mortality stemming from illegal abortion practices under the previous abortion legislation (Mhlanga, 2003).

The South African Choice on Termination of Pregnancy Act (CTOP) of 1996 aimed at promoting women's right to have an early, safe and legal abortion (Harries et al., 2011). Under the CTOP Act, pregnancy may be aborted at a woman's request during the first 12 weeks of gestation, from the 13th

week of gestation through the 20th week, if the medical practitioner is of the opinion that the pregnancy poses danger to the woman's mental or physical health, or if the pregnancy will cause foetal anomaly, or if the pregnancy was a result of rape or incest, and if carrying to term would considerably affect the social and economic situation of the woman (CTOP Act No. 92, 1996). The CTOP Act allows for both doctors and nurses or mid-wives to perform abortions for pregnancies within 12 weeks of gestation or less, provided they have completed the prescribed training course. Only doctors are allowed to perform abortions above 12 weeks gestation (CTOP Act No. 92, 1996).

Furthermore, the CTOP Act states that the state shall promote the provision of non-mandatory and non-directive counselling before and after an abortion of a pregnancy (CTOP Act No. 92, 1996). It does not specify in detail the context in which counselling should take place nor does it emphasize the importance of abortion counselling training. Moreover, it does not specify the grounds on which nurses can refuse to provide abortion services, which is problematic because nurses continue to practice conscientious objection without the full understanding of the Act, and the unwillingness to offer abortion services limits safe and quality legal access to abortion (Harries et al., 2020).

Abortion counselling training generally takes place within general training of abortion provision. Therefore, there is little published research that focuses specifically on training in abortion counselling. In order for nurses or midwives to provide abortion counselling and services, they need to undergo certain prescribed training. The South African Nursing Council requires nurses to complete 160 hours of training, 80 hours of theoretical training, and a further 80 hours of clinical training under the supervision of experienced practicing physicians in accredited hospitals. The clinical training must be complete within three months of the theoretical training (Dickson-Tetteh & Billings, 2009). The abortion care training curriculum emphasizes that abortion care services should not be provided in isolation but rather as an integral component of comprehensive reproductive health. Training includes providing comprehensive abortion services to women with normal pregnancies of no more than 12 weeks gestation, treating incomplete abortions, alleviating and referring women who present with abortion complications and have more than 12 weeks gestation to trained medical physicians in hospitals; offering post abortion contraceptive services and follow-up care to women receiving abortion services; and lastly offering other reproductive health services as needed to women receiving abortion services (Dickson-Tetteh & Billings, 2009).

Training and certification of registered midwives or nurses were identified as critical steps for making high quality abortion services accessible to all women, specifically in the underserved rural areas (Harries & Constant, 2020). Regardless of the establishment of the midwifery abortion care program

after the implementation of the CTOP Act, there are limited opportunities for providers to attend abortion training especially the practical component necessary to be certified as technically competent. Training of trainer's programmes and other mentorship programmes have recently been developed through the Royal College of Obstetricians and Gynecologists Leading Safe Choices programme to strengthen family planning and comprehensive abortion care services in South Africa. Furthermore, Harries and Constant (2020) argue that one way to ensure on-going abortion training is to integrate abortion education into medical and nursing school curricula, as part of reproductive and women health.

South Africa is well placed to undertake this for two reasons; firstly, because it is one of the first countries where both nurses and doctors are allowed to perform abortions; and secondly, it has one of the most liberal laws globally, with little impediments to abortion provision. However, abortion education has not been incorporated into medical and nursing school curricula, and no attempts have been made to date by nursing colleges and/or universities in South Africa to implement guidelines and/or formal abortion care training for nurses or doctors (Harries & Constant, 2020).

The CTOP Act mandates that the termination of pregnancy may be provided by a medical doctor or a trained registered nurse on request by a woman up to 12 weeks of gestation. It furthermore stipulates that from 13 weeks up until 20 weeks of gestation, termination of pregnancy may be performed by a medical doctor only. The abortion may be performed if only the doctor is certain that the pregnancy poses danger to a woman's mental or physical health, that the foetus presents abnormalities, that the pregnancy resulted from rape or incest, or from the certainty that the pregnancy would have a harmful effect on the woman's social and economic status (Hodes, 2016). These rights were ruled to be accessed by all women in South Africa, including minors; with no required parental consent (Benson, Anderson and Samandari, 2011).

In 2008, The Act was further amended due to complaints made by healthcare providers and women's rights advocates due to unmet mandated abortion guidelines. It allowed designated health facilities with a 24-hour maternity service to provide first trimester abortion services without the legislative permission that was formerly required (Macleod, Beynon-Jones and Toerien, 2017). These amendments included facility licensing to the provincial level and increasing the number of trained abortion nurses. The National Abortion Care Programme (NACP) was also established to meet the need for lack of trained healthcare workers, it aimed to increase high-quality abortion care services to public facilities through: (1) training nurses in low-cost safe abortion methods; (2) training nurses in managing incomplete pregnancy terminations and performing first trimester abortions with MVA; and

(3) training providers in post-abortion contraceptive counselling. The programme furthermore conducted national workshops whereby doctors and healthcare providers were trained as abortion care trainers in their respective provinces (Benson, Anderson and Samandari, 2011).

Regardless of the implemented CTOP Act, there is still an increase in second trimester abortion requests. Second trimester abortions account for over 20% of abortions performed in South Africa, which is greater than other countries with legalized abortion such as the United States and Vietnam where 12% or less of abortions occur in the second trimester (Harries et al., 2007). Abortions performed after 12 weeks of gestation pose greater risks of medical complications than abortions performed during the first trimester. Furthermore, procedures performed after 12 weeks of gestation may be costlier for women in many respects, such as financially, emotionally, and medically. Second trimester abortions pose greater risks of medical complications and mortality than abortions performed before 12 weeks (Drey et al., 2006).

In second trimester abortions, both medical and surgical abortion procedures are used (Harries et al., 2012). Medical abortion is usually performed at earlier stages of pregnancy (between 7 and 12 weeks gestation) using mifepristone and misoprostol, and the contents of the foetus is suctioned using a device; this is called medical vacuum aspiration (MVA) (Lim & Singh, 2014). On the other hand, surgical abortion also known as dilation and evacuation (D&E), is the dilation of the cervix which involves insertion of instruments and removal of bulky uterine contents, and is commonly used for second trimester abortions (Lim & Singh, 2014). However, shortages of trained doctors and nurses contribute to poor quality service and limited access to the services, which have radical implications for second trimester abortion services (Harries et al., 2012).

According to Drey et al. (2006), second trimester procedures are difficult and challenging to obtain because fewer providers offer them, which limits access. Furthermore, limited access to second trimester abortions is compromised by difficulties in locating facilities that offer them (Harries et al., 2007), and women in need of this service have to travel long distances to have access to an abortion facility/services (Varkey, 2000). Travelling times and long distances contribute to women seeking second trimester abortion, particularly for women from rural areas and underserved provinces (Dickson et al., 2003).

The reasons why women present for second trimester abortions are complex. Harries et al. (2007), suggests that problems with irregular periods and poor recall and recording of menses, often results in difficulties in recognizing pregnancy (Harries et al., 2007). Limited biological knowledge about basic reproductive issues such as the fertile window period and early signs of pregnancy (Varkey, 2000),

inappropriate referrals before obtaining an abortion, waiting periods of over two weeks, unwilling and judgemental nurses may result in women seeking second trimester abortions (Harries et al., 2007). Furthermore, women in Harries et al.'s (2007) study were aware of abortion being legal, but not aware of the time restrictions involved, suggesting that information on the availability of abortion services particularly the time restrictions involved should be included in reproductive health care, so that women with unintended pregnancies can be able to make informed choices (Harries et al., 2007).

In a US study, Drey et al. (2006) found out that referrals and trouble locating a provider suggest a link between the scarcity of the second trimester providers and increased delay hence, fewer providers are available for women seeking second trimester abortions, especially those with public funding (Drey et al., 2006).

Linton, Mendez and Simon (2020) point out that it is unlikely that the first healthcare provider a woman sees when seeking an abortion is an abortion provider. Thus, she may have to spend a significant amount of time in search of another provider on her own or obtaining a referral from a general health care provider. Furthermore, presenting for an abortion referral may be a negative experience due to women's concerns over their providers judging them, opposing the abortion, delaying the process or eventually turning them away (Linton et al., 2020).

Further hurdles in terms of obtaining an abortion may stem from the provider's lack of knowledge regarding the process of referral (Linton et al., 2020). Therefore, given the potential difficulty in obtaining referrals through clinics, women may use the internet as a source to locate abortion facilities. Women who are most likely to rely on the internet to locate abortion services are the least likely to access accurate information with which to locate an abortion provider (Dodge et al., 2018). This inaccurate access of information leads to high mortality and morbidity rates, and therefore restricts quality access of abortion services.

Drey et al. (2006) point out that understanding the reasons for abortion delay may encourage the improvement of referral networks and facilitate the development of health education programs that reduce the need for second trimester abortions. Furthermore, such education may help women recognize unwanted pregnancy earlier, thus increasing a woman's options for pregnancy termination by rapid referrals to clinics and by enabling a woman to choose an abortion procedure of their choice (Drey et al., 2006). Andersson et al. (2004) argue that a provider having clinical knowledge of second trimester procedures and abortion services are crucial, as being competent gives strength and a sense of security which makes it easier to deliver accurate and quality information to women in need of this service (Andersson et al., 2004).

### 3. Conscientious Objection

Unsafe abortion is a preventable phenomenon; however it remains a continuous major public health problem in many countries especially in the global South. This is partially due to providers' opposition to render or participate in the provision of abortion services often on the grounds of religious or moral beliefs (Harries et al., 2014). Autorino, Mattioli and Mencarini (2020), found in a study conducted in Italy that objection is widespread but it is particularly strong in the South where lower-income regions are concentrated, giving rise to concerns that conscientious objection may unduly affect women who live in disadvantaged areas.

Harries et al (2014) argue that nurses' right to freedom of conscience with respect to abortion provision is a complex phenomenon both locally and globally, and that conscientious objection as it relates to the South African law raises issues of competing constitutional rights with regards to a woman's right to exercise reproductive autonomy and a healthcare worker's right to freedom of conscience, belief, thought and religion. The issue of conscientious objection arises when healthcare providers and clinicians refuse to provide certain services due to their religious, moral or philosophical beliefs, and it is commonly invoked with regards to abortion (Autorino et al., 2020). Conscience-based refusal is often claimed as a right of freedom of religion, conscience and thought being a basic human right (Steinberg, 1989). However, Fiala and Arthur (2004) argue that conscientious objection in reproductive healthcare should not be regarded as a right, but as an unethical refusal to treat, as the outline of unconfirmed personal beliefs in healthcare undermines quality practice based on scientific evidence and medical ethics. This consequently results in an abandonment of professional obligations to patients.

Badro (2011) found that work experiences shape healthcare workers' moral development over time, which suggests that there is more to conscience than merely acting upon pre-existing personal beliefs. On the other hand, conscientious objection is justified when the patient is not disproportionately burdened and the physician seeks to preserve their moral integrity (Brock, 2008). Moral integrity is typically understood as a harmonious, consistent unity between belief and action resulting in an uncompromised sense of self (Brock, 2008). According to Harries et al. (2014), moral conflict around abortion is unique in relation to other medical practices in South Africa, and is the only instance where healthcare providers can invoke their right to conscientious objection. Furthermore, the right to refuse to render abortion services applies only to the actual abortion procedure. Thus, in regards to the law healthcare providers who are not directly involved with the abortion procedure cannot use their beliefs or morals as a reason for not assisting a woman seeking an abortion (Harries et al., 2014).

Mavuso and Macleod (2019) point out that the refusal to provide abortion services results in those who provide the services reporting hostile working environments marked by victimization and isolation, and often burn out. Therefore, in order to disentangle the resistance to abortion provision in general, and of 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 can it be applied, including the measures that need to be taken in order to lodge one's right to conscientious objection accompanied by careful record keeping (Harries et al., 2014). Moreover, difficulties in terms of poor understandings and implementation of the CTOP legislation need to be addressed, including the distinctions regarding what one can object to on the grounds of conscience and what one cannot (Harries et al., 2014). This is because many providers use conscientious objection as a means of refusing to provide abortion, and many facility managers use it as a reason to act as gatekeepers and as a means to prevent abortion services from being provided in facilities they manage (Trueman & Magwentshu, 2013).

#### **4. Abortion Stigma**

Stigma refers to an attribute or act that is deeply discrediting (Lipp, 2011). This attribute is only seen as discrediting within certain contexts and relationships. According to Kumar, Hessini and Mitchel (2009), stigma is produced and reproduced in four ways. Firstly, people differentiate and categorize human differences. Secondly, governing cultural beliefs associate categorized individuals with undesirable characteristics and negative stereotypes. Thirdly, the categorized persons are placed in distinct groups to accomplish some degree of separation. And fourthly, categorized people experience discrimination and status loss that leads to unequal treatment and opportunities (Kumar et al., 2009).

Abortion services and abortion providers are often referred to as "abortionists" and "murderers" by other providers, those opposed to abortion the media and others in many places around the world. These are highly stigmatizing categories that contribute to the exclusion of abortion as a legitimate part of reproductive healthcare by equating it to an abhorrent crime (Kumar et al., 2009). Abortion stigma is a negative attribute ascribed to women who seek to abort a pregnancy, which marks them internally or externally inferior to the ideals of womanhood (Aniteye, O'Brien & Mayhew 2016). The stigmatization of abortion clients occurs when women who receive abortion services are: ascribed negative characteristics such as promiscuous and irresponsible; perceived to deviate from feminine ideals; and condemned for perceived sexual activity outside of social norms (Puri et al., 2012).

Whether it is self or felt stigma, stigma can result in delays in women accessing safe abortion services (Lipp, 2011) or they may seek out illegal unsafe providers (Puri et al., 2012). According to Gray

(2002), self or felt stigma refers to the shame and expectation of discrimination that hinders individuals from talking about their experiences and prevents them from seeking help. Enacted stigma (external stigma) refers to the experience of unfair treatment by others. Felt stigma can be as damaging as enacted stigma since it leads to withdrawal and restriction of social support (Wuest et al., 2002).

As a result of the stigma surrounding abortion, privacy is of outmost concern for women seeking an abortion; the need for privacy may compel women to seek abortion in clandestine settings rather than in public hospitals or clinics where abortion is legal and free (Payne et al., 2013). If a woman is unable to protect her identity in the public hospital or clinic, she has a solid reason to seek out an abortion in a more remote location (Payne et al., 2013). Women seeking or receiving abortion services may feel less empowered to ask questions, challenge poor treatment, or disclose their clinical history (Puri et al., 2012).

Providers in South Africa have reported feeling stigmatized and isolated (Harries et al., 2012). Societal constructions of womanhood play a significant role in shaping individual women's sense of self and consequently their ability to exercise personal power in relation to their sexual and reproductive health (Braam & Hessini, 2004). These constructions do not only affect women seeking abortion services, but also affect the nurses who work in providing this service. For instance, in a UK study by Gallagher et al. (2010), abortion providers reported experiencing different reactions in their place of work, which make them aware of various negative attitudes towards abortion, and how their role in abortion services is seen as provocative. They were hesitant to discuss their work or what it entails with people. The stigmatizing reactions were reiterated through clients' preconceptions of what nurses' attitudes would be and how they would be received when they went for an abortion (Gallagher et al., 2010). This strong stigmatizing and marginalizing atmosphere can deter providers from providing quality abortion services, and from freely disclosing their type of work to others. Stigma, thus serves as a powerful barrier to providers obtaining training for and ultimately providing abortion services (Payne et al., 2013).

## **5. Global challenges for TOP provision**

Nurses are often referred to as the backbone of the health system because they make up the majority of healthcare professionals compared to other healthcare professional categories, and because they are often the first point of contact for communities in various geographical settings (Xaba & Rispel, 2013). Since nurses form the backbone of the country's healthcare system, the successful implementation of the CTOP Act is critically dependent on increasing the availability of trained

abortion providers to ensure the provision of quality services at designated facilities (Potgieter & Andrews, 2004).

Quality access to sexual and reproductive healthcare services including safe abortion services requires a skilled, compassionate and motivated health workforce that is sensitive to women's needs. However, the availability of trained and willing healthcare providers remains the most pertinent determinant of safe abortion (Teffo, Levin & Rispel, 2018). There is still a lack of trained providers to perform abortions and facilities designated to provide abortion services specifically in the rural areas (Harries, Gerds, Momberg & Greene Foster, 2007). This often leads women to being subjected to barriers such as delays in accessing first trimester abortion services due to inappropriate referrals before obtaining an abortion; waiting periods of over two weeks; and unwilling and judgemental nurses. As a result, women often require second trimester abortions and encounter difficulties in locating facilities that offer second trimester abortion, and resistance of nurses that provide second trimester abortion (Harries et al., 2007).

The dearth of willing and committed health care providers to deliver timely, thoughtful and supportive abortion care may directly or indirectly contribute to maternal mortality due to unsafe abortions as a result of inaccessible abortion services (Loi et al., 2015). Delays in accessing early abortion services results in high need for second trimester abortions, and abortions above 12 weeks gestation poses greater risks of medical complications than abortions performed during the first trimester (Harries et al., 2007). The lack of trained abortion providers may also be related to healthcare providers who offer abortion services feeling unsupported and alienated by their colleagues (Varkey, 2000). Furthermore, negative attitudes towards nurses who provide abortion services subject them to anxiety, stigma, and violence (Teffo & Rispel, 2017). As nurses are central to the worldwide provision of healthcare services, how they experience their roles has implications for individual staff well-being and the quality of patient care (Nicholson, Slade & Fletcher, 2010).

Abortion still remains a controversial subject in both the public and nurse profession domain. Although the role of services is to enhance quality of life, enhancing one life supposedly at the expense of another, as argued by some, has the potential to create dilemmas (Nicholson et al., 2010). This contributes to nurses' unwillingness to volunteer in providing abortion services. In a study by Loi et al. (2015), nurses from sub-Saharan Africa and Southeast Asia reported disliking being involved with abortion services and are resistant because the expectation to provide abortion conflicts, in their view, with their professional duty to protect life based on the Code of Ethics for Nurses.

As the number of abortions rises owing to familiarity with the procedure, more stress may be placed on nurses (Lipp & Fothergill, 2009). Moreover, the emotional labour that is embedded in the process may be taxing. For example, abortion sometimes involves the foetus being passed vaginally while the woman is fully conscious (Lipp & Fothergill, 2009). This can be a traumatic experience for the provider performing an abortion (registered nurses either perform these procedures themselves if the foetus is less than 12 weeks gestation, or assist the medical practitioner if the pregnancy is between 13 weeks and above (Mayers et al., 2005). Certain facets of mid-trimester terminations between 12 and 24 weeks gestation are identified as being particularly emotionally demanding (Nicholson et al., 2010), and nurses often suppress their feelings regarding aborted foetuses and do not experience relief from their unease or fears related to the death of foetuses (Yang, Che, Hsieh & Wu, 2015).

Nurses from a UK study by Gallagher et al. (2010) reported an unwillingness to care for women seeking an abortion as the gestation of the pregnancy increases, because of the reduced ability to focus primarily on the woman as the client. Gestational age is a key indicator of the acceptability of abortion, and, as a result, nurses find it more traumatic to deal with a termination performed between 17-20 weeks than a termination at 12 weeks. At late gestation the foetus is ascribed more personhood and resembles an infant (Harries et al., 2012). Furthermore, a second trimester medical abortion includes a foetus delivery, and providers find it difficult to handle the foetus especially when it shows vital foetal signs (Andersson et al., 2014). Hospitals often do not encourage abortion providers to discuss their struggles with providing abortion. In addition, they experience more emotional stress and guilt when the foetus is already formed compared to when it presents with anomalies (Yang et al., 2015).

Paying adequate attention to abortion providers' needs such as ensuring a supportive working environment at designated facilities, protecting nurses from abuse, instituting regular debriefing and counselling sessions, and encouraging more nurses to undergo abortion training can help reduce workload for trained abortion providers and enhance quality abortion provision (Xaba & Rispel, 2013). In contrast, lack of management support including management's failure to provide the necessary infrastructure, equipment, supplies and supervision undermines the purpose of legalizing abortion and providing abortion services (Sibuyi, 2004). A considerable burden is placed on nurses by expecting them to cope with situations that have the potential to cause the nurses significant psychological trauma, nurses are expected to manage whatever they are exposed to during their work without the understanding of the lack of support in the nurses' work environment (Huntington, 2002).

Providers in Gresh and Maharaj's (2014) study conducted in South Africa, at a university in Durban admitted that abortion is something that is not often talked about in communities, within families, or even among friends, as it is socially unacceptable. They fear being outcast from their communities, which perpetuates the cycle of unsafe and illegal methods of aborting. Furthermore, they found nurses and other health care workers to be deeply judgemental and often to impose their own views of abortion on their clients (Gresh & Maharaj, 2014). Harries and Constant (2020), indicates that in South Africa little is known about the personal and professional attitudes of providers who are currently working in abortion service provision. Exploring the factors that determine health care providers' involvement or disengagement in services and improving training and support for services providers can facilitate improvement in the planning and provision of future services (Harries & Constant, 2020).

## **6. Present Research**

This research study is part of a training course, titled Abortion Counselling Certificate Course (ACCC) developed by Yamini Kalyanaraman, as part of her PhD. The goals of the training are to: build nurses' skills in abortion counselling; promote client-centred and contextually relevant counselling based on reproductive justice (RJ) principles and the Guidelines published by the Critical Studies in Sexualities and Reproduction (CSSR) research unit; dispel myths regarding abortion consequences with evidence-based research; and to contribute towards nurses conducted within the CSSR on current abortion counselling practices. A formative evaluation of the course was needed. Thus, my research study was developed as part of the abortion counselling training course.

My study explored nurses' experiences of the abortion counselling training course and their understanding of quality abortion services. The following question guided each stage of the research: How does participation in a woman-centred abortion counselling training course alter or confirm participants' reported practices and understanding of abortion counselling? Within this, research sub-questions for the study were: (1) What understandings and practices were reported by participants at the beginning of the counselling course? (2) How did these reported understandings or practices change (if at all) two months after completion of the course? The study is underpinned by a symbolic interactionism (SI) lens and a grounded theory informed analysis.

Using grounded theory methodology alongside symbolic interactionism, this thesis explores nurses' experiences of an abortion counselling training course and their understandings of quality abortion services. To collect the data, recordings from three sessions of the training course and individual semi-structured interviews were conducted. The providers who participated in the training course

were 8 females and 1 male from different hospitals and health care centres in the Eastern Cape. The grounded theory methodology allowed for nurses' understandings of quality abortion and their experiences of the training course to be explained. This research will afford the developers of the training course the opportunity to improve the course, since there is limited research on abortion counselling training (Bluff, 2005).

### **7. Notes on Terminology**

As the author of this thesis, I refer to myself in the first person. In doing so, I am positioning myself within the research process of knowledge production rather than locating myself as a neutral researcher, which would position me as an objective outsider.

I have chosen to use the term 'participants' as opposed to 'research subjects'. The former recognizes the active involvement of the nurses while the latter suggests that the nurses who partook in this study were something to be studied and is thus degrading. I also used the terms "nurses" and "providers" interchangeably throughout my writing to acknowledge the participants' profession as more than abortion providers.

I use the terms "abortion" and "termination of pregnancy" interchangeably. I have used the term foetus when discussing legal gestational access to abortion services and refrained from using "baby" due to its offensive denotation.

### **8. Overview of the chapters**

This thesis comprises of seven chapters in total. In chapter 1, I engaged with contextualizing my research. In chapter 2, I discuss the theoretical framework and perspectives used to inform my research process. Starting broadly from grounded theory, I move on to outline important concepts concerning symbolic interactionism, constructivist grounded theory and how grounded theory has been applied in nursing research in previous studies. I discuss some of the advantages and disadvantages of using grounded theory. In chapter 3, I review the literature on the need for abortion counselling, the potential pitfalls of abortion counselling, the role of the provider, client-centred abortion counselling, and women's experiences of abortion counselling globally. I also highlight any gaps in the research. Importantly, I look at nurses' experiences of offering abortion counselling, their experiences with their colleagues, reasons for working as abortion providers and abortion training in South Africa.

Chapter 4, the methodology chapter, discusses in detail the research process. In addition to discussions around data collection and data analysis, the chapter covers a section on the ethical

considerations related to this study as well as a section in which I reflect on the research process and the various decisions made that inevitably shaped the ‘final product’. My analysis and interpretation of the data are spread over two chapters. In chapter 5, firstly I discuss the various themes that emerge from the data collected through the nurses’ discussions around current counselling practices, whereby nurses discussed background practices and counselling experiences as abortion providers. Secondly, in the reflection activity, nurses were tasked to work in pairs and reflected on their counselling sessions in accordance to the training course guidelines. Thirdly, from case presentations, the providers presented cases encountered from their field work two weeks after the initial training commenced. Lastly, from the semi-structured interviews I discussed data that emerged from open-ended questions that were asked to participants to find out whether or not participating in the abortion counselling training course altered their practice and understanding of quality abortion counselling. Finally, I conclude this thesis in chapter 7, by discussing the findings of participating in abortion counselling training course, which concluded that participating in the abortion counselling training course did alter the nurses’ practices and understanding of quality abortion counselling however, systemic issues still poses hindrance in accessing quality abortion care and services. I then discuss the limitations of the study and recommendations for future practice.

## **Chapter Two: Theoretical Framework**

### **1. Introduction**

I begin this chapter by introducing the concept of grounded theory. My research is informed by grounded theory because it provides a way of unveiling the common understanding of a certain phenomenon and its relationships from the perspective of those involved and enables the emergence of new relationships that are theoretically relevant (Anderson, Inoue, & Walsh, 2013). My research is specifically interested in nurses' experiences of an abortion counselling course, and if and how their participation in the course influence their practice. Symbolic interactionism (SI) thus, is a suitable framework because it focuses on human interaction, and how individuals make sense of their world. Integrating SI and grounded theory for my research helped illuminate how nurses experience their professional conduct of abortion counselling, prior to and after being of the abortion counselling training course, since the methodology has the capability to elucidate the lived experiences of individuals within human interactions (in this case abortion counselling and abortion counselling training).

### **2. Grounded Theory and Methodology**

Grounded theory is a general methodology for developing a theory that is grounded in data that are systematically gathered and analyzed (Strauss & Corbin, 1990). It is a theory/method that aims at discovering and defining processes (Charmaz, 1996). It attempts to explain and provide insight into the phenomenon under study, requiring a creative process that is suitable to use when there is a lack of knowledge or theory on a topic (Bluff, 2005). A grounded theory is a theory that is discovered, developed, and conditionally confirmed through systematic data collection and data analysis pertaining to a certain phenomenon. It is an iterative theory that requires constant comparison across forms of evidence to control the conceptual level and possibility of emerging theory (Japhet & Usman, 2013). Grounded theory methods are referred to as inductive in that they are a process of building up theory from the data itself. Induction of theory is achieved through successive comparative analysis (Birks & Mills, 2015). It is an analytic technique based in the interpretative tradition, which is used to examine social situations and construction of reality. Grounded theory is informed by symbolic interactionism (Stanley & Cheek, 2016).

Grounded theory emerged in the 1960's as a result of Glaser and Strauss's (1960) sociological research programme on dying in hospitals. They crafted a method that enabled the researcher to systematically generate a substantive theory that is grounded in empirical data, with the aim of

discovering a theory that fits the data, and that would work in the real world (Walker & Myrick, 2006). Grounded theory is, thus, generated and developed through the interaction with data collected during research projects. The goal for this type of theory is to contribute toward closing the gap between theory and empirical research (Strauss & Corbin, 1990).

As a general methodology, grounded theory encourages a way of thinking about and of conceptualizing data. It is designed to guide researchers in providing theory that is conceptually dense, meaning that it is designed to help researchers develop a theory that has various conceptual relationships. These relationships are stated as propositions, which set it apart from other qualitative methods that are often presented in discursive forms (Strauss & Corbin, 1990).

The methods in grounded theory are suitable for studying individual processes, interpersonal relations and reciprocal effects between people and larger social processes. They require the researcher to attempt to describe, explain and understand the lived experiences of a group of people (Charmaz, 1996). Grounded theory researchers are interested in patterns of action and interactions between and among different types of social units. They are interested in discovering processes of reciprocal changes in patterns of interactions (Strauss & Corbin, 1990). This type of study aims at capturing the worlds of individuals by describing their situations, thoughts, feelings, actions and by portraying the research participants' lives and voices (Charmaz, 1996).

Charmaz (1996) argues that a grounded theory method offers a way of constructing sociological reality, which may be fostered through developing analytic and conceptual constructions of the data. In their analyses, grounded theorists aim to create theoretical categories from the data and then analyze relationships between key categories. By beginning with the data from the lived experiences of the research participants, the researcher can, from the start, attend to how participants construct their world. Thus, lived experiences shape the researcher's approach to data collection and analysis (Charmaz, 1990).

According to Andrews et al. (2017), grounded theory is one of the most widely used qualitative research methodologies in nursing comprising a set of steps that are rigorous and systematic, and guide researchers from the time they enter the field to when they leave.

Grounded theory methodology has the potential to provide an action guide through a broader understanding of the phenomenon, which is very important in the nursing and health field.

There are three main versions of the methodology, namely, classic grounded theory founded by Glaser (and Strauss, initially), Straussian grounded theory founded by Corbin and Strauss, and

constructivist grounded theory founded by Charmaz. The latter version originated in response to what was seen as grounded theory's failure to take account of postmodernism, specifically debates around the nature of reality, resulting in grounded theory being criticized for being objectivist (Andrews et al., 2017).

The objectivist approach is characterized, among other aspects, by neutrality, passivity and observer's authority. It understands the analysis of data as an objective process (Crossetti, 2016). The constructivist approach presents an interpretative understanding, in which it is understood that the observer's values, priorities, positions and actions affect the observations. It recognizes the subjectivities of the researchers in the data analysis, which is built based on reflection (Charmaz, 2009). This approach assumes that people, and even the researchers, construct the realities they share. The constructivist investigation begins from experience and inquires how participants construct experience; thereby, both the researcher and participant interpret the meanings and actions of this experience. Researchers in constructivist grounded theory assume that both data and analysis are characterized as social constructions. Thus, the whole analysis is situated in time, space, culture and the experienced condition (Charmaz, 2009). In this perspective, the constructivist approach suits the nature of qualitative studies in nursing which seek to understand experiences of the complex interactions built into healthcare labour (Siqueira & Herdmann, 2008).

Chamberlain-Salaun, Mills and Usher (2013) argue that symbolic interactionism forms the foundation of essential grounded theory methods. Thus, prior to discussing constructivist grounded theory, I outline key concepts within symbolic interactionism. Symbolic interactionism is a theoretical framework often applied in nursing research because of the ongoing human relationship that happens between patients and the nursing staff in the interactive process of care (Lopes & Jorge, 2005). Furthermore, by enabling the understanding of human responses and uncovering the meanings attributed by individuals to those experienced situations, it values the language of speech and also the symbolic nature of their behaviour (Carvalho, Silva, Oliveira & Camargo, 2007).

### **3. Symbolic Interactionism**

Symbolic interactionism (SI) is a worldview that provides a philosophical underpinning to grounded theory (Miliken & Schreiver, 2012). It is an empirical social science perspective used in the study of human group life and human conduct (Chamberlain-Salaun et al., 2013). Symbolic interactionism has often been identified as a component of the theoretical foundations for applied qualitative health research (Handberg et al., 2015). Bowers (1998) defined SI as a social psychological theory of action.

It focuses on the processes of social interaction by which individuals make sense of the world (Oliver, 2016).

George Herbert was the founding father of SI; however, this perspective was named and popularized by his student Herbert Blumer. “The core principle of SI is that human beings act toward things on the basis of the meanings that these things have for them” (Blumer, 1969, p.2). Thus, a central feature of SI is the inseparability of the individual and the context within which the individual exists, and because of this, SI has been considered a powerful framework to guide research that is intended to lead toward an understanding of human health and healthcare behaviour within a social context (Handberg et al., 2015).

According to Charmaz (2006), symbolic interactionism in grounded theory results from the influence of the Chicago School of Strauss, which saw people as active agents in their lives, and that they are not passive to the social forces that surround them. Furthermore, in its theoretical perspective, SI sees society, reality and individuals as established through interaction, including language and communication. This view assumes that interaction is fundamentally dynamic, interpretive, and this is how people create, represent and alter meanings and actions (Crossetti, 2016).

SI believes that the behaviour of individuals and the roles that they adopt are determined by how they interpret and give meaning to symbols. The meaning of symbols such as language, dress and actions are shared by people within a culture and are learned through a process of socialization. Giving meaning to symbols enables the behaviors of others to be predictable, and individuals respond to these predictions by adapting their behaviours to others. Thus, grounded theory makes explicit the reality of how individuals perceive their world and the way they interact with each other (Bluff, 2005).

According to Handberg et al. (2015), SI builds on three relatively simple assumptions (1) individuals strive and act toward what represents meaning for them, (2) meaning arises out of social interaction, and (3) meaning is dealt with and modified through interpretative processes. Elaborating on these assumptions, the authors assert, firstly, that human beings interact individually and also collectively. They act toward things on the basis of the meanings that they have for them, meaning they do not directly respond to objects but rather attach meaning, modify that meaning, and act on the basis of that meaning. Secondly, individually or collectively, the meaning one makes of things arises from social interactions. And because meaning is also founded on the way other individuals act, SI presumes that people act on the basis of a shared understanding of meaning in their environment. Lastly, SI assumes that these meanings are handled in, and modified through, an interpretive process (Handberg et al., 2015).

The SI lens tells us that interaction occurs through the use of symbols starting with the self and others within a particular reference group (Burbank & Martins, 2010). It can help do justice to multiple and intersecting meanings that may be at play. Furthermore, its distinctive role requires the researcher to remain open throughout data collection and analysis to the social context within which people's subjective experiences are shaped (Burbank & Martins, 2010). SI makes meaning accessible in the sense of understanding both the meaning itself and also what the participants are striving for in relation to it (Handberg et al., 2015).

The researcher using SI is therefore curious not only about specific meanings that arise but also about how meaning actually functions as a core element in the phenomenon under study (Handberg et al., 2015). SI compels the researcher to look closely at the research participants' interpretations of their actions and situations. This is because symbolic interactionists assume that as thinking, acting, and creative individuals, people respond to the actions of others. Thus, a symbolic interactionist's perspective leads one to look at the self and meaning as a process (Charmaz, 1990).

Carlson (2013) indicates that the core principles of SI can be summarized as meaning, language and thought. I elaborate on these three points below.

### ***3.1. Meaning***

In SI, meaning making is understood to be a social process which defines a situation. What is understandable and meaningful to individuals, is not given in the nature of things themselves but rather emerges from an interpretative process. During this process, language becomes the means through which humans negotiate. In other words, people are social and reflecting individuals and the interpretative process is based on the use of socially constructed objects or symbols such as verbal and non-verbal communication. Therefore, to understand and create meaning people need to think and reflect on previously gained experiences; this process or function is described as the mind (Meltzer, 2003).

According to Oliver (2016), meaning does not inhere in things, but stems through interaction between subject and object. Meanings are handled in, and modified through, an interpretative process used by the individual dealing with the things they encounter. This means that humans can be understood only through what they do, and inquiry should be directed at that which makes a practical difference in the real world of human action.

### ***3.2.Mind/Thought***

The mind develops simultaneously with the self. For symbolic interactionists, the mind is the process of internal conversation, of the individual in symbolic interaction with the self. It is socially derived, stemming from communication and association with others. As a result of this interaction and role playing, the individual internalizes the definitions, symbols, meanings, and perspectives of others and is able to process information internally within a variety of contexts (Milliken & Schreiber, 2012).

It is the mind that enables people to comprehend and employ the symbols that make human society possible. This occurs through the three unique features of the human mind, (a) the use of symbols to designate objects in the environment, (b) the ability to rehearse covertly the alternative approaches to action toward objects and situations, and (c) the capacity to select appropriate courses of action. This selectivity does not necessarily reflect conscious behaviour; however, it suggests that the individual plays a role in shaping their own environment (Meltzer, 2003).

### ***3.3.Language***

Language itself patterns experience and this symbolic communication, drawing on shared meanings, allows people to become aware of the experiences of others and interpret their meaning (Oliver, 2016). Although symbols arise from social interaction, at the same time, they shape social interaction and create social realities. Languages are powerful symbol systems that structure the nature of what can be seen and considered (Milliken & Schreiber, 2012). Similarly, languages develop and are used variously by different groups of people in response to their needs (Oliver, 2016).

The centrality of language as a symbol has many implications for the grounded theorist in that data are composed of either spoken or written language, and field observations are recorded either electronically or in written language. Language, thus, is the only means researchers have to consider and communicate understandings of social phenomenon (Milliken & Schreiber, 2012). An SI study is about the ways in which individuals develop their lines of action in alignment with, or as a reaction to those of others, including researchers. The purpose is to understand how people and groups make meaning and act in situations in which automatic responses are inadequate (Oliver, 2016).

## **4. Constructivist Grounded Theory**

According to Charmaz (2009), constructivist grounded theory seeks to do the following: uncover what happens in research settings where the researcher is integrated; understand how research participants explain their statements and actions; and also question the analytical understanding that the researcher can obtain from these data, that is, the understanding of the experience studied. Furthermore, its characteristic feature is the exploration of the process underlying the phenomena studied in order to

demonstrate which social and psychological processes laid the foundation of these phenomena (Tarozzi, 2011). In constructivist research, humans, although historical and social beings are responsible for preserving or transforming the context in which they live. Researchers also seek flexibility and adaptation and show the relation between the researcher and participants of the study (Thoferhn, Leopardi, & Amestoy, 2008). Thus, using constructivist grounded theory to inform my research study will help demonstrate how nurses experience and adapt in their practice when providing abortion counselling and abortion services. This will illuminate what they consider and experience as quality abortion services.

#### ***4.1. Methodological procedures in Constructivist Grounded Theory***

The following section will discuss data collection and analysis, researchers in grounded theory, constant comparison and theoretical sampling. These are procedures that inform constructivist grounded theory when conducting research.

##### ***4.1.1. Data Collection and Analysis***

Although the majority of grounded theory researchers use interview data, grounded theory can consist of various types of data, quantitative or qualitative, as well as data from any verbal or written sources. Often, interview data can be augmented through observation and written sources, such as the researcher's field notes or journals kept by research participants (Hernandez, 2010). I specifically for this thesis engaged in recordings of discussions around abortion counselling, role play activity, case presentations and individual semi-structured interviews to collect my data. Grounded theory researchers are advised to always collect their own data, unless this is impossible due to language barriers or site access issues: audiotaping or videotaping is essential in such situations. In addition, the researcher enters the field with a general curiosity to know more about a specific area of research but should not have definitive preconceived hypotheses (Hernandez, 2010).

In the initial stages of grounded theory, semi-structured interviews are usually conducted. The suggested interview is of the intensive type, characterized by broad and open-ended, non-evaluative questions, in which the interviewer expresses interest to deepen a particular theme. This type of interview allows for the examination of precise speech details of an interviewee with relevant experiences (Charmaz, 2006).

Grounded theorists affirm, check, and refine their developing ideas, but they do not limit themselves to preconceived hypotheses nor do they follow prescribed principles of traditional random sampling required for statistical verification. Grounded theory researchers derive their analytic categories

directly from the data, and not from preconceived hypotheses (Charmaz, 1996). Grounded theory also differs from other qualitative approaches. Most qualitative approaches emphasize collecting copious amounts of data before delving into the analysis, and researchers using such approaches often complete their major analytic work long after they have left the field (Charmaz, 1990). This is not the case in grounded theory research, because grounded theorists collect and analyze their data simultaneously.

In grounded theory, data analysis occurs concomitantly with data collection so that the researcher can build their data and realize the need to expand the number of participants and/or select the key features that can contribute to the understanding/interpretation of the phenomenon. The possibility of increasing the number of participants characterizes the theoretical sampling, which is another important feature of grounded theory that is linked to analytical and methodological assumptions of grounded theory (Crossetti, 2016). Although my methodology did not allow for the recruitment of additional participants, analysis started after the counselling programme and continued during the collection of interview data. In general, grounded theory interviews take place in parallel with the method of constant comparison at all levels of analysis, coding from the data, development of concepts rather than descriptions, conducting memos, diagrams, concept maps, illustrations to aid understanding and construction of categories (Crossetti, 2016).

#### ***4.1.2. The role of researchers in Ground Theory***

The initial decisions regarding grounded theory are not established on a preconceived theoretical framework of the phenomenon under study but rather on the general understanding of the phenomenon under investigation, which is considered sufficient for the initiation of the research. The initiation of the grounded theory research involves, simply, the selection of an area of inquiry by the researcher and an appropriate site for study (Egan, 2002). Researchers are prompted to begin with an area to study and proceed to build theoretical analysis on what they discover to be relevant in the actual worlds under study (Charmaz, 1996).

In grounded theory, the researcher looks for processes that occur in social situations and they study these social processes in order to arrive at a theory that explains the action in the social context under study (Stanley & Cheek, 2016). Thus, grounded theory is specifically useful in areas where limited or little knowledge about the phenomenon of interest exist or where there are few adequate theories to explain an individual's or group's behaviour. It was, therefore, essential for this theory to inform my research because there is little knowledge on how nurses respond to a client-centred abortion counselling training course. Grounded theory's focus is on the daily life situations of individuals

where the processes, relationships, meanings and adaptations require explication, and the researcher attempts to discover these processes individuals use to make sense of their situation (Stanley & Cheek, 2016).

The researcher should initially focus on relaying observations and maintaining a theoretical sensitivity regarding the categories emerging from the data. This means that the researcher begins with individual cases, incidents or experiences and progressively develops more abstract conceptual categories to synthesize, explain and understand, and to identify patterned relationships within the data (Charmaz, 1996). Categories provide meaningful pictures which helps the reader to see and to hear vividly from the perspective of study participants (Egan, 2002). Categories need to be given labels. These may be direct phrases said by the research participants that represent theoretical definitions of what is happening in the data (Charmaz, 2009).

According to Charmaz (1990), throughout the research and writing processes, grounded theorists follow interest, leads, and hunches that they find or identify in the data. They may furthermore gather more data, ask more questions, and check their developing categories, and these emergent categories explain and conceptualize the data, common sense understandings of these data, and most likely other theoretical interpretations. This is because grounded studies aim for analytic power and conceptual grasp which synthesize, explain and interpret the data. The rigour of the grounded theory method depends on, firstly, developing a range of relevant conceptual categories, and, secondly, saturating, which is filling, supporting, and providing repeated evidence for those categories, and explaining the data (Charmaz, 1990).

In general, grounded theory is seen as a method for building theory, not verifying it (Seidel & Recker, 2009). The approach is based on two main principles. First, the process of the theory building is highly iterative, during which theory and data are constantly compared. This process can be referred to as comparative analysis. Secondly, grounded theory method builds upon theoretical sampling as a process of data collection and analysis that is driven by concepts that emerge from the study and appear to be of relevance to the nascent theory (Seidel et al., 2009).

#### ***4.1.3. Constant Comparison***

Constant comparison method is the heart of grounded theory where the analyst starts by coding the data for incidents that explain what is happening in the data. As codes are developed, they are compared with previous codes from within the same interview and from other interviews. These codes are progressively clustered into categories, and as the coding continues, the constant comparative

units change from the comparison of codes representing incidents to comparison with the properties of the categories (Adolph, Hall & Krutchen, 2008).

Constant comparison method is facilitated by the simultaneous and iterative collection of data and analysis. This is what differentiates grounded theory from other methods of inquiry, where all data are collected during a data collection phase and then analyzed during an analysis phase. Furthermore, this method enables the researcher to adjust their questions as the on-going analysis begins to reveal the key concerns and problems the participants are resolving. Thus, the developing theory guides the inquiry, because without constant comparison there is no grounded theory (Adolph et al., 2008).

#### ***4.1.4. Theoretical Sampling***

Grounded theory employs theoretical sampling where the analyst jointly collects, codes, and analyses their data and decides what to collect next and where to find it, in order to develop the theory as it emerges (Adolph et al., 2008).

Theoretical sampling begins during the data collection phase of the study and involves searching the transcripts for emerging categories that characterize the narrative and seem important. It is a process of data collection for generating theory whereby the analyst jointly collects codes and analyses data and decides what data to collect next in order to develop theory as it emerges (Glaser, 1978). Furthermore, theoretical sampling and constant comparison reflect cyclic processes which are fluid and flexible. Researchers should, however, at the same time ensure that the analysis is planned and well-grounded on the data, rather than disorganized, which can lead the analyst on paths that divert from the focus of the study (Japhet & Usman, 2013).

Much theoretical sampling is devoted to the quest of attaining theoretical saturation, and the theoretical categories are mandatory for this achievement. Theoretical saturation means saturation of the properties of a theoretical category. It is a process that occurs when more data that are gathered ceases to shed any more light on the properties of their theoretical category (Charmaz, 2008). At this stage, where no new information emerges, a grounded theory study is concluded and the researcher begins to write up the results (Egan, 2002).

Grounded theory has gone on to become one of the most widely popularized methods on the qualitative health research spectrum (Morse, 2009). It has been taken up as an ideal approach for documenting the core processes associated with change in social groups, and for explaining what is happening within a social context. It is an approach to research that formalizes and informs theorizing from the data (Handberg et al, 2015).

## 5. Grounded Theory in Nursing Research/Practice

The nature of nursing as a social and humanistic discipline presupposes actions, whose interaction among the subjects involved occurs despite the contexts or situations. This social interaction is mediated by the meanings attributes by these subjects to phenomena of practice whose interpretation enables building a conceptual basis, and promoting the development of the area. This produced theoretical knowledge can guide how nursing is done, towards the accuracy of the care process (Crossetti, 2016).

Grounded theory is growing in popularity in nursing research as it allows explanations of experiences and behaviours of nurses which have the potential to encourage them to think about the effectiveness of certain behaviours (Milliken et al., 2020). This is because grounded theory offers an explanation of the main concern for participants and the patterns of behaviour that are grounded in the everyday realities used to resolve or process this concern (Glaser, 1978).

The grounded theory methodology encourages the exploration of patterns of behaviours that are grounded in the realities of day-to-day practice, thus, informing practice and future research (Hunter et al., 2011). The quality and usability of grounded theory are of key importance for the practicing nurse striving to utilize relevant evidence than can underpin their practice. And one way of judging the quality of the work is by evaluating methodological rigour and how the methods used can have an impact on the quality of the emerging theory (Markey et al., 2020). Researchers have an obligation in ensuring rigour whilst generating research findings that have relevance and efficacy for the practicing nurse, as a means of improving the transition from research to practice (Markey et al., 2020). Providing quality and safe patient care underpinned by paramount evidence is fundamental to health care services globally. However, as health care services and evidence supporting practice continue to evolve, keeping abreast with relevant evidence in day-to-day nursing practice is essential (Markey et al., 2020).

Grounded theory is a powerful research methodology for understanding client behaviour in a specific area, and it is therefore especially relevant for nurse researchers. Nurse researchers use grounded theory more frequently than other qualitative analysis research methods because of its ability to provide insight into clients' experiences and to make a positive impact (Hernandez, 2010). Knowledge gained from grounded theory research can be utilized to establish measures for enhancing client-nurse relationships, improving quality of care, and ultimately improving a client's quality of life. Moreover, it can serve to expand disciplinary knowledge in nursing because the resulting

substantive theory is a middle-range theory that can be subjected to later quantitative testing (Hernandez, 2010).

According to Glaser (2005), grounded theory has become popular in nursing, and also the most frequently cited methodology for use with qualitative data (Loiselle, Profetto-McGrath, Polit, & Beck, 2004). Thus, grounded theory is chosen for this inherent purpose to illuminate nurses' experiences of an abortion counselling training course, their understandings of quality abortion services and whether or not being part of this training course has altered their practice.

## **6. Advantages of Using Grounded Theory**

The main advantages of grounded theory are its intuitive appeal, ability to foster creativity, its conceptualization potential, its systematic approach to data analysis, and the fact that researchers using it can gather rich data (El Hussein, Hirst, Salyers & Osuji, 2014). Each of these is discussed below.

Myers (2009) argues that grounded theory has an intuitive appeal for new investigators because it allows them to get immersed deeply within the data. This immersion is translated practically in the constant comparison, coding and memoing approaches to data analysis. Charmaz (2006) also supports this notion and affirms that grounded theory provides new researchers with the needed principles and exploratory devices to begin, stay involved, and finish the project at hand. Furthermore, intuitive appeal informs researchers on how to carry out their research, and is very useful in answering their questions, illuminating their thinking and for providing them with reassurance when uncertainties arise during the research process (Charmaz, 2006).

Grounded theory allows for the potential to conceptualize. It is unique in its ability to generate concepts by using the logic of constant comparison and frequent memo writing (Glaser, 1978). This specific approach to theory development is derived from the continuous interplay between data collection and data analysis (Myers, 2009). Glaser (1978) argued that concepts have broadening power and are easier to remember as they encompass a myriad of incidents, which facilitates the transferability of these concepts into unfamiliar contexts. Furthermore, there is much value in the conceptualizing and conceptual ordering of research data (Glaser, 1978).

A notable advantage of grounded theory is in its systematic approach to data analysis. Glaser (1978) defined grounded theory as "systematic generating of theory from data that itself is systematically obtained from social research" (p.2). This systematic approach of analyzing data is essential in judging, generalizing and comparing the results of grounded theory research (Strauss & Corbin,

1990). Systematic procedures such as simultaneous collection and analysis of data, the constant comparative logic and theory that emerges from data provide grounded theory with rigour that is not accounted for in other qualitative approaches (Charmaz, 2006). Additionally, being systematic provides the researchers with enough evidence to support their claims (Myers, 2009).

### **7. Disadvantages of Using Grounded Theory**

According to Myers (2009), new researchers can become overwhelmed at the coding level with grounded theory, as open coding is a time consuming, tiring and laborious process. The process of abstracting and encompassing concepts is not an easy task, and new researchers may become so hindered and absorbed with the coding process that they may lose sight of achieving the task of discovering the ideas and themes that emerge from the data (Myers, 2009).

Using grounded theory, may result in high potential methodological errors. According to El Hussein et al., (2014), new researchers may use only one source of data; it is recommended that a researcher undertakes both observations and interviews as part of the data collection process (which occurred in this study). If a researcher ignores this advice, it may cause them to focus on the lived experiences of the participants instead of on the social process (El Hussein et al., 2014). Hence, this research study used four sources of data; discussions around abortion counselling, reflection activity, and case presentations (where participants were being observed), and semi-structured individual interviews.

Another limitation to using grounded theory is the reviewing of literature without developing assumptions. Reviewing the literature is a contentious and debatable issue in grounded theory that sometimes discourages academics from using the method. Throughout the evolutions of grounded theory, researchers have repeatedly debated how best to approach and utilize existing literature within the research study (Charmaz & Bryant, 2010). For some, researchers are bluntly encouraged to write the literature review after completing the analysis so as not to contaminate the research findings (Charmaz & Bryant, 2010). For others, it is an iterative process. The researcher becomes sensitive to what is in the data through immersion in it, as well as based on the researcher's preceding professional and personal knowledge and experiences (El Hussein et al., 2014). In other words, these insights prepare the researcher to understand and interpret data. It is through awareness and acknowledgement of the researcher's background, knowledge and perspective that the researcher is able to see the data without prejudging it or forcing preconceived explanations on it (El Hussein et al., 2014).

Using grounded theory can also limit generalizability. According to Polit and Beck (2010), "generalization is an act of reasoning that involves drawing broad conclusions from particular instances that makes inferences about the unobserved based on the observed" (p. 1451). The issue of

generalization is less frequently discussed in qualitative research, and is considered complicated and controversial because the main goal of qualitative research is to provide a rich and contextualized understanding of human experience (El Hussein et al., 2014).

Research questions that are explored through grounded theory methods permit for a unique opportunity to deduce findings that further explain research participants' experiences. This unique opportunity is due to the nature of grounded theory exploration and its ability to illuminate high level concepts and theories that are not specific to particular participants or settings (Glaser, 2002). Stebbins (2001) emphasized that the main goal of exploratory research is the production of inductively derived generalizations about the group, process, activity, or situation under study. Afterwards, the researcher weaves these generalizations into grounded theory (Stebbins, 2001). Thus, considering the nature of grounded theory as a qualitative method of inquiry, threats to generalizability may be limitations of the research being undertaken and warrant consideration by the researcher (El Hussein et al., 2014).

## **8. Conclusion**

This theoretical chapter began with a broad look at grounded theory and the symbolic interactionism framework which may be seen as the overarching theory underpinning this research. As mentioned previously, symbolic interactionism argues that through human interaction, individuals define and experience their world. Through this interaction, meaning arises and individuals act towards what has meaning for them, and interact with groups with whom they share the same meanings. Furthermore, I discussed the utilization of grounded theory in nursing research and practice. Finally, I outlined the advantages and limitations of using grounded theory as a methodology. In the following chapter I review the literature around abortion counselling and nurses' experiences of providing abortion services. The literature was reviewed before data was analysed in order to gain background and knowledge on some of the research done relating to my research topic, and after to ensure that it relates to the findings emerging from the data collected.

## **Chapter Three: Literature Review**

### **1. Introduction**

The aim of this chapter is to highlight the areas of abortion counselling research that are relevant to this study. In the previous chapter, I introduced grounded theory and symbolic interactionism as a framework that has the potential to illuminate nurses' reported abortion counselling practice. It allows for the exploration of patterns of experiences and behaviours of nurses that are grounded in the realities of day to day practice, therefore informing practice.

I begin this chapter by discussing the need for abortion counselling, which highlights the kind of counselling women seek. I proceed to discuss the goals of counselling and examine literature on the different objectives of offering abortion counselling. I then delve into discussing potential pitfalls in abortion service provision, the role of the provider, client-centred abortion counselling, and women's experiences of abortion counselling. Finally, this chapter will discuss abortion counselling training.

### **2. The Need of Abortion Counselling**

Abortion procedures often cause women who undergo an abortion to experience a range of emotions that include regret, guilt, sadness and relief. Emotions may include a sense of isolation when accessing abortion services and undergoing the procedure (Baron, Cameron & Johnston, 2015). Thus, it is important that abortion services offer women a safe, rights-based environment that supports open discussion with referral to support services as required (Birdsey, Cranshaw, Mould & Ramklaas, 2016).

Counselling in abortion is a focused and interactive process that allows a woman to voluntarily receive support, information and non-directive guidance from a trained provider (Birdsey et al., 2016). According to Hoggart (2015), counselling is the provision of an opportunity for women seeking an abortion to discuss their situation, and to obtain information, explanation and advice.

According to Baron et al. (2015), abortion counselling has different functions. Firstly, it offers pregnant women the opportunity to talk through and to better understand the implications of their proposed course of action to abort an unwanted pregnancy; secondly, counselling provides emotional support to women who undergo abortion; and lastly, it helps women deal with problems, if any that may arise from the procedure, both physically and emotionally. Joffe (2013) also argues that abortion counselling involves three separate functions: obtaining informed consent from clients, which includes ruling out coercion; patient education, which involves explaining the actual technical aspects of the procedure and possible complications; and counselling that involves addressing the client's

feelings about her forthcoming procedure. Rowland (2008) argues that there is a need to distinguish between the different types of counselling ranging from general support and information, through to therapeutic counselling, because much of the research focuses on what has been described as decision counselling, which is often more therapeutic in nature.

Abortion counselling is mainly envisaged in the context of ensuring that all women who are considering an abortion are provided with enough information with which will help make an informed decision, and that they are not pressured into making their decision (Hoggart, 2015). Counselling services are required to inform potential clients of abortion procedures, possible risks and of alternative options (Sasha, Shrestha, Koirala, Kandel & Shrestha, 2007). Research indicates that women value being given clear information about abortion at the pre-abortion consultation (Rowlands, 2008). Women seeking abortion services need information and education due to misinformation, inadequate knowledge or misunderstandings of reproduction and contraception matters (Tabbutt-Henry & Graff, 2019). This service ensures that clients have the necessary information and support to understand and complete all aspects of abortion procedure (Breitbart, 2000).

Decision counselling, for the most part, does not involve therapeutic counselling. However, if women are experiencing difficulties with abortion decision-making, for any particular complex reasons, then therapeutic counselling should be available (Hoggart, 2015). Women value an uncomplicated referral process for such counselling (Rowlands, 2008). Therapeutic counselling plays an important role of providing support and reassurance for women rather than objectively aiding the decision making process (Baron et al., 2015).

Despite the need for abortion counselling, some authors are concerned with making it mandatory. In their study in Central and Eastern European countries, Hctor and Lamackova (2017) found that mandatory counselling is often directive, and focuses on the negative aspects of abortion such as claims that abortion causes psychological harm. Counselling mandated by the state/government often requires healthcare providers to overemphasize the risks involved in abortion procedures, to portray abortion as harmful, or to provide other inaccurate information. Furthermore, mandating that a woman undergo counselling before an abortion contravenes the need for counselling to be entered into voluntarily, and undermines the women's right to refuse information and to proceed to treatment without it (Hctor & Lamackova, 2017). This is because mandated counselling requirements can contain misleading elements that may exacerbate stigma, as they often direct women seeking an

abortion toward continuing the pregnancy, and underscore possible risks of abortion (Sonalkar, Gurney, McAllister & Schreiber, 2017).

Brown (2013) argues that making counselling mandatory changes the fundamental nature in which counselling ought to take place. This is because, if it is a legal requirement, the role of the counsellor may then be put into question meaning: is their role to grant permission for an abortion, to place a woman in a position to justify her decision to terminate the pregnancy, or merely to be present? Mandatory counselling gives power to the counsellor with the potential of altering the relationship between counsellor and client. Therefore, in such instances, the concern of the client may be more about providing the “right” answers than engaging in a free and open discussion (Brown, 2013).

Moore, Frohwirth and Blades (2011) argue that the goals of abortion counselling are to be empathetic and supportive, in order to ensure that a woman understands her options, and to provide information about the abortion process and the procedure. Nevertheless, the way abortion counselling is carried out is often determined at the clinic ownership level (if privately owned), and can vary according to the clinic philosophy and capability based on staff and client flow (Moore et al., 2011).

Khanal, Joshi, Neupane and Karkee (2011) maintain that because abortion can be a sensitive process, abortion counselling is a good space within which to discuss family planning measures that can help to save time, pain and resources that may arise due to seeking abortions services. In Nepal where their research was conducted, the provision of information on contraception in abortion counselling is seen as needed to meet reproductive health service standards. This is because contraception acceptance is a prerequisite to accessing abortion care in this country. There is however, controversy about this kind of requirement. Not only does it violate the principle of voluntary counselling and client-centred care based on non- coercion, but it also increases chances of contraceptive discontinuation in the future (Birdsey et al., 2016). Furthermore, if contraceptive use is not sustained by repetitive counselling during consecutive visits, the chance of repeat abortion increases. Moreover, family planning is only continuous when there is reinforcement of building skills to sustain behaviour change (Khanal et al., 2011).

### **3. Potential pitfalls in counselling**

According to Brown (2013), the relationship between abortion performed under safe and legal conditions, and mental health has become increasingly contentious, and many of those against abortion insist that massive, and long-term mental and emotional distress is the outcome. These so-called negative effects may be used in counselling to dissuade women from choosing to terminate their pregnancy (Brown, 2013). However, there is no evidence of psychological fall-out as a result of

the abortion for the majority of women who have undergone an abortion. Women who have experienced emotional distress after an abortion often had previous mental health problems which suggest that the underlying problem causes the mental health issue (Charles et al., 2008).

Other misinformation such as risk to life, risk of breast cancer, future infertility and foetal pain, is also insisted upon by anti-abortion organizations, mostly in the UK and USA, and is usually based on distorted interpretations of scientific literature (Brown, 2013). Abortion counselling in these instances acts as an extension of surveillance and control over women's bodies rather than as a means to enable women to make meaningful choices (Vincent, 2011).

In many contexts abortion counselling practices have constructed the woman who seeks an abortion as someone who is in crisis. The idea of abortion seeking being evidence of a crisis in the lives of individual women has been accompanied in South Africa by media and public alarm at the concept of repeat abortions or women using abortion as a form of contraception (Vincent, 2011). Vincent (2011), also points out that an appropriate abortion counselling service in a state where freedom of religion, belief and conscience are constitutionally protected needs to take care that it does not proceed on the basis of contested assumptions about the 'trauma' of abortion and the socially constructed guilt that goes along with it.

In the construction of a hierarchy of deservingness, providers legitimize the provision of abortion services to some clients and delegitimize provision of services to others (Vincent, 2011). Counselling need not be explicitly politically motivated to be inundated with implicit assumptions about who is more or less deserving of an abortion. One of the mechanisms that are employed in normative counselling is to categorize abortion along a continuum of appropriateness and acceptability. The women whose abortions fall into differing appropriate or acceptable categories are in turn hierarchically grouped as more or less deserving of support and care (Vincent, 2011).

Moreover, research shows that counselling may be unnecessary or even unwanted, since many women have already made their abortion decision when they present for care, and few feel coerced into not having the abortion (Gould et al., 2013). Hoggart (2015) points out that although women may be distressed when faced with an unwanted pregnancy, many are comfortable with their decision. In addition, abortion can be a positive experience showing how making such an important decision and exercising autonomy can itself empower women (Hoggart, 2015).

#### **4. The Role of the Provider**

Providers play a key role in abortion counselling to ensure that women seeking an abortion are supported and proceed with their choice. Researchers have argued that providers who are involved in the provision of abortion counselling need to be knowledgeable about the procedure itself, be non-judgemental, ask open-ended questions, and be sensitive to the unique situation of each client (Moore et al., 2011). Tabbutt-Henry and Graff (2019) argue that if counselling is defined as a two way communication conducted to help clients make decisions and to deal with their feelings about their circumstances, providers should integrate counselling into all aspects of abortion care because such communication can help providers assess the clients' needs and feelings about what they will undergo: all of this can also help facilitate the client's decision-making, following the procedure (Tabbutt-Henry & Graff, 2019).

Upadhyay, Cockrill and Freedman (2010) argue that although a woman usually arrives at an abortion decision privately, she will interact with health care providers who are tasked to help inform her decision and support her physical and emotional health before and after her abortion. The providers are at each step expected to provide good quality emotional support to women undergoing an abortion. Emotional support/care is a process in which a woman's emotions are discussed and explored; abortion counsellors are tasked with the role to explore how the woman arrived at her decision to abort, to assess the level of social support she is receiving, ask about her feelings, and beliefs about abortion, and assess her ability to cope after abortion (Upadhyay et al., 2010).

According to Tabbutt-Henry and Graff (2019), in abortion counselling, the provider should be able to assess what the client already knows about her situation by finding out what the woman seeking an abortion thinks is happening to her body and what she thinks the medical staff are going to do to treat her. This will help the provider to quickly determine the woman's perceptions and fears about her condition, as well as her overall level of reproductive education and any misconceptions or gaps in her knowledge. The provider's role is to then provide only the information that the client needs and present it in a simple and comprehensible manner (Tabbutt-Henry & Graff, 2019). Additionally, for a woman who is resolved in her decision to have an abortion, the first step should be a conversation that involves discussing how she came to her decision and exploring the context in which the decision was made. At the same time this enables providers to identify the minority of patients who may be at a greater risk of poor psychological outcomes after an abortion, and thus provide additional support and/or referrals to these women (Upadhyay et al., 2020). Moore et al., (2011) also found that women seeking an abortion valued an interaction when the counsellor was friendly because it made them feel accepted and less judged for their decision to terminate the pregnancy (Moore et al., 2011).

Tabbutt-Henry and Graff (2019) maintain that providers cannot be expected to act as therapists or social workers, but they can deliver abortion care efficiently with only a limited range of emotions; and even such limited support may be found helpful by clients. This can be done through offering basic information and communicating effectively with clients.

### **5. Patient-centred Abortion Counselling**

According to Breibart (2000), a patient-centred approach to abortion counselling, which is counselling that solely focuses on the client's needs, has led to substantial improvement in the quality of abortion counselling services. Patient-centred counselling has a number of features. Firstly, for quality abortion counselling, the providers have to ask open-ended questions. Open-ended questions are questions that usually elicit more detailed information than those requiring a yes or no response. This approach enhances communication by asking questions that invite women to express themselves freely and by responding with sensitivity. Secondly, the provider ought to validate the clients' emotions rather than minimize them. This assures the client that her feelings are normal, and she is invited to fully explore her emotions or ask for help. Thirdly, the provider needs to encourage the patient's questions; this is because a woman's questions often demonstrate her concerns and the extent to which she understands the information given by the counsellor. Fourthly, the provider needs to be on the look-out for non-verbal clues, because women's behaviour often expresses more than her words. Lastly, the provider must use 'if then' statements to convey important information which can help women understand the reason behind a particular directive and thus increase the likelihood of a successful outcome (Breibart, 2000).

Surman and Surman (2001) argue that women who seek an abortion want different things when they seek counselling. Counselling should be based on the woman's needs and wants, and involve an exploration of feelings of things that she wishes to discuss. This may include the pregnancy, the potential impact that termination can have on the woman's relationships, values around termination options, how others in her life feel in case they were aware, and possible difficulties with coping post-procedure. Thus, counselling should involve whatever a woman wishes to discuss in relation to her pregnancy. Furthermore, it is of importance that the counsellor is able to respond appropriately to the issues women raise in a session and offer them support to make a decision that is right for them (Surman & Surman, 2001).

Abortion counselling requires open communication and trust. These attributes are specifically important when a provider is helping a pregnant woman to explore her feelings, make informed choices, and gain a sense of control over her situation. Both the provider and client need to feel

comfortable addressing concerns that are emotionally as well as physically intimate. Breibart (2000) argues that there are three aspects that providers should take into account when providing counselling for abortion seekers. These three aspects inform a patient-centred counselling approach. Firstly, effective communication is important because it can provide a safe outlet for the client's self-expression without bias and without shying away from the emotions that she displays. Furthermore, providers can facilitate effective communication by not taking client's expressions personally, viewing the situation from the client's perspective, avoiding defensiveness, and working with the client to help maintain a sense of autonomy and comfort. Secondly, because abortion is a time restricted reproductive service, decisions should not be delayed too long. Therefore, providers have to recognize that time taken to convey information, answer questions, and alleviate anxieties is time well spent, and clients who feel well informed and supported are more likely to have a positive experience. Thirdly, patient participation is also an essential aspect which providers of abortion counselling ought to consider. This is because a well-informed client who actively partakes in her own care provides distinct clinical advantages. A woman who feels in control of her own health decisions is more likely to choose behaviours that are in her best interest. Moreover, a woman who feels empowered is more encouraged to communicate with the provider and ask for support. A patient-provider partnership has the potential to produce quality service and good health outcomes for the client (Breibart, 2000).

Beja and Leal (2010) argue that a client-centred approach to abortion counselling is beneficial to women seeking an abortion. This is because, a client-centred counselling approach focuses on the specific needs of each client and emphasizes the importance of client-provider interaction in the provision of care. Its benefits include positive and respectful client-provider interactions, which can result in higher client satisfaction, less negative feelings due to a lack of clinical information, and greater compliance with follow-up care. This can further lead to effective contraception use, post-abortion adjustment, and increased client-participation in the protection and promotions of their own health by further seeking healthcare in the future (Beja & Leal, 2010).

Mavuso and Macleod (2020) also suggest that a feminist client-centred counselling approach has positive implications for abortion counselling practices, since it would mean that providers support the reproductive autonomy of their clients. This is achieved by normalizing the procedure through constructing abortion as a safe, beneficial, and legitimate healthcare practice and reproductive decision. It is also achieved by challenging the stigmatization of abortion. The provider is attentive to the ways in which clients speak about and refer to their pregnancy and then adopts those language practices (Mavuso & Macleod, 2020).

Kim (2000) suggests that nursing practice must combine two separate philosophical orientations, the philosophies of therapy, and those of care. The philosophy of therapy addresses clients' specific problems or challenges regarding an unwanted pregnancy, and the philosophy of care focuses on the client as a person in the healthcare situation with specific and unique histories and experiences. Successfully combining of the above mentioned orientations will enable the nurse to facilitate a positive client-nurse interaction, where there is mutual acknowledgement of the client's health care goals, and both the nurse and client are empowered to attain the goals of the client. One way to attain the client's goals is through the use of language (Kim, 2000) as indicated above. This is because inappropriate language that appears to be judgemental and/ or the use of words that views abortion as a life-threatening procedure often coerces women seeking an abortion to reverse their decision to terminate a pregnancy.

## **6. Women's Experiences of Abortion Counselling**

Investigating women's experience of abortion counselling can contribute to a deeper understanding of how abortion counselling assists or keeps women from making an autonomous decision when seeking an abortion. In a US study by Gould et al. (2013), women receiving abortions reported that they received counselling about the decision to have an abortion and nearly all of them found counselling help fulfill. No evidence that women felt pressured by providers to have abortions was found. In a Portuguese study by Beja and Leal (2010), participants seeking an abortion also described abortion counselling as useful in terms of information provision, which allows the providers to obtain the woman's informed consent and ease her anxiety towards the abortion process. Furthermore, some participants thought that emotional support was the element that made counselling useful, while others thought decision-making support was essential. Decision-making was only considered important in abortion counselling in two circumstances; firstly, when the woman shows no ambivalence but receives counselling support for her decision, and secondly, in an unlikely case where she is ambivalent then counselling helps her to reach a decision that best suits her. Also, two participants pointed out that a good counselling experience is one that might encourage women to seek healthcare services in the future and could help prevent poor emotional post- abortion adjustment (Beja & Leal, 2010).

In a Belgium study, Vandamme et al., (2013) found out that although women are sometimes in a negative mood and are at times reluctant to have counselling sessions when they enter the abortion facility, they highly appreciate the uniform as well as the personalized sessions, and feel better after a session. In addition, women seeking an abortion considered the provision of information as the most important aspect of counselling, and found contraception and the decision-making process undesirable

topics to address during their counselling sessions In Nowergian research, Kjelsvik et al. (2018) found that ambivalence related to having an abortion is a common experience for a subset of women seeking an abortion, but has limited attention in the literature. In addition, the study found that certain women were at greater risk for developing mental health problems after termination. These included women who are ambivalent when making the decision, who experience coercion or pressure and lack of support, or who have a history of psychiatric illness (Kjelsvik et al., 2018). Therefore, compulsory counselling was found to be in conflict with the vast majority of women who did not experience any doubt. However, the few women who are uncertain of their decision should be offered counselling. Also, little is known about the experiences of women who consider aborting a pregnancy, and are interviewed early in the pregnancy before an abortion was fully decided upon or carried out (Kjelsvik et al., 2018).

A UK study by Brown (2013) revealed that women seeking abortion want information, a less complicated referral process, and easy and quick access to the procedure. Moreover, the women interviewed in Brown (2013)'s study reported to be certain of their decision to request an abortion, and had discussed it with people they trusted prior to consulting a medical doctor or provider. They had clear reasons for their decision. Abortion counselling was offered to all participants, but was seen as unnecessary by most, and therefore declined.

### **7. Nurses' experiences of providing abortion counselling**

Nurses' experiences of providing abortion counselling are located within the context of them providing an intimate and controversial service. Bolton (2005) argues that many of the procedures associated with gynecology are seen as uniquely women's problems of a personal nature which remain inscrutable to those outside the field. Bolton (2005) indicates that gynecological nurses are seen as physically, socially and morally tainted. Nurses are physically tainted because of the close association with intimate parts of the body, socially tainted because of unmentionable topics such as menstruation and abortion, and morally tainted through the visibility of what should remain invisible. Kumar et al. (2010) argues that nurses who provide abortions are often referred to as abortionists and murderers by other providers who are opposed to abortion.

In a study by Mclemore et al. (2015) providers indicated that participating in abortion care was not only about having the technical skill set but also about understanding why a woman came to the decision to seek an abortion. Before providing abortion care, providers needed to know the background and contextualized reasons for the abortion, and not all providers felt capable of providing this service. Moreover, providers who routinely worked in abortion care found it frustrating

to provide basic information about the context of the abortion to other providers when an escalation of care was needed.

In a Kenyan study conducted by Kamhawi, Underwood, Murad and Jabre (2013), nurses reported that they did not provide counseling due to time restraints. When they did counsel women seeking an abortion, it was often rushed, conducted in an open setting, and incomplete in that most providers failed to discuss the side effects associated with the client's chosen termination method. Furthermore, providers acknowledged that inadequate and improper counselling resulted in the discontinuation of women seeking an abortion, and an increase of unmet needs (Kamhawi et al., 2013).

### **7.1.Nurses' experiences with their colleagues**

How nurses experience their working relationship with their colleagues has an impact on how they experience their work. In a study by Andersson et al. (2013), nurses reported finding it difficult talking about their job with relatives. They were afraid of being misunderstood, and hesitant to talk about their involvement in second-trimester abortion care. However, in the same breath, they wanted to raise public awareness about services to improve abortion care. They also, reported that opportunities for regular reflection/debriefing, and support from other providers were useful. These were seen as opportunities for developing the ability to find solutions, to gain practical knowledge and to move on from feeling anxious about providing and working in abortion services.

Participants in a Canadian study by Gallagher et al. (2010) also reported experiencing different reactions to their place of work. These reactions made them aware of some social attitudes towards abortion, and that their role in abortion services could be seen as controversial. They also spoke about feeling reluctant to tell people about where they work and about the nature of their work. Participants in this study reported attempting to first gauge a situation when they were asked to discuss their jobs; one way they achieve this was by assessing the individual with whom they were conversing first before mentioning their job profile (Gallagher et al., 2010).

Health care providers who were participants in a South African study conducted by Teffo et al. (2018) report that negative attitudes by other staff members and the community towards abortion providers and abortion services make it difficult. Dickson et al. (2003) point out that South African abortion providers operate in an environment where resources for this reproductive service are limited. Additionally, the attitudes of frontline providers or management may be negative. It was reported that some providers decided to cease providing abortion services due to the harassment they received from their colleagues. Some trained providers have been unable to set up abortion provision services in their facilities as a result of resistance and constraints imposed by the facilities' management (Dickson

et al., 2003). This shows that the training of nurses in abortion service provision is not sufficient to meet the demand for an increased number of abortion service providers, as there are further hurdles at a facility level such as sufficient management support and a challenging work environment (Teffo et al., 2018).

### **7.2.Nurses' experiences of their roles as abortion counsellors**

The way in which nurses experience their role has implications at different levels for individual staff well-being, for the organization in terms of staff absence and turnover rates, and for the quality of patient care (Nicholson et al., 2010). Furthermore, participants in a study conducted by Nicholson et al. (2010) in South Africa reported that they found their work in abortion to be emotionally draining and stressful due to their experiences with the women. In moving from one patient to the next, providers shared that they needed to switch their emotions, empathize with different needs, adjust behaviour, discuss different options with clients, and use different languages to describe the same process. In addition, structural difficulties such as a lack of support from colleagues or management added to their stress. Some ways of coping with these demands included actively restricting thoughts and feelings, compartmentalizing, and keeping emotions under control (Nicholson et al., 2010). Other providers reported that talking to each other was a well-recognized strategy that nurses used to cope with the demands and stress of their work. Also, one of managing the contrasting needs of patients included making a foetus more human or less human, depending on whether terminations were for social reasons or for foetal abnormality (Nicholson et al., 2010). This means that providers found it easy to care for women seeking abortion when the foetus shows anomalies than when abortion was a woman's personal choice. Thus, the foetus would be given personhood if termination was a personal choice rather than one that is medically indicated.

Often nurses rendering abortion services experience stress and trauma from the role of providing abortion services, and caring for women undergoing an abortion. According to Lipp and Fothergill (2009), one of the psychological impacts that nurses may suffer from is secondary traumatic stress (STS). Secondary stress can be defined as stress resulting from helping or wanting to help a traumatized or suffering person. This is most likely to be experienced by nurses when a woman may either suffer a miscarriage, abortion of a wanted pregnancy due to health deficits, and caring for a woman who has had an incomplete backstreet abortion. It requires the nurse to be emotionally stable but can become emotionally draining due to the difficulties involved in providing continuous psychological care, and this can further propel nurses to respond with cold and negative attitudes towards their women patients (Lipp & Fothergill, 2009). These cold and negative attitudes are a result of compassion stress, which is a type of stress that providers who may usually be empathetic and

emotional, are most likely to suffer from. This is because being emotionally involved may compel nurses to try and dissuade a woman's decision to have an abortion which is unethical (Lipp & Fothergill, 2009).

Providers in Mayers et al.'s (2005) study described feeling trapped as they had to perform work that nobody else was willing to do since their colleagues were resistant to work in the abortion care unit. Other providers reflected on how other nurses' refusal to treat affected how they felt about themselves and the nature of their work.

In a study conducted in Taiwan by Yang et al. (2016) it surfaced that nurses in abortion care experience a range of emotions depending on the reason for abortion. They may experience anger and frustration, rather than sympathy, when abortion is used as a form of contraception or is considered an easy option. Or they may experience sadness when the foetus is abnormal. Also, the providers reported feeling upset, angry, impotent, and insecure and experienced conflict related to their morals and values. The study revealed that nurses often suppress their feelings with regard to aborted foetuses and thus, do not experience relief from their unease or fears related to the deaths of foetuses because they are worried about being haunted by foetus's ghost. These feelings of fear, depression, and guilt were particularly experienced when the foetus aborted was older than 12 weeks gestation. The provider used passivity and compromise to overcome their own conflicted feelings from being in a morally stressful environment. Furthermore, the providers reported that rendering abortion services increased sociocultural and moral distress, and hospital management did not encourage nurses to discuss their inner struggles with abortions (Yang et al., 2016).

Reasons for providers' involvement in rendering abortion services are often tempered by direct or indirect personal experiences. According to Harries et al., (2009), for some providers' participation in rendering abortion services was part of a likely career trajectory. For others, involvement was linked to prior exposure to mortality and morbidity associated with illegal involvement in abortion services, and hence demonstrated passion and commitment. Some providers were prepared to restrict their involvement to pre and post abortion counselling or basic nursing duties, and were not willing to provide direct abortion care including performing abortions. They were vehement in their dislike of abortion care (Harries et al., 2009). But, mostly, Harries et al. (2009) found that almost all providers perceived an unwanted pregnancy due to rape or incest as different and a legitimate reason to obtain an abortion. The few providers who commented on foetal abnormality suggested that healthcare providers are generally more understanding towards a woman seeking an abortion for what they perceived as a legitimate medical reason. Moreover, it was assumed that a woman with a foetal

anomaly pregnancy was more deserving of more support than one who voluntarily seeks to terminate (Harries et al., 2009).

Dodge, Haider and Hacker (2016) also found that participants in their US study were supportive of legal abortion in cases of rape, incest, life endangerment, health endangerment, foetal anomaly, etc., and they were also supportive of public and private of abortion services. However, they were unsupportive of mandatory ultrasound viewing and the provision of information linking abortion to negative future outcomes. Providers without religious affiliations, furthermore, were more likely to be more supportive in these settings and of abortion funding.

There is limited knowledge of abortion providers' experiences and the informal interaction that prevails in abortion services. A study by Lindstrom, Wulff, Dahlgren and Lalos (2010), conducted in Sweden, revealed that providers usually tried to make sure that the women undergoing an abortion would not suffer or have any pain during the procedure. The abortion providers focused on providing the women with support, being well-trained and good at performing the procedure and reducing the amount of physical pain women seeking an abortion may experience. Furthermore, the providers reported that repeated abortions made them become more passive in their role to render abortion services because they felt women used abortion as a contraceptive method. The providers also reported their concern for women's right to receive quality care and believed that their working routines influenced that. They stressed that for them to render quality services they had to be convinced by the woman about her sureness of terminating her pregnancy before the day of the abortion. The providers in this study reported no doubts in participating in abortion services, but they experienced their work as contradictory and frustrating but also as challenging and rewarding (Lindstrom et al., 2010).

In Rwanda, Pafs et al., (2020) argue that providers have a strong influence over abortion care services, and may enhance or curtail women's access to these services, despite the legal context. The reluctance of providers in Rwanda to render abortion care is often due to religious and moral grounds against the practice. This is because nursing is perceived as a respectable job in their communities and is associated with saving lives and legalizing abortion would threaten this association. Also, inadequate assurance of confidentiality was presented as a predicament that could cause distrust in health care.

### **7.3.Value Clarifications & Abortion Counselling**

One progressively important approach to help increase the standard of abortion services provision is the use of interventions based on values clarification (VC) principles. VC engages people in the health sector, the community and other groups to address barriers stemming from misinformation,

stigmatization of women and providers, lack of respect for women's rights and obstructionist behaviours. VC is considered an integral part of abortion training for health care providers who are involved in all areas of abortion provision, including pre-and-post counselling and referrals (Harries & Constant, 2020). Abortion VC workshops are considered to be useful for addressing barriers that hinder safe access to quality abortion services, as they engage health care providers and other patrons in a process of self-examination, with the aim of transforming or shifting abortion related attitudes and behaviours in a direction that is supportive of women seeking abortions (Harries & Constant, 2020). Furthermore, abortion VC workshops allow health care providers to engage with and reflect on their feelings and views about abortion on both a personal and a professional level (Harries & Constant, 2020). This is because values are closely related to and affected by beliefs, ideals and knowledge, and they affect attitudes and behaviours. They serve as an internal roadmap, playing a key role in the decisions people make, how they spend their time and energy, and how they act (Turner et al., 2008).

However, according to Turner et al (2008), such interventions have not been well documented or evaluated, and there is a scant published literature on evaluations of successful strategies for changing attitudes and behaviours of health care providers or other stakeholders. Although more rigorous research is needed, existing evidence supports the use of VC principles as a general strategy to improve attitudes and behaviours for various social and health issues and audiences, and the World Health Organization (WHO) has included VC in abortion training programs for service providers (Turner et al., 2008). Despite positive feedback and favourable evaluations from health care providers, VC workshops have not been sustained or provided on a regular basis, which has been attributed to few local trainers to facilitate workshops and reliance on international NGOs for provision (Harries & Constant, 2020).

Xaba and Rispel (2013) argue that it is important to ensure that providers have a supportive environment at designated abortion facilities. This includes, protecting providers from abuse, instituting regular debriefing and counselling sessions, encouraging more nurses to undergo training in order to reduce the heavy workloads for trained abortion providers, and offering appropriate incentives which can in turn help improve the quality of safe abortion services. Thus, creating safe spaces for providers to understand and speak abortion as well as their own experiences are necessary.

## **8. Conclusion**

In this chapter, I started off by discussing the need for abortion counselling which highlighted that abortion can be a sensitive period for a woman seeking this reproductive service, and that its needs not to be mandatory but voluntarily in order for women to have autonomy over their bodies. I then went

on to discuss the goals of counselling, which emphasize the importance of informing women of the different options they have when accessing abortion services, and the chance to choose options which they find more suitable for them. Thereafter, the discussion looked at the potential pitfalls of abortion counselling, the role of the provider, and patient-centred abortion counselling which emphasizes that counselling should be conducted in a manner that allows the client's needs to be put first and not infringe on their rights.

In addition, this literature review discussed women's experiences of abortion counselling in order to review the relevance of integrating abortion counselling in abortion services. Furthermore, nurses' experiences of abortion counselling were discussed, which is the crux of this study. Thus, different aspects such as nurses' experiences with their colleagues, experience of rendering abortion counselling and reasons for offering these services were discussed. The manner in which the aforementioned topics have the potential to positively and negatively influence the provision of abortion were highlighted.

Lastly, I discussed abortion training which outlines the hours and areas providers are subjected to during training. However, the CTOP Act does not outline in detail how abortion counselling training specifically ought to take place. Furthermore, the introduction of value clarifications workshops cannot be relied on to produce willing trained abortion providers/counsellors as there is scant evidence on its effectiveness.

## **Chapter Four: Methodology**

### **1. Introduction**

My study employs a qualitative methodology to understand the nurses' experiences of an abortion counselling training course and their understanding of quality abortion services. This exploratory research was conducted using an interpretative qualitative design, based on a symbolic interactionism (SI) framework and grounded theory. An interpretative position entails that the researcher understands the subjective meaning of social action (Bryman, 2012). Symbolic interactionism is often defined as a social psychological theory of social action (Bowers, 1998). In other words, SI focuses on the processes of social interaction by which people try to make sense of the world, as there is inseparability of the individual and by the context within which the individual exists. In my research, SI provides a lens through which nurses' experiences are explored within the context of an abortion counselling training course, with the intention to lead toward an improved course, as well as an understanding of quality abortion services. The goal of a qualitative design is to construct an in-depth understanding of the perceptions, experiences and reflections of the research participants, interpreted within their own frame of reference. Keeping this in mind, I have combined SI framework, group discussions, and semi-structured interviews of the participants, to develop an understanding of how nurses' experience rendering abortion counselling services. Merging these specific elements provides insight into the distinctive experiences of each provider and generates contextual information based on personal narratives.

This chapter describes the different methods that were used to collect data. I commence with the description of my research question. Activities and group discussions during the abortion counselling training programme conducted on Zoom (three recorded sessions) and semi- structured interviewing (five recorded interviews) were employed as data collection. A grounded theory analysis was conducted. I describe the data collected followed by an explanation of the 'data driven' grounded theory analysis. I discuss the ethics and credibility of this research, concluding with a segment on reflexivity, which has played a central role throughout my research process.

### **2. Research Questions/Aims**

This research aims to investigate how partaking in a women-centered abortion counselling training course may modify or improve nurses' practice of abortion counselling, and their understanding of quality abortion services.

Main research question:

- How does participation in a women-centered abortion counselling training course alter or confirm participants' reported practices and understanding of abortion counselling.

Sub-questions:

- What understandings and practices are reported by participants at the beginning of the counselling course?
- How do these reported understandings or practices change (if at all) during the course and two months after completion of the course?

### **3. Method**

Willing (2008, p.22) states that “a good qualitative research design is one in which the method of data analysis is appropriate to the method of analysis”. In the following section I discuss how participants were recruited, the nurses who were participants in this study, and how data were collected.

#### **3.1.Sampling**

A sample is a portion of a population or universe (Etikan, 2016). The population it refers to does not essentially mean a number of people, but it can also denote to a total number of the things or cases which are the subject of the research.

In grounded theory research, the sample size can vary but tends to be very small. From the beginning the researcher uses purposive or purposeful sampling as a sampling method to acquire research participants. Purposive sampling was a strategy used in this study due to the need for a particular type of participant. Purposive sampling is a sample method that involves the selection of participants who relate to the phenomenon under study (Etikan, 2016). This means that participants have knowledge of the phenomenon being studied, and help with providing the research with data that will illuminate the questions under study.

In this current study, purposive sampling was used to select nurses who were trained abortion providers who partook in the abortion counselling training programme, and who were willing to share their experiences of the course and as abortion providers.

#### **3.2. Research Participants**

The main researcher and course-facilitator (Ms Yamini Kalyanaraman) requested permission from the Department of Health, Eastern Cape (DoH, EC) to recruit abortion providers from the EC Province to participate in client-centred abortion counselling training course. The course, titled Abortion Counselling Certificate Course (ACCC) 2020 was accredited by Rhodes University (RU). A letter of

permission that described the goals and outcomes of the course and the aims of the research were provided. I as the co-researcher also produced a consent form (Appendix A) that was distributed to participants at the start of the course to request their participation in the research part of the training course.

Flyers (Appendix D) detailing all aspects of the training course and research component were shared with the DoH to distribute to the relevant facilities for recruiting willing abortion providers. The different facility managers distributed the flyers to the relevant nurses, and those who were interested were encouraged to contact the main researcher, whose details were on the flyer. The DoH was informed of the ethics clearance (Appendix C). In this manner, nurses from different abortion facilities across the EC were then able to enquire and subsequently register for the training course. The requirements clearly stated that declining to partake in the research would not preclude the nurses from taking part in the training course itself or/and completing it successfully. This point was reiterated to all the participants at the start of the training course to ensure that no one felt pressurized to participate in the research. It was also stated that all participants who successfully met all course criteria would receive a certificate and a letter of attendance at the end of the course.

### **3.3. Attrition of prospective participants and further sampling**

The initial response from most of the abortion providers was positive. Within the first two weeks, nine nurses had registered to participate in the study. Due to COVID-19 restrictions, face-to-face interaction was prohibited. Therefore, the course was adjusted to an online platform. All course materials and consent forms were mailed out to participants in advance. In addition, documents were shared with participants, via email, during the span of the course, which took place on an online application called Zoom. All participants gave their consent to partake in the research part of the course. Hence, all nine participants' input on the relevant recorded sessions during the training sessions were used as data. Two months later interviews were scheduled to take place; however, four participants for reasons unknown were no longer willing to participate in the individual interviews. Only five providers were individually interviewed two months after training by myself.

### **3.4. Participants' particulars**

*Table 1 details the characteristics of the participants, such as age, race, gender and type of facility.*

<b>Pseudonym</b>	<b>Race</b>	<b>Age</b>	<b>Gender</b>	<b>Type of Facility</b>
Lilly	Black	54	Female	Health Centre
Beauty	Black	27	Female	Clinic
Jane	Black	47	Female	Hospital

Mary	Black	55	Female	Hospital
Peter	Black	34	Male	Hospital
Faith	Black	39	Female	Hospital
Thandi	Black	27	Female	Hospital
Nandi	Black	56	Female	Hospital
Bonga	Black	48	Female	Hospital

The participants consisted of eight black females and one black male. Seven of the nine providers work in hospitals and two work in local community health centers/clinic. Their age ranges from late twenties to mid-fifties. The first five on the column are the providers interviewed individually two months after training. Pseudonyms were used as substitutes of participants' real names to protect their privacy and maintain confidentiality.

#### 4. Data Collection and Analysis in Grounded Theory

In grounded theory, data collection and data analysis are processes that take place simultaneously during research. Data collection in grounded theory is not time discrete but it is woven in with data analysis. Initially, before the data collection begun I composed an interview schedule. However, after collecting and analyzing data from three sessions, which were collected in November 2020, I reworked the interview questions used to conduct individual interviews, to collect data that were more related to my research questions which took place in April 2021. Through this I was able to reach data saturation. The continuing data collection process involves the exchange between data collected in the naturalistic setting and the codes, categories, and rationale developed during the research process (Egan, 2002). The theory evolves during actual research and it does this through a continuous interplay between analysis and data collection.

*Table 2: outline the exact data collected and the timeline in which they were collected*

Session no	Week	Mode	Activity	Content	Time/Period
1	2	Zoom (break out rooms)	Discussion around current counselling sessions (prior to	Background counselling practices/experiences/cases	30 minutes

			attending the course)		
3	2	Zoom video (break out rooms)	Participants worked in pairs (interviewed each other)	Participants reflected on their counselling sessions in relation to the Guidelines (what might I start/stop/continue?)	10 minutes
5	5	Zoom video (Screen sharing)	Case presentations	Participants presented a case from their field-work. Includes input on successes, challenges, learnings etc.	1hr45 minutes
	Two-months after training	Zoom and whatsapp calls (recorded)	Individual interviews	Participants gave accounts of their experiences from their field work two months after training	15mins

According to Bluff (2005), qualitative data in grounded theory are derived from the same sources as those of other qualitative approaches. Stanley and Cheek (2015) indicate that a range of methods and techniques are used to collect data in grounded theory. This research study used in particular as mentioned in the table above recording from activities, group discussions and semi-structured interviews to collect data.

#### **4.1. Discussion around Current Counselling sessions**

At the beginning of the training course, in week 2, session 1, participants were asked to interview each other in the Zoom breakout rooms on the background of their practices, counselling and experiences as abortion providers.

Nine (9) participants were grouped into four groups; three groups consisting of two participants each; and one group consisting of three participants. For 30 minutes they discussed their experiences of providing abortion counselling practices, and cases. When the break-out rooms ended, one member

from each group shared a summary of what had been discussed amongst them with the larger group; and this session was recorded.

#### **4.2. Reflection Activity**

As part of the counselling training course, participants were tasked to work in pairs (interview each other) and reflect on their counselling sessions in relation to the guidelines (what might I start/stop/continue?). Feedback from this session was recorded and used as data in order to find out what nurses have started, stopped or continue doing in their practice during counselling sessions two weeks into the training course. Each reflection interview took ten minutes and one member shared their experiences from the interview.

#### **4.3. Case Presentations**

Data were also collected from participants' case presentations, which formed part of the abortion counselling training. Each participant presented a case from their field work two weeks after the initial training. The presentations ran for one hour and forty five minutes (1hr45mins) and the session was recorded. Initially, the participants were to present their cases in a power point format; however, due to lack of access to technological equipment such as laptops and computers the participants were advised to present from their diaries or reflective journal. This session was recorded, and all recorded presentations were transcribed and translated (in cases where participants used Xhosa words) where needed by the co- researcher (myself).

#### **4.4. Semi-structured Individual Interviews**

This study used semi-structured interviews. A semi-structured interview is a verbal exchange between the interviewer and the interviewee, whereby the interviewer attempts to elicit information from the interviewee by asking questions (Longhurst, 2001). It is a method of inquiry that requires the researcher to ask probing, open-ended questions that provide independent thoughts of each individual on topics that participants may not be open about if sitting with peers (Mussardo, 2019).

Mussardo (2019) indicates that tone is very important when asking questions during the interviews. Interviews should take a casual, conversational approach that is pleasant, neutral, and professional, without becoming overly emotionless or overly familiar. In such a comfortable environment, probing is accomplished without the interviewer sounding astonished or shocked by anything said, but rather intrigued (Mussardo, 2019). The interviews for this study were conducted via the Zoom application and not face-to-face due to the COVID-19 restrictions. The environment was neutral and comfortable for the participants because the interviews were conducted individually and not in a group format.

Network and technical glitches were experienced during two of the five interviews. In these two instances WhatsApp calls were a solution to continue with the interviewing.

Feher (2010) indicates that it is important for the researcher to frame the interview question in a semi-structured in-depth manner as this will enable the participants the freedom to relay their experiences without restraints and allow the gathering of rich data. In this study, semi-structured open-ended questions were asked in order to gather rich data from the participants. The questions were structured in a manner that allowed the participants to fully express themselves during the interviews without the researcher's impositions. Semi-structured interviews generally consist of one or two open-ended questions, which allows the research participants to openly say as much or as little as they wish without the researcher's imposing their own ideas (Bluff, 2005).

The interview guides for the study were developed in consideration of this. In developing the interview guides, nine questions were formulated, six focusing on reporting practices and understandings of nurses' experiences of offering abortion counselling since receiving training. From question seven to nine, the questions focused on finding out if the nurses found the training beneficial and if they had anything they would like to add. I chose semi-structured interviews based on interview guides because my objective was to collect nurses' experiences from rendering abortion services, especially on abortion counselling and their understanding of quality of abortion services. Hence, I paid attention to enabling interviewees to express themselves freely and openly within the realm of specific themes.

The individual interviews took place two months after the training course. In total five out of the nine participants were able to participate in the individual interviews. These interviews were conducted in order to find out if participating in the training course elicited any alterations or confirmations if any, to the nurses' understandings and practice of abortion counselling. The interviews were conducted in English. Where participants used Xhosa, I was later able during transcribing to translate terms/words to English where relevant. These transcriptions were verified by both my supervisors, Professor Catriona Mcleod and Ms Yamini Kalyanaraman. Through the constructed open-ended questions, participants were able to share what had changed in the way they conduct abortion counselling since training, and what had remained the same in their practice. Refer to (Appendix E) for the interview questions asked to gather data from the participants. conducting these interviews helped to reach saturation because data collection become more focused and the nurses had the opportunity to see clients therefore giving more precise experiences on the altered and/or improved manner in which abortion counselling was now being rendered in their respective facilities. All the individual

interviews were recorded and saved in password protected computer file; the participants were reminded of this aspect of the interview before the interview commenced. To analyze the data collected from the sources, I used Ian Parker's (1992) transcription conventions to transcribe my data. Refer to (Appendix D) for symbols and meanings that are used to explain the transcription made to the data.

#### **4.5. Data Analysis**

Data analysis is a process of inspecting, cleaning, transforming and modeling data with the aim of determining useful information, informing conclusions and supporting decision- making (Cresswell, 2007). This research study utilizes the three grounded theory informed analysis steps described by Japhet and Usman (2013).

Data analysis in qualitative research manages words, language and the meanings behind them (Walker & Myrick, 2006). Initial or open coding is the first step of data analysis. It is a way of identifying and labeling accordingly important words or groups of words in the data (Birks & Mills, 2015). Coding is one way of exploring bits of information in the data, and looking for similarities and differences within these bits to categorize and label the data (Walker & Myrick, 2006). The checking of similarities and differences is done through a method of constant comparative analysis. Comparative analysis is a process that compares incidents, codes, and categories until a grounded theory is fully integrated (Birks & Mills, 2015). Constant comparative method is a grounded theory key feature in which data collection and data analysis take place simultaneously and interactively. The process also involves constant comparison between words, sentences, paragraphs, codes and categories. It is a detailed and thorough process involving reading and listening repeatedly to tape recordings and transcriptions. This interaction with the data enables the researcher to understand the phenomenon under study (Bluff, 2005). Throughout this study process, comparative analysis was done rigorously to help describe simply the participants' categories at a theoretical level.

##### **4.5.1. Coding and Categorizing**

Charmaz (1990) argues that the codes and categories reflect emerging concepts rather than merely describing them. The codes and categories help the researcher begin to take the data apart and frame analytic questions about it. In this way, the codes and categories help the researcher to build an analysis of the data rather than remaining at the level of ethnographic description. By grounding the categories in the data as specifically yet analytically as possible, the grounded theorist can then sharpen the category that develops, and begin to look for consequences of it. Conditions mean those

prerequisites which influence and shape views, interactions, and events, rather than determine them (Charmaz, 1990).

Furthermore, Charmaz (1990) suggests that line by line coding during initial coding prompts the researcher to study the data, to dispel earlier preconceived assumptions about the data, and start viewing the data analytically. As the researcher begins to render some codes into categories, he or she defines them analytically and outlines their properties. The researcher's definitions of reality shapes what categories they construct, and line by line coding keeps the researcher examining the collected data, rather than lapsing entirely into theoretical hops of elaborations which have little connection to the data (Charmaz, 1990). Stanley and Cheek (2015) also indicate that line by line coding and assigning in-vivo codes, which can be a word or short phrase that describes what is happening, often quite close to the original words of the participant. Therefore, in my research study line by line coding was employed using in-vivo codes from the participants; this was done to avoid constructing analytical references based on assumptions and not from the original data. Thus, in my analysis, phrases from the participants were coded and categorized to build theory from the ground and not from the researcher's assumptions.

Coding for processes, actions, assumptions, and consequences rather than for topics often leads to greater analytic precision. Furthermore, coding for process assists in defining major activities and issues; such coding also helps the researcher to recognize connections between structures and events. Similarly, the researcher's search for processes is also fostered by coding for actions. The researcher then looks for phrases, contributing conditions and consequences of those actions (Charmaz, 1990).

Coding begins the emergent process of analyzing data in grounded theory. According to Japhet and Usman (2013), it involves three phases namely; open coding, axial coding and selective coding. These different phases and their application depend on the researcher's comfortability and understandings of the phases. The differentiation between these steps is first and foremost an analytical one. This means that these three steps cannot be separated nor put into sequential order (Kuckartz 2010: 79). The following section focuses on the major tasks involved in coding, illustrating them with references to my study, rather than recounting open, axial, and selective coding in detail.

The first task is for the researcher to immerse themselves in the data, which is mainly done using open coding. Open coding requires a close reading and interrogation of the data (Charmaz, 2008). It is an analytical phase process through which concepts and their properties are identified and discovered in data (Japhet & Usman, 2013). During this initial phase, it is essential that the researcher remain open-minded and willing to be surprised by the data. In my study, I initially advanced line by line, asking

myself questions about the meaning, conditions, causes, objectives, and results of the action and about alternatives to it, and then drawing comparisons to similar incidents. This enabled me to understand how the participants developed their arguments and to engage with the internal logic of their experiences. After coding each piece of raw data, I identified the categories that seemed central to the respective participant's experiences about (1) their represented realities and (2) their reported meanings of the course. I was thus able to quickly identify recurring themes and relevant categories that I could elaborate on in the analysis. Over time, relationships between codes started to emerge and more conceptual work on individual codes was initiated; meanwhile, other codes remained at a preliminary stage because there was limited relevance to the research question, and new codes were still in the making. Therefore, the coding process was characterized by the constant comparison of all the transcribed data and the elaboration of codes and categories at various levels of analysis.

The second task of coding is the constant comparison of categories, concepts, and empirical incidents. This is mainly done using axial and selective coding. Axial coding involves re- building the data by establishing new relationships between categories and their subcategories. It is termed axial because coding occurs around the axis of a category, connecting categories at the level of properties and dimensions, and naturally represents categories that describe the open codes (Japhet & Usman, 2013). As the transition from open to axial coding is effortless, the researcher can return to open coding and review codes and categories at any point in time (Bryant et al., 2012). In my study, open coding led to the development of two broad categories entitled represented realities and reported meanings of the course that comprised a large number of lower-level concepts. During the axial coding I developed these concepts and the relationships between them by constantly comparing the underlying empirical incidents. The analytical tools of posing questions and drawing comparisons led to the further development of concepts and categories. To advance the theoretical integration of the interpretive work, which is the main purpose of selective coding, I then focused my attention on a limited number of core categories. Selective coding is the third phase of analysis and aims at integrating and refining the categories into a theory, which accounts for the phenomenon being researched, and validates the statements of relationships between concepts and fills in categories in need of further fine-tuning (Japhet & Usman, 2013). The selective coding process connects all categories and sub-categories to the core category thus facilitating the emergence of the theory (Bluff, 2005). From the beginning I drafted coding notes for each data source as well as analytical memos about individual memos about individual concepts and their relationships with other concepts. This process produced a large amount of written material; however, it also raised the analysis to a more conceptual level and facilitated the elaboration of the categories and their relationships.

## **5. Data Interpretation**

In order to interpret the data acquired from the participants' experiences, I adopted the above mentioned three grounded theory informed analysis steps. I engaged with the data using a symbolic interactionism (SI) lens. The SI lens tells us interaction occurs through the use of symbols starting with the one self and others within a particular reference group (Burbank & Martins, 2010). In this study, language was the symbol of interaction that unveiled the participants' interactions with clients seeking abortion services and how these experiences affect practice and understanding of abortion counselling. Language is one way of symbolic communication/interaction that draws on shared meaning, and allows individuals to become aware of the experiences of others and interpret their meaning (Oliver, 2012).

A grounded theory was utilized for this study because it is suitable for studying individual processes, interpersonal relations and the reciprocal effects between people and larger societal processes. Furthermore, as a grounded requirement of the researcher, an attempt to describe, explain and understand the nurses' experiences of providing abortion counselling was an aspect that guided analysis of the data. Thus, through the three steps of open, axial and selective coding, the data were analyzed and as themes emerged a theory was grounded and codes connected in an attempt to answer the research questions of the study. Using grounded theory to inform this study illuminated nurses' understandings and practices which can afford the developers of the course the opportunity to improve the course (Bluff, 2005), since there is limited research on abortion counselling training.

The themes and codes were recorded in my memo. Memo writing helped formulate a structure in which the data were to be analyzed. I made use of highlighters to differentiate the categories and sub-categories in order to link codes that were either promoting or hindering the delivery of quality abortions services. Making use of memo writing provided guidance on what themes to focus on when collecting further data. It also helped with recognizing when data saturation occurred. While only five interviews from a possible nine were conducted, it was felt that data saturation had been achieved. This resulted as theoretical sampling, because the five participants were interviewed specifically to gather more data for themes needing further elicitation.

## **6. Ethics**

Before researchers begin conducting a research study, they need to obtain ethics clearance in order to commence the study. Furthermore, they need to provide information to the recruited participants and obtain their permission to participate in the study. The study participants should be apprised of the motivation of the researcher. This disclosure helps to build rapport between the researcher and the

participants (Creswell, 2007). The broader research study within which my study was conducted was granted ethics clearance by The Rhodes University Research Ethics Committee (RUESC) with ethics clearance number 4456. The following principles were followed by the researcher.

The first principle is beneficence, which requires the researcher to have welfare of the research participants as a goal in a research study (Corey et al., 2003). This research study was conducted within a broader study, an abortion counselling training course underpinned by a participatory pedagogical practice aimed at putting the participants at ease in engaging in professional growth. Since this research dealt with providers who provide a sensitive service, it was important to create an environment in which participants felt comfortable talking about their professional practice. Hence, as the co-researcher, I was present at all the sessions, and therefore was able to develop a relationship with the participants prior to the interviews.

Secondly, the researcher needs to ensure that the research participants must not sustain any harm in instances that include sexual, financial, and emotional or any other form of exploitation. This is called non-maleficence (Corey et al., 2003). The participants were alerted beforehand that there will be no monetary exchange for participating in this research study. Thus, no deemed exploitation took place because the participants gained from the training, and those who participated in the interviews willingly provided their time in recognition of this.

Thirdly, for a research study to run smoothly the researcher is required to inform the participants about the procedures of the research study, and all the possible consequences. Typically, this takes the form of consent forms before the research study commences to ensure that participants enter the study voluntarily. In this study, participants were given consent forms to sign, with stipulations of what was required of them, which clearly stated that not participating in the research study would not preclude them from partaking in the training course. All nine participants at the beginning of the study consented to partake in the research component of the training course. The consent form is attached in Appendix A.

The fourth requirement of ethics consideration is confidentiality. This stage requires the researcher to protect the research participants' information from unauthorized access, use, disclosure, modification, loss or theft. It helps ensure a trust relationship between the researcher and the participant (Resnik, 2015). Since this research study made use of audio recordings, the participants were alerted and consented to having certain parts of the training course recorded, as well as the interviews. Furthermore, consent to use the data extracted from the recordings for reporting findings at the end of the research study, and an agreement to protect what they disclose during the recordings was obtained.

All the raw data and audio recordings were transcribed by myself, and stored in my personal computer in a password-protected file. Only I and my supervisors had access to the transcribed data from the recordings for academic assessment purposes. Participants were made aware of this aspect as I was introduced as a Masters student conducting this research for academic purposes, and that my supervisors would be privy to the data. The transcription form is attached in (Appendix B).

For the fifth requirement, in order to produce valuable results, the researcher has to be honest and transparent about the research aims, data, methods and all the procedures that will take place during the study (Resnik, 2015). Transparency and honesty were sustained throughout the duration of the research study and through consistent communication between researcher and the participants. The participants were encouraged to share their inputs throughout the training course to ensue interest in continuing partaking in the study.

Lastly, the researcher is required to commit to promote social virtue, through research, public education and advocacy; this is called social responsibility (Resnik, 2015). The aim of this research is to contribute to the development of an abortion counselling training course, and to explore the nurses' understandings and practice of quality abortion services. The research thus, aims at promoting access to qualify abortion counselling and informing the ways in which counselling is conducted to meet the need of those seeking to access abortion services.

## **7. Trustworthiness and Credibility**

Trustworthiness and credibility of a study is demonstrated through data collection that supports the researcher's ultimate argument concerning their study, and credibility deals with the focus of research and refers to the confidence in how well the data explains the focus of a study (Elo et al., 2014). A study is trustworthy when the researcher is viewed as having made methodological practices visible and therefore auditable. This is because detailed methodological description enables the readers to determine how trustworthy the data constructs are and whether or not they can be accepted (Gunawan, 2015). Lincoln and Guba (1985) indicate that trustworthiness in a qualitative study is established through the inclusion of documentation of several data collection methods and various triangulation procedures. Triangulation was reached through the different sources of data, which include individual interviews, group discussions and analyst triangulation, whereby peers from CSSR (Critical Studies in Sexualities & Reproduction) provided feedback on my work and analysis. This helped in reducing biases and enhanced trustworthiness of the study.

To ensure credibility of the study, excerpts of participants' own words were used in the analysis chapters to also convince readers that the support for the claims made is strong enough to serve as a

basis for understanding, to eliminate biases and increase the researcher's truthfulness in accounting participants' experiences (Golafshani, 2003). To support the analytical findings of this research, I include literature supporting the experiences that providers have shared to reinforce the conclusions I have drawn. It is important to note that not all readers will interpret the data in a similar manner; however, it is essential for them to determine and identify the means by which the interpretations were reached (Houghton, Casey, Shaw, & Murphy, 2013).

## **8. Reflexivity**

I introduce reflexivity under its own heading, stressing the importance of this feature and its presence from the beginning of this research study to the submission of the final draft.

According to Berger (2013), reflexivity is a researcher's mindfulness and measured effort to be attuned to their own reactions to participants and to the way in which the research account is constructed. It helps identify and elucidate possible or actual effects of personal, contextual, and circumstantial aspects on the process, and findings of the study (Berger, 2013). The construction and interpretation of the participants' accounts were made keeping in mind my own subjectivity, which can influence the findings.

The practice of reflexivity improves the quality of the study because it allows the researchers to ponder the ways in which who they are may both assist or hinder the process of co-constructing meanings; it allows researchers to present the data better, and to consider complex meanings (Berger, 2013). Furthermore, reflexivity positions the researcher as non-exploitative and compassionate toward the research participants. This, in turn, helps to address potential negative effects of power between researcher and research participants. Hence, I positioned my role as a learner when the participants shared their experiences with me, and as a researcher seeking to find understanding of their role as abortion providers through their own voice.

In the first stance, I aimed to be as non-intrusive as possible following the semi-structured interview principles of allowing the participants to freely relay their experiences without my interjecting. As a young black woman, it was less challenging to relate with the participants because they were virtually all black women, with one being a black man. Also, being present throughout the training course they were familiar with my presence which made conducting the interviews less challenging. My role as an observer also involved assisting the participants with technological glitches when they struggled with connecting to the Zoom during the training sessions. This rapport allowed me to listen with sensitivity and compassion towards the participants and enhanced a better understanding of the providers' practices in providing abortion services. I allowed myself to be schooled through the providers'

experiences in order to write up findings that fully reflect the providers' experiences as abortion providers. Positioning myself as a researcher seeking to fully reflect the providers' experiences in my writing, I kept a journal to write down my thoughts and feelings, which helped me to continuously refrain from being biased and subjective towards the participants. This helped me to connect with the participants and enhanced my understanding towards their experiences and the phenomenon under study.

## **9. Conclusion**

A methodology chapter aims to give a step-by-step process that elucidates how a research study commences to the analytical findings that emerge from the data collected. It helps in understanding the research procedures adopted to situate the analytical claims made by the researcher, while making the entire process transparent.

In this chapter, I provided a detailed account of the methods that supported my data collection and analytical claims. Placing the providers' experiences of rendering abortion counselling services at the centre of this study, helped to elucidate the different areas within the service that have the potential to promote or hinder quality delivery and accessibility of the service. I was able to cover the aspects of a grounded theory analysis and incorporated how it marries with symbolic interactionism to elucidate the nurses' experiences, and how that can enable understanding of practices that inform their delivery of abortion counselling. The discussion moved to the ethical considerations of the study. Thereafter, I attempted to critically reflect on the research process and the aspects that influenced and shaped the final research product. I also outlined how the trustworthiness and credibility of this study has been reached through different sources and analytic triangulation. Finally, I discussed reflexivity, on how I constantly positioned myself as a learner in order to have a better comprehension of relaying the participants' experiences as abortion providers, and therefore enhancing my research.

In the following chapter I discuss my analysis and interpretation of the data. These two are divided so that I discuss the nurses' experiences of offering abortion counselling and services in the first part of analysis. The second part (interpretation) I discuss how the training course may or may not have altered the nurses' understanding and practice of rendering abortion services from partaking in the abortion counselling training course.

## **Chapter Five: Analysis**

### **1. Introduction**

The focus of this chapter (the first two devoted to analysis and interpretation) is experiences outlined by the nurses in this study as abortion providers. In sharing their experiences of providing abortion counselling, participants gave accounts of their practices prior to the abortion counselling training course (Discussion around abortion practices), reflection activity (on what to start/stop or continue during counselling) their practice in the two weeks during initial training (case presentations) and of their practice two months after (interviews). In this chapter I analyse data collected from the above-mentioned sources in order to comprehend the multilayered accounts of nurses' experiences of their practice in relation to abortion counselling services, and participating in the abortion counselling training course.

The symbolic interactionism framework of this research emphasizes that the behaviour of individuals and the roles they adopt are determined by how they interpret and give meaning to symbols such as language, dress and actions shared by people within a culture, and learned through socialization. In using such a framework, I hope to illuminate nurses' experiences of abortion counselling through the abortion counselling training course. A grounded theory analysis enables me to unpack the experiences of the research participants to achieve a complex and nuanced understanding of how their participation in the abortion training course altered their practice.

The chapter consists of two categories, namely, represented realities and reported meanings of the course, each consists of sub-categories that describe nurses' experiences outlined: prior to participating in the abortion counselling training course; in their reflection activity; in their case presentations and, lastly in the individual semi-structured interviews two months after receiving training. Under each data source there are different themes that emerge.

### **2. Represented Realities**

The following describes the reported practices of nurses at various times in the process: before they participated in the abortion counselling training course; in the reflection activity, the case presentations and the interviews.

#### **2.1. Prior Counselling Practices**

Participants were asked to interview each other for 15 minutes about their background in counselling/their counselling practices, their experiences/cases that went well, and the challenges they experienced with particular cases. They then reported back. In the following subsections there are two

broad themes relating to: (1) practices, including “difficulties negotiating with third parties”, and “referrals as supportive”, (2) institutional challenges, including “lack of institutional support” and “poor outcomes for women in their second trimester”.

### **2.1.1. Difficulties in negotiating with third parties**

In the following excerpts, nurses reported on how they dealt with the involvement of third parties when they encountered clients coming in for abortion services, and how this involvement influenced or coerced the women into particular decisions regarding the outcome of the pregnancy.

*Extract 1 [Trans.1 Mary]*

*[...] Peter tried to convince the pastor that it must be the child's choice to do the termination not the pastor (1) but the pastor was having a problem that the congregation is : going to look at him with negative eyes that he impregnated the child in the church (2) and the child was convinced by the pastor that she want to do it although (.) it's supposed to be her choice not the pastor's choice to do it (.) unfortunately (.) he gave her some //network glitches //two days to decide (.) but the child came back to do it (.) so it was very interesting to me (.) that's it (.)*

*[...] there's one that felt very common (.) uhm (.) the one of a mother that brings a daughter (.) and then the mother is // throat clearing//forcing the daughter to do the TOP but during the interview (.) the interview is like counselling session one on one (2) so the client confessed I do not want to terminate (.) so she had to counsel the mother but they came back with the baby and they were happy (.) they were grateful to her so well done to her (.)*

*Extract 2 [Trans.1 Nandi]*

*[...]grandmother (.) because her mother is not working and her stepfather is not working (.) but the lady said 'no she didn't want to do an abortion' because her boyfriend is not working (.) but he promised he was going to find a job so that he can support her (.) we did counselling (.) the lady refused (.) she don't want to do it (.) so I had to refer her to social worker (.) now the social worker did sessions (.) now she agreed (.) and I told the mother and the grandmother (.) you don't have a say here in this particular... because the person who has a decision to do i [an] abortion is the pregnant lady (.) if this lady don't want to do i [an] abortion she's not going to do it (.) but ke [then] shame she finally agreed then I did i [the] abortion (.)*

In extract 1 above, Mary speaks to two instances where third parties were involved when clients were seeking an abortion service. In the first instance, the client seeking an abortion is an 18- year-old who got impregnated by a pastor. In the second instance, the provider highlights that the involvement of a parent trying to influence their daughter to have an abortion is common in their practice. In this instance, a mother was forcing the daughter to have an abortion. The extract speaks to the coercion that third parties may exercise on clients – “child was convinced”, “forced her daughter” – a

circumstance that is difficult for providers to deal with. Providers are depicted as having to make extra effort to counter the coercion: “tried to convince”; “had to counsel”.

In extract 2, Nandi had a client who was accompanied by both her mother and grandmother, and who was pressured to have an abortion due to socio-economic issues. The extract illustrates the difficulties of countering coercion. The provider tried to educate the client’s mother and grandmother that the decision to have an abortion is not their own but that of the client alone. But the client ended up choosing to have the abortion later on, even though initially she did not desire to have it done. The word “shame” at the end of the extract suggests that the provider felt that her intervention did not have the desired effect, and that the client “decided” to have the abortion because of pressure from her family. This is in contrast to Mary’s declaration “Well done!” in the first extract.

### **2.1.2. Referral as support**

In the following two extracts, the providers give accounts of cases that needed referrals due to lack of capacity to handle cases.

*Extract 3 [Trans.1 Nandi]*

*[...]we did counselling (.) the lady refused (.)\_she don't want to do it (.) so I had to refer her to social worker (.) now the social worker did sessions (.) now she agreed (.)*

*Extract 4 [Trans.1 Lilly]*

*[...] a 16 year old came in for abortion (.) saying she was raped.... Seeing that she was above 12 weeks I referred her as I don't do above 12 weeks in my institution (.) I phone Thembaletu (.) I discussed with the ... there was a constable (.) I spoke to Constable Kiernan there (.) he said 'they must start at the police station to open up the case' the...//glitches// from the police station they will be taken by //glitches//*

In extract 3, Nandi had to refer a client to social services for a social worker to continue with counselling sessions because the client refused to be counselled and the case involved third parties; the client agreed to be counseled when her case was referred to a social worker. In extract 4 Lilly referred her client because it was a rape and late gestation case. She was unable to assist the client because her institution only offered abortion services up to 12 weeks gestation. Both the providers were able to refer their clients to relevant parties that could further assist them. The providers speak in ways that depict the referral process as smooth, providing information as well as the desired outcomes.

## 2.2. Institutional Challenges

The following excerpts illuminate the institutional challenges that nurses faced prior to participating in the abortion counselling training course namely; lack of institutional support as challenging and poor outcomes for gestational limits.

### 2.2.1. Lack of institutional support as challenging

In the following extracts, the providers relay how lack of support in their practices proves to be difficult for them in providing quality abortion services to their clients.

*Extract 5 [Trans.1 Beauty]*

*[...]so now ehh we have a challenge of not being supported by the ehh (.) managers and also not being supported by the doctors (.) so it's the same thing cause everytime we have to do i [the] CTOP (.) for us the scan should be confirmed by the doctors (.) you cannot work without the doctors confirming the scan neh [right] (.)*

*Extract 6 [Trans.1 Thandi]*

*I also have a problem with my management a lot (.) cause my CMO is not comfortable with CTOP at all (.) he even suggested that we only do it on Tuesday and not Thursdays too (.) because she only allocated one doctor for me to do the CTOP (.) but the problem is when the doctor is on leave no one is available to confirm i [the] scan for me (.) so it's really difficult working with them (.)*

In the above extracts (5 and 6) the providers report that lack of support from their managers hinders them from practicing and offering quality abortion services. This lack of support is depicted as a “challenge”, a “problem”, and “really difficult”. Not having the power to confirm gestational dates on a scan, to decide on the days on which services will be provided, or to allocate doctors to the service, the service providers are at the mercy of managers who may not be “comfortable with CTOP at all”.

Such lack of support was not reported by all providers however, unlike the providers in extract 5 and 6, the provider in extract 7 did not encounter the same challenges with her manager.

*Extract 7 [Trans.1 Bonga]*

*At the present moment I don't have any challenges here in my hospital (.) ehh (.) my mangers they support me a lot (.) and even the doctors they do i [the] all them (.) if I ask them to do i [the] scan for me (.) they are always there for me (.)*

In extract (7) Bonga reported that she was receiving support from her manager and the allocated doctors. She feels that “they are always there” for her. However, this comes with a caveat – “at the present moment” – suggesting that she knows this may not always be the case.

### 2.2.2. Poor outcomes for gestational limits

In the following extracts, the providers report on the poor outcomes that they encounter in their practice owing to gestation limit. These limits can be consequential and hinder their capacity to help clients coming in for an abortion.

*Extract 8 [Trans.1 Beauty]*

*Then on my side there was a case (.) she came it was already late for TOP (.) and then I... three days after when I off (.) I was called in casualty that there's a client of mine (.) when I arrived (.) it was the same lady that I had said it's too late (.) I think she was 16 weeks but she got the tablets wherever she got them (.) now she had terminated (.) the reason being was that yena [she] she cannot go ...they are paying.. she's going to get married so she cannot afford to go with the pregnancy (.) that's not the boyfriend's pregnancy (.)*

*Extract 9 [Trans.1 Thandi]*

*[...]also come sometimes (.) and I turn them away //glices// I tell them ukuba [that] you are above 12 weeks so we can't help you but you can go to P.E or go to East London (.) but I did try to call Queenstown for them (.) but Queenstown is only ... helps when it's 12 weeks (.) so for now they go home (.) I ...when I counsel them I make sure that I open a card for them (.) so that they can be able to go to the clinic (.) but now after a week or three days or so (.) you'll find that the same person comes to casualty and now's she's bleeding and the answer will be 'no I just bled I don't know what happened' (.) so those are the problems we are encountering thank you (.)*

In the above extract (8) Beauty had a case where a client presented with late gestation in their pregnancy and was unable to have an abortion. The client later came back presenting with an unsuccessful abortion procedure. Therefore, the gestational limit hindered the provider to offer abortion services to the client; hence, they resorted to an illegal method of having an abortion. There is a similar report from the provider in extract (9). Despite this, Thandi engages in helping actions: phoning to see if a nearest hospital can assist; opening a file for her clients to have records for further assistance. However, after few days or months clients come in presenting with unsuccessful abortion procedures.

In the following extract, the provider refers to structural inadequacies that hinder their ability to provide services.

*Extract 10 [Trans.1 Nandi]*

*[...] above 12 weeks because u [the] above 12 weeks is only Frere that is doing u [the] above 12 weeks and Marie Stopes (.) Marie Stopes is a private hospital where people are supposed to pay money (.) then Frere is the only one supporting Craddock (.) Grahamstown (.) Queenstown (.) Mthatha (.) Mdantsane (.) every places (.) then there is a lot of files (.) and they always say*

*they have got only three beds (.) then if there is a gynae problem they are going to take care of those people who coming in to do i [an] abortion (.)*

*Extract 11[Trans. 1 Jane]*

*I told her that 'the only place which is doing above 12 weeks is Frere hospital' (.) but Frere (.) the nurses there or the sisters say 'the clients should very early there' (.) 'there's a lot of people who are doing CTOP there' (.) so before they can do i [the] CTOP somebody must have a bed in gynae ward (.) so they must go early or else she must go there and sleep there (.) and they wake up at about four o'clock for them to get i [the] bed there Frere hospital (.) so I told her that uhm (.) 'here in my hospital I don't do above 12 weeks' (.) so she must go there to Frere hospital because she was afraid of the husband (.) because she was impregnated by a boyfriend (.) so I refer her to go to Frere hospital (.)*

In the extracts above (10 and 11), Nandi and Jane report that their facilities only provide abortion for up to 12 weeks gestation. This limitation is consequential in that clients are unable to access abortion services when they present with pregnancies above 12 weeks. The provider refers them to facilities that can help them. However, there are multiple barriers to the referral: there is only one health institution that offers above 12 weeks abortion services and it is a referral point for many surrounding health facilities in the Eastern Cape; because of lack of beds, the hospital beds cannot accommodate every referred case; clients need to pay for access to Marie Stopes services since it is a private facility; a high number of clients come in for second-trimester abortions and thus, clients have to wake up early or sleep at the facility waiting on queues to access a bed. This limitation can be challenging for both providers and clients because providers are unable to assist based on their institutional obligations; clients presenting with late gestation, and referral second-trimester abortion facilities are also congested with late gestation abortion.

### **2.3. Reflection Activity**

The participants were tasked with a reflection activity. In this task providers were tasked to discuss and report back what they would start, stop or continue doing in their practice to ensure women seeking abortion services access quality services. The following are the themes that emerged from their reported experiences.

#### **2.3.1. Changes in practice**

Providers indicated that they would like to change the following: cease asking clients for reasons for the abortion in the first trimester, and providing mandatory counselling. Space and time emerged as limiting effective counselling and maintaining confidentiality. They would like the latter changed, but of course, this is not in their hands.

### **2.3.1.1. Ceasing asking for reasons in the first trimester and mandating counselling**

Participants indicated that previously they had asked clients for reasons for their requesting an abortion. Below are extracts that illustrate the challenge they face because the institutional form they complete has a section, “reason for request”.

*Extract 1 [Trans. 2 Peter]*

*[...]there are two things that we decided to stop (.) one was the ehh (2) asking the reason for request (.) because that's what was in the guideline (.) that if the patient is less than 12 weeks (.) it is not mandatory to ask why the patient is requesting a termination of pregnancy (.) but (.) in contrast the forms and the documents that we use (.) that guides us there is a question there that says 'reason for request' (.) so it was like a norm for us to ask (.) why do you request TOP (.) so that was the first one (.)*

In the above extract, the provider reported that they decided to cease requesting the reason for abortion from their clients despite the institutional form wanting a “reason for request”. Through training they were made aware that asking clients for the reason of termination of pregnancy below 12 weeks of gestation runs contrary to the CTOP Act, which states that pregnant women may *request* an abortion up to 12 weeks. This suggests that no reason needs to be given. The contradiction between the course and the official DoH forms created a sense of confusion for the provider. However, the “guideline” accompanying the source cancelled out the other “official” source, thereby allowing participants to talk about a change in practice.

Knowing the reason why clients wanted to terminate seemed to be an attitude adjuster for providers. Providers reported that they would be polite to the clients after they disclose that reasons for termination may be lack of financial stability, poverty or unemployment.

*Extract 2 [Trans. 2 Jane]*

*[...]we were talking about reasons of the form of requesting CTOP (.) because it's got those questions that you must ask the client what is she here for (.) why she's requesting CTOP (.) but as we know ke [then] most of the answers they say is socio-economic (.) others are not employed so (.) we don't just go rough to them (.) we just fill the form (.) so the revisit of the form is needed. (.)*

The above extract suggests that the provider felt if the reason for requesting an abortion was not justified, the treatment of the client would be affected and would result in them being treated roughly. This also suggests that quality treatment and service was justified by the reason for requesting an abortion.

Previously before undergoing abortion counselling training, the nurses reported practicing mandatory counselling because they were unaware that they had to find out from the client if they want it or not.

*Extract 3 [Trans. 2 Faith]*

*Okay (.) I n my group we talked about counselling (.) we were not asking our clients about will they want to be counseled or not (.) so we've learned that we have to ask them if they want to be counseled or not (.) and they would like to be counseled about (.)*

Faith, in the above extract indicated that the group previously assumed that a woman requesting abortion is always in need of abortion counselling. This is despite the fact that the CTOP Act explicitly specifies that counselling should be non-mandatory. Therefore, through training the providers learned that counselling should be non-mandatory and that clients should be asked whether they wanted counselling, and of what nature (contraceptive counselling, procedure counselling, pre and post abortion counselling).

### **2.3.1.2. Space and time limiting effective counselling**

For some providers lack of space for counselling made it difficult to maintain privacy for their clients and in most cases individual one-on-one sessions could not be held. Providers had to improvise in order to provide counselling that meets the clients' needs.

*Extract 4 [Trans. 2 Jane]*

*[...] there's a challenge of space because I've got a mini theatre (.) and then even my consultant room is so small (.) So when I'm going to do education to them (2) I must group them (.) if they are four (.) I must group them in four before this covid (.) so even now in this pandemic (.) they must be four if they are four (.) but I must be space in between (.) because I've got a challenge of space (.) when I'm doing counselling (.) I'm doing the group counselling (.) so when I'm reading that consent form for them (.) they are all here all of them (.) and I'm doing group counselling (.) the only privacy, (.) is when I'm doing the procedure because it's one on one (.) but counselling is a group (.) but if I can get space (.) as I can hear ke [that] the one on one counselling is very important (.) because it's where the client is able to voice her fears or knowledge (.)*

*Extract 5 [Trans.2 Nandi]*

*[...] for i [the] counselling I don't have too much space (3) I'm doing I groups, but ke [then] there is another lady who is coming for i [the] NGO from breath of life (.) naye [she] is also doing counselling (.) she's helping me (.) but ke [then] her end yena [she] is to adopt the children (.) but she's doing counselling but don't have a space (.) even NGO is also testing in that room (.) but ke [then] after doing that group counselling (.) if somebody who need more counselling then I'm doing one on one, but ke [then] I'm doing one on one in the procedure room because we don't have rooms (.)*

In the extracts above, the providers spoke of the experiencing a lack of counselling space and having to render group counselling; they resorted to carrying out further counselling during the procedure since it was the only level of privacy they could afford the client. In extract 4, Jane believed that the lack of counselling space limits the client from expressing their fears or knowledge openly. She indicates that things would be better “if I can get space”. Space is a problem for the second participant above, because it had to be shared with an NGO for women who might be interested in adoption rather than abortion. Thus, sharing an already congested environment limited privacy.

Space was not the only constraining elements spoken to. Time featured as well.

*Extract 6 [Trans.2 Thandi]*

*[...] but I think I should have more time with them to...like to discuss about everything and the CTOP (.) because I think that part I'm not doing it well (.) that's why they coming now and then (.) now and then (.) because I had a client today (.) whose coming for the third time for CTOP (.) I don't have many clients (.) I know all of them but ke [then] they come now and again, now and again (.)*

Thandi felt she needed to have more time in one-on-one sessions. She notes that she is “not doing it well” because clients come for repeat abortions. She felt that being able to give more information will decrease the need for repeat abortions. Hence, the provider felt a sense of self-blame for her clients’ decisions.

### **2.3.2. Maintaining Practices; confidentiality**

Providers reported that in terms of their practice, maintaining confidentiality towards clients undergoing an abortion is what they would like to continue when offering abortion counselling.

*Extract 7 [Trans. 2 Peter]*

*And ehh (.) as far as what we would like to continue (.) ehh (2) it was the issue of confidentiality (.) for one because that was one aspect that we all agreed upon (.) That's the one thing we are doing (.)and the guideline actually stipulates exactly what we are doing (.)*

The provider in the above extract, Peter, reported that during their reflection activity confidentiality was seen as an important aspect to maintain when conducting abortion counselling. Furthermore, they regarded it as important because the institutional form requested them to maintain confidentiality when rendering abortion counselling.

Whilst participants reported that confidentiality is an aspect of counselling that should remain in practice, another provider in the extract below indicated that it is easier to maintain confidentiality

when there is enough counselling space and when counselling is offered individually than in a group session.

*Extract 8 [Trans. 2 Beauty]*

*[...] when it comes to confidentiality (.) on my clients it's a one on one (.) I've got too much space (.) so the person comes one by one (.) when it comes to that confidentiality so (2) so far for me I think I'm handling it fine (.) yes (.)*

This provider connects the structural issues referred to above to the requirement of maintaining confidentiality. Implicit in the statement is that without sufficient space, confidentiality is a challenge.

## **2.4. Counselling after practice period**

In the case studies presented after the practical period, the following themes emerged as changes in practice: being non-judgemental, and observation. Handling third parties, listening and ensuring counselling is not mandatory appeared under the “maintained practices”. The nurses showed an understanding of their role as abortion providers by being aware of their mannerisms and conduct during counselling sessions.

### **2.4.1. Reported changes in practice**

The sub-themes that emerge under this category are being non-judgemental and observation. The following excerpts describe how nurses' practices changed two weeks since participating in the abortion counselling training course.

#### **2.4.1.1. Being non-judgemental**

Being aware of their attitude towards their clients during counselling sessions enabled providers to provide abortion counselling without making the client feel judged for opting to have an abortion.

*Extract 1 [Trans. 3 Peter]*

*So I was just showing positive regard (.) and a non-judgmental attitude (.) those two aspects of my counselling made my client comfortable enough to talk (.) so uhm (1) those are the two attitudes that I displayed (.) i did offer a procedure after the options counselling (.) then the client said to me she felt as if she had no option (1) but to terminate her pregnancy (.)*

*Extract 2 [Trans. 3 Lilly]*

*[...] and I've learnt not to be judgemental (.) and I've learned that abortion is a clean medical procedure like any other procedure (.)*

*Extract 3 [Trans. 3 Mary]*

*(.) I've learned more especially the abortion counselling (.) that we mustn't judge the client, (.) and we must be in a positive manner (1) so I gained a lot (.)*

In these instances above (extract 1, 2 and 3) the providers acknowledged their non-judgemental and positive stances. This reportedly allowed for rapport to be built between the provider and the client, and enabled client to be open because they felt comfortable and not judged for their decision to abort. This stance seems to be supported by providers themselves seeing abortion in a positive light ('a clean medical procedure like any other').

Being non-judgemental was depicted as something new, but also as something difficult to maintain.

*Extract 4 [Trans.3 Peter]*

*[...]I was no longer imposing my views (.) no matter if I met a case that I felt it was tapping on my other types of (.) you know feelings (.) but I could like you know (.) control the situation because of the course itself (.)*

*[...]I thought to myself (.) let me create a safe space (.) that was my approach to this client (.) let me create this safe space for her (.) so I like introduced myself (.) offered her a seat (.) and I introduced myself to her before she could talk (.)*

*Extract 5 [Trans. 3 Beauty]*

*[...] So she came in complaining of nausea and vomiting (1) to a point she was saying she cannot tolerate food (.) Then after seeing that I know this client (1) I'm sorry I chased her out of my office (.) I was very much angry (.) I chased her out (.) Cause she was coming (.) last year (1) 2019 she was here in May (1) this year in May again she was here for the second time (.) And then now is the third time (.) I couldn't hold myself (1) I chased her out (.) Then I thought to myself (1) I used the self-calming techniques to calm myself yho [wow] just to try and make myself understand (.) not to be judgemental (1) and keep in mind that it's her choice to do termination of pregnancy (1) at the end of the day (.)*

In the above extract (4), Peter reported that since receiving training he keeps a check on his own emotions when encountering a case that evokes negative feelings towards the client. He reports previously "imposing his views". Furthermore, being aware of his behaviour, the provider tried to create a safe space by introducing himself and offering the client a seat so that the client can feel comfortable before the counselling session could commence. In extract (5), Beauty indicated that she struggled in the beginning to control her emotions and was judgemental towards a client coming for a repeat abortion. However, due to receiving abortion counselling training, she was able to prioritize the abortion counselling session by making it about the client's needs. The provider was able to comprehend that the decision to access abortion sessions repeatedly was the client's reproductive right. The confession of having acted judgmentally is followed by reflection – "thought to myself", "calm myself".

*Extract 6 [Trans 3 Thandi]*

*[...]and she just came directly to me and told me (1) sister (1) she told me that she came here to do termination of pregnancy (1) and she knows ukuba [that] it is not right to do it for the second time (1) and I told her ukuba [that] it's not my place to judge and it's her choice (.)*

*Extract 7 [Trans. 3 Bonga]*

*[...] I've noticed that I think plus minus 6 months (.) she was here at the clinic for termination of pregnancy (.) but I didn't show that I recognize her (.) and I continued talking with her (.)*

Providers in the above extracts (6&7) were able to offer quality abortion counselling services by assuring the clients that accessing abortion services is their reproductive right and they can access it whenever they need to. The first provider explicitly mentioned not judging to the client, while the other pretended to not recognize the clients.

#### 2.4.1.2.Observation

During the training course the providers were taught about the importance of paying attention to appearance and demeanor since it will give them an idea on how to proceed or approach the counselling session. The client-centred approach which informed the abortion training course emphasizes that paying attention to appearance such as dress, emotions, verbal and non-verbal cues of clients will help the counsellor to prioritize clients' needs and to be in the know of which aspects to begin with or focus on when rendering counselling services.

*Extract 8 [Trans. 3 Peter]*

*[...] she came to the clinic by herself (.) she looked very anxious (.) very reserved uhm (2) but by the look she was well dressed (.) you know (.) well-groomed (.) she was orientated (.)*

*[...] and during the counselling session she started feeling comfortable (.) more relaxed (.) she started like sitting up (.) and then she played with her hands (.) you know (.) she started to use all these non-verbal communication that would tell me she's comfortable (.)*

In extract 8, Peter reported that a client came in seeking an abortion but looked anxious, aloof but overall well-dressed. The provider, thus, noted both physical appearance and deduced an emotional state. During the counselling session, the provider was able to observe the comfortability of the client based on the non-verbal cues such as sitting up, playing with her hands which indicated that she was still a little bit anxious.

This non-verbal communication gave providers an idea on how to adjust or proceed with the counselling session, which is important to practice when rendering abortion services in order to administer a service that is specific to a client's needs, thus, increasing the quality of care and service.

Extract 9 [Trans. 3 Bonga]

[...] what I noticed from this patient she was so anxious (.) and I asked her and (.) I gave her i [the] information about the choices (.) and she opted for i [the] surgical procedure (.) And I asked her if she knows about I family planning (.) and she said that she knows about family planning (.) but she doesn't want to take i [the] family planning now (.)

Extract 10 [Trans. 3 Lilly]

So on arrival (1) the patient was very emotional (1) she was very stressed (.) and (.) she was very indecisive (.) if she really wants to do (.) if she's doing the right thing by resorting to do termination (.) So what I did I gave her counselling (1) telling her that it's her right (1) her choice to do abortion (.) if she feels that she is not emotionally and physically fit to have the child (.) I explained to her that abortion is a clean medical procedure (1) like any other procedures (.)

Extract 11 [Tran. 3 Faith]

[...] she couldn't listen well (.) even if I said sit down (.) she would say ja [yes] but she was so anxious (.) Then I showed her the sit (.) and I ensured that it's only the two of us (.) but we're going to do the counselling (.) She sat down (.) and I introduced myself, (.)

[...] I gave her information about the consent (1) now she was a little bit relaxed but (1) she couldn't even narrate what she reading on the consent form (.) So I had to explain everything to her (1) and she agreed to it and signed the consent (.) then I told her about the method of termination she chose MVA (.)

In extract 9, the client appeared anxious, but the provider was able to give out information regarding the two abortion procedures available and the client was able to go through with one with which she was most comfortable. And in extract 10, the client was indecisive and stressed about whether or not they would like to continue or terminate their pregnancy. The provider was able to reassure the client that she had the right to have an abortion. In extract 11, the provider reported that her client was anxious and could not listen well even when she was instructed to sit down. This observation allowed the provider to respond appropriately to the client by offering her a seat and by ensuring her that privacy was maintained. After giving the client information about the consent, the provider noticed that the client began to relax, but because she could not read, the provider had to explain what the consent form entailed.

The above excerpts illuminate that when providers pay attention to clients' non-verbal cues, they are able to proceed with the counselling session in a manner that allows the client autonomy over their bodies. Providers treated the clients as individuals capable of making an informed decision regarding

their bodies and were respectful of the clients' decision to proceed with a procedure and decision they were most comfortable with respectively.

#### **2.4.2. Reported maintained practices**

In this category, nurses reported that they continued to maintain in their practice making referrals, handling the involvement of third parties, providing beneficial information, listening efficiently and ensuring that counselling is not mandatory when rendering abortion counselling.

##### **2.4.2.1. Referrals and handling third parties**

The supporting nature of referring clients presenting with second trimester pregnancies and handling the involvement of third parties were reported as being maintained practices that providers effected in their abortion counselling sessions, in order to promote quality access to abortion services.

*Extract 12 [Trans. 3 Peter]*

*And then she told me that currently (.) she wants to do termination of pregnancy (.) that's all she's interested in uhm (.) she's well aware that is not right but (.) this is a situation that she has found herself in (.) so I just carried on giving her information (.) about procedures and types of procedures that we have (.) and the options where she could (1) if she's interested to talk to someone else like a social worker (1) or I could refer to Thembaletu care centre (.) and they can contact the police on her behalf (1) she can open a case or talk to someone if she wanted to (.)*

In extract 12, the provider reported that he had a client who was sure of their decision to have an abortion but felt guilty. Since the client seemed to be struggling with guilt, the provider went on to suggest referring her to several other places where she could be further assisted, which included the social worker, the Thembaletu care centre and police. This knowledge of referring a client to access other services for further assistance with their case is an indicator and practice of quality abortion services.

The difficulties with third parties were once again spoken of. In the extract below, the provider prioritized the client's needs and was able to advocate for her when her rights were imposed upon.

*Extract 13 [Trans. 3 Mary]*

*[...] The mother quickly gets in (1) and she was shouting the girl (1) 'why are you fooling me?' (1) 'Because you said to me you have irregular menses and tenderness of the breasts'(1) ' now you just quickly run into this clinic requesting termination of pregnancy'(1) 'Do you know that I'm a Christian?'(1) 'and I'm saved?'(1) Ehh (2) she was shouting the girl (1) I quickly intervene taking the girl to the other room (.) leaving the mother with me (.) I tried to explain to*

*the mother (.) firstly (1) I asked her how old is the girl (1) 'how old is she?' (.) The mother said 'the girl is 19 years old' (.) Okay (.) I said 'no it's her choice to do termination of pregnancy' (1) and 'even our government legalized it'(1) 'if somebody didn't want to live with the pregnancy (1) so you cannot control your child (1) saying that she cannot do termination of pregnancy' (1) but (.) at last the mother understand because (.) this child was not the first time being pregnant (.) Okay I go to the girl (.) to the other room (1) and then I told her that I've talked to your mother (1) you mother understands what is going on (.) I tried to explain the procedure that we are doing in the clinic (.) Because she delivered the first child (.) she didn't terminate the first one (1) so she didn't want this pregnancy (.) the second one (.)*

In extract 13, Mary had a client come in with their mother who was unaware that she was pregnant. The client wanted to have an abortion; however, she had concealed her pregnancy from her mother. After providing a description of the conflict, the provider indicated that she intervened separately with the two parties. She instructed the client's mother about the CTOP Act, using language that stressed bodily autonomy. She then reassured the client.

#### 2.4.2.2. Providing beneficial information

Providers spoke about providing beneficial information as something they felt happy about.

*Extract 14 [Trans. 3 Beauty]*

*Okay uhh (1) good day everyone (.) uhh (1) my two weeks have been exciting I should say (.) I took clients that okay (1) the other one came in January (1) when she came it was already late to do i [the] termination (1) then I tried reassuring her and whatnot (1) she never went to backstreet ehh (1) abortion clinics (1) she kept the baby (.) Recently she wrote a message to me appreciating what I did to her (1) and she gave birth to a baby boy (1) which was exciting to me (.)*

*And then the other one came again (.) she was 37 years (.) uhm (1) she was pregnant for the third time (.) She wanted to do termination but (1) she wasn't sure because she was crying (1) you know these myths people have (1) that when you are 37 and older you give birth to babies that are not okay and whatnot (.) So I tried counselling her and she left here fine (.) and she wrote a message later and said she wants to thank me for what I did to her (1) she no longer wants to terminate she wants to keep the baby (.) so for me it was something (.) I would say an achievement or something (.) at least if we doing this and people are appreciating (1) it gives us the power to do more nehh [right] (.)*

The provider in the extract above talks about “reassuring” a client who presented with an above 12 weeks pregnancy. This process ensured that they refrained having a backstreet abortion. Here the provider is seeing her role as not only confined to providing first trimester abortion, but also preventing harm beyond that. In the other instance, the provider “counsels” a woman about the obstetric risks involved in pregnancies in the late 30s, indicating that it is not a foregone conclusion that the child will be born with anomalies. This information helped the client to make an informed decision not based on “myths”. The client later showed gratitude to the provider for helping her and

the provider was left encouraged to continue working as an abortion provider because of the appreciation she received from the service she provided the client. This indicates that rendered quality abortion services can be beneficial and satisfactory for both provider and client when both parties acknowledge each other as capable and knowledgeable individuals.

#### 2.4.2.3. Listening

In the following extracts (15 & 16), the providers reported on their learned skill to listen to their clients and how it helped improve their practice.

*Extract 15 [Trans. 3 Peter]*

*[...]so I listened (.) and then she went on to tell me because I didn't ask this (.) because I had told her that (.) uhm (.) that it was not mandatory for her to tell me why (.) she's seeking termination of pregnancy (.)*

*Extract 16 [Trans. 3 Thandi]*

*Uhm (1) well the course was really good (1) actually (1) it really helped me a lot with the listening skills (1) and the counselling because I didn't do much of the counselling when I was doing the procedures (.) So it really helped me a lot there (.)*

In extract (15) Peter was able to practice listening which helped the client to openly express the reason she wanted to terminate her pregnancy without being coerced into doing so. In this way the provider was able to uncover what the client needed and was able to prioritize the client during the counselling session. In extract (16), Thandi also reported that participating in the abortion training course has helped improve their listening skills and counselling. These participants feel that training on listening skills, which is one of the aspects of a client- centred approach, can positively improve the nurses' practice and quality when rendering counselling to clients seeking abortion services.

#### 2.4.2.4. Ensuring counselling is not mandatory

The CTOP Act states clearly that abortion providers should refrain from making counselling mandatory. The providers came across cases where women seeking an abortion declined both therapeutic and contraceptive counselling because they were certain about their decision to terminate.

*Extract 17 [Trans. 3 Bonga]*

*[...] I asked her if she wants to be counselled on this termination of pregnancy (.) and she was not interested in counselling (.)*

*[...] And I asked her if she knows about family planning (.) and she said that she knows about family planning (.) but she doesn't want to take i [the] family planning now (.) she go to her nearest clinic for family planning (.) And I did i [the] termination of pregnancy (.)*

*Extract 18 [Trans. 3 Thandi]*

*(.) She told me that she doesn't want any kind of counselling (1) she knows what is going to happen (1) and she will prefer doing I manual vacuum aspiration procedure (.) and I was fine with that (.) And then she (1) ehh (2) told me that she also wants to do a BTL [Bilateral tube ligation] (1) and then I asked if she's really sure about it because it's irreversible (1) if she decides to do it there's no going back (1) and then she said no she's sure (1) she wants to do it (.) And uhh (1) yes (.) we didn't talk much cause she told me ukuba [that] she knows the procedure and everything (.) she's not interested in the counselling and stuff (.)*

In the extract above (17) Bonga reported actively asking the client whether or not they wanted counselling. The provider went to offer the client family planning and the client also declined the contraceptives because she receives them from her nearest clinic. And in extract (18), Thandi spoke to the reason counselling should not be made mandatory, viz., women have agency and are best able to decide whether they would like counselling. This client was aware of the process she was to undergo and of the procedure she wanted. Furthermore, the client was also aware of the type of contraceptive they wanted to have. The extent of the counselling was, the provider making sure to ask if the client was certain with their choices before proceeding with any procedures.

In extract 19, the client who came in was also not interested in both counselling and contraceptives.

*Extract 19 [Trans. 3 Faith]*

*(.) I introduced myself and all that (1) then the counselling (1) she didn't want the counselling (.) So we did the scan (.) then I explained the procedure and what is going to happen (.) and also we did uhh (2) we went through the consent (1) then I explained and I opened a platform for her to ask questions if she has any (.) and then I also tried to explain to her (1) about the consequences of doing repetitive TOPs at her age nehh [right] (.) And then I counselled her about the contraceptive methods but (1) she said she still doesn't want to contracept (.) so it wasn't my place to force her anyway so I left her like that (.)*

Here the provider reported that she provided only the necessary information (procedure, consent), because the client did not want counselling. However, she then proceeded to caution the client about the consequences of doing repetitive abortions and speaks about contraception. This extract indicates the possible slippage between a stated commitment to non-mandatory counselling and the insertion of counselling within the session.

### **3. Reported meanings of the course**

The following themes and categories emerge from the nurses' reports in the interviews conducted two months after receiving training. Individual interviews were conducted to find out if the nurses

experienced any changes, learnings or challenges in their practice since partaking in the abortion counselling training course.

### **3.1. Changes**

Under this category there are four themes that emerge: boosted morale, improved language and conduct, being empathetic and providing choices, and ambivalence regarding rights in relation to repeat abortion and contraceptives. These themes elucidate the changes that might have taken place in the nurses' practice two months since undergoing the abortion counselling training course.

#### **3.1.1. Boosted morale**

In this category, the participants shared how partaking in the abortion counselling training course had changed and increased their confidence of providing abortion services to seeking clients.

*Extract 1 [Trans. 4 Lilly]*

*Uhm (2) it did help me a lot (.) It boost my spirit (.) yeah it did uplift me a lot (.) you know (1) as a result I'm walking tall uhm (1) yeah (.) I just close my ears and eyes (.) to whoever might be talking bad about my service (.)*

In this instance, Lilly reported that participating in the training course changed how she feels about being an abortion provider. Furthermore, it helped her to pay less attention to people negatively criticizing her job as an abortion provider. The course, according to this participant, provided some protection against the stigma abortion providers' face.

This boosting of morale helped not only the providers, but also the clients.

*Extract 2 [Trans. 4 Peter]*

*And for me that has boosted a lot of my morale (1) because I see that me going through the course (1) learning how to do proper counselling (1) that is recommended and actually implement it (1) it has made my clients more free to talk (.) It has made my clients more comfortable in coming to my clinic (1) and actually talking about their problems (.) Not only limited to abortion (1) but generally you know (.)*

The provider in extract (2) shared that participating in the abortion training course boosted their confidence and has taught them to practice counselling that meets the clients' needs and this has changed how their clients respond to the services. Clients became more comfortable to express themselves, accessing abortion services and more general services.

The boost of morale also came from seeing clients happy with the services, and the positive reputation this fostered.

Extract 3 [Trans. 4 Lilly]

*Also (1) you see it when they go out (1) their smile it makes you feel good (1) that you have done something good for your client (.)*

Extract 4 [Trans. 4 Peter]

*Letting people know that go see Peter (1) he is amazing (1) he gives out quality information (1) his open (1) his non-judgemental*

In extract (3), Lilly reported that the looks on her clients' face make it known to the provider that they appreciate the service provided. This made her "feel good". And in extract 4, the provider reported that since the training course, there have been changes in the number of clients coming in for abortion services due to referrals from previous clients. This has increased the provider's confidence of providing abortion services, and boosted his morale ("amazing").

Participating in the abortion counselling did not only boost the providers' morale, but also helped them to positively respond to the stigma attached to their work as abortion providers.

Extract 5 [Trans. 4 Lilly]

*[...] Okay (1) with the stigma that is attached (1) I'm not worried (.) Due to the training that you guys have given me (1) so I don't bother myself a lot about it (.)*

In the above extract (5), the provider reported that participating in the abortion counselling training course has helped them to pay no notice to the stigma that is attached to their work as an abortion provider, and because of the training they received they don't worry themselves about it.

### **3.1.2. Improved language and conduct**

Participating in the training course made a difference in how providers speak during the counselling sessions.

Extract 6 [Trans. 4 Peter]

*(.) I have seen the difference in my clients (1) how they speak to me has changed you know (1) Even the emotional state (1) because at times we will not be giving out information (1) but we will be graphic in doing so (1) in terms of how the procedure goes (1) possible risks associated with abortion (1) and referring to the fetus as the baby (.) Those are few things that is wrong, that now I feel ukuthi [that] I have mastered (.)*

Extract 7 [Trans. 4 Bonga]

*You as a provider (1) you must not ask the patient why she is coming to do this abortion because it's her right (.) So you must not ask her (.) You must just give her options (.) Give her more information on what she is planning to do (.)*

Peter in extract (6) above relayed how he changed his language regarding the procedure and how to refer to the foetus. This awareness, he reports, has improved the quality in which as a provider renders abortion services and counselling. In extract (7) Bonga, reported that since partaking in the training course, she now has an understanding that her role as an abortion provider is to provide their client with enough information to make an informed decision regarding their body, and not request the reason for abortion as a pre-requisite to access the abortion service. Here the language of “rights” is fore fronted.

### **3.1.3. Being empathetic and providing choices**

Although some providers suspected that abortion was being used as a form of contraceptive due to the number of repeat abortions, they tried to not be judgemental to their clients because they understood termination to be a woman’s right and they understood their job was to provide the service and not impose their opinions.

*Extract 8 [Trans. 4 Mary]*

*(.) and it their right not to have it as long as we have talked about the contraceptive (1) because as a TOP provider (1) I have to give them the options of contraceptive to choose from (.). So it’s their choice to choose (.)*

In the above extract (8) the provider reported that the changes in their practice include issuing information about contraceptives from which their clients can choose and to also respect the clients’ decision if they choose not to use any contraceptives. The provider understood that it is the client’s right to use or not to use contraceptives.

*Extract 9 [Trans. 4 Beauty]*

*And if the client does not want counselling (1) you don’t need to do it (.). But if she wants it you must always be willing (.). And to always be empathetic to our clients (1) uhh (2) give them chance to speak (1) must have a warm welcoming (1) so that they can be able to express themselves and express their feelings (.)*

The provider in extract (9), reported that the changes in their practice include being empathetic and welcoming towards clients in order for them to express themselves freely during consultation. She also tried to be respectful towards clients who decline counselling services, but always remain willing to offer counselling if clients seek it.

The providers, thus, reported that the changes experienced include refraining from forcing or coercing clients to take contraceptives even when they are coming back for a repeat abortion. They understood

their role is to give out information to the client and allow them to practice autonomy over their bodies.

### **3.1.4. Ambivalence regarding rights in relation to repeat abortion and contraceptives**

Participants indicated that they now tried to respect the rights of women to make decisions about their bodies.

*Extract 10 [Trans. 4 Lilly]*

*I will tell them abortion is a clean medical procedure (1) just like any other medical procedure (.) And it is every woman's right (1) even if they come a thousand times (1) they must just give their right (.) Because really we can't be judgemental for various reasons (.) because some of them who come there (1) are not open enough to tell you that (1) maybe someone raped them (1) so to give them their right (1) I would tell them not to be judgemental (.) That it is a woman's right and (1) that abortion is a clean medical procedure just like any other procedure (.)*

In this instance, Lilly speaks about abortion as a safe medical procedure and that it is every woman's right to access it. Her caveat (the reason could be rape), however, somewhat belies this assertion, suggesting that she possibly feels that abortion is only really justified in certain circumstances, and that non-judgmentalism is needed only because the client may not be open about the reason.

The concerns that providers have about repeat abortions is spoken to below.

*Extract 11 [Trans. 4 Bonga]*

*There are some hiccups (1) whereby now as you taught us that the client (.) we mustn't chase them away when they come back for termination for the second or third time (.) Now what I've noticed (1) the clients didn't want to use contraceptives (1) they want abortion (.) And I don't want to lie Laura (1) it's frustrating because these clients some of them are 13 years (1)12 years (1) they came in December (1) now they came again (.) So that is my big problem that I have noticed (.) I cannot do anything (1) I have to do this abortion as long as she wishes (.)*

Bonga here admitted that it is frustrating to render abortion services to clients coming in repeatedly especially when clients are young. Partaking in the training course, the provider had learned that abortion services should be accessible to clients seeking it as many times as they request it, and their role as willing providers is to provide it. This results in frustration and a sense of despondency ("I cannot do anything").

### 3.2. Challenges in providing abortion services: continues lack of managerial support

The following excerpts are experiences that illuminate the reported challenges the providers still face regardless of participating in the abortion training course. These challenges have the potential to hinder quality practice for nurses offering abortion counselling and services.

The participants reported experiencing resistance from their managers regarding their role as abortion providers.

*Extract 12 [Trans. 4 Peter]*

*In terms of abortion services (1) I still have lot of challenges in terms of support from management (1) because management is not really pro-choice (.) They really are not supporting this program (1) And the second challenge is (1) when you have managers that are not supportive (1) whatever problem you are to face (1) that may be directly involved in terms of providing or rendering services (1) like the equipment (1) for instance (1) we are running out of sterile packs (1) human resources (1) because I am running the clinic all by myself (.) I have nurses who have been inspired by the services I render (1) but management is not training them (.)*

*Extract 13 [Trans. 4 Beauty]*

*Uhm (2) the managers not being supportive (1) right now since last week (.) I don't have the scanner since it broke (.) My manager (.) yho [wow] it's a struggle (.) They that it should be a problem for the doctors not me (.) it's more like mna [me] I am overlooked when it comes to scan use (1) so as long as I'm the one who's reporting (1) they are not going to bothered (.) They want the doctors to report (.)*

*Extract 14 [Tran. 4 Bonga]*

*Challenges that I am experiencing (1) is the challenge of not having someone who is working with me (.) Because that is the only challenge that I am experiencing (.) because if I am off sick or I am on leave (1) there is no one on my service (.) So the service program is closed [...]*

*Extract 15 [Trans. 4 Peter]*

*[...] There is no training that is scheduled (1) so I am alone (1) I am overworked (1) and I am not remunerated for my work (.)*

In the above extract (12), the provider reported continued lack of support from managers which deter the provision of abortion services. This leaves them stranded when facing challenges, with insufficient equipment and human resources to ensure quality abortion service delivery. Moreover, this leads to other willing nurses not being trained. The provider in extract (13) relayed that lack of equipment and urgency in fixing equipment proved to be a hurdle when providing abortion services. The scanner enables the provider to assess whether or not the client is legally eligible to undergo an abortion. The

provider felt had it been the doctor reporting this hurdle, the managers would have acted swiftly on the matter. Thus, an abuse of power and authority seem to be detrimental to the quality access of abortion services.

In general, there is a low number of willing abortion providers; the lack of trained abortion providers limits the accessibility to quality abortion services, and leaves current providers overworked. The provider in extract (14) reported that not having help due to lack of willing trained providers proves to be a challenge when she's on leave or sick because no one is able to continue rendering the services to women seeking an abortion; thus, an absence due to leave means an absence of abortion services. The provider in extract (15) reported that insufficient human resources expose them to long working hours. The provider reported feeling alone and overworked, and this could be stressful and demotivating and thus can increase the desire to cease from rendering abortion services.

Indeed, the lack of support was seen as something that could lead to nurses leaving the service.

*Extract 16 [Trans. 4 Bonga]*

*I had challenges Laurah (1) I had challenges in October (1) because they asked me to go work in theatre (.) The operational manager who is supervising me (1) said to me one day I must go to theatre to assist there (1) I said to her (1) 'but I do have a patient with me here who came here for my help' (1) She said to me 'no (1) they've come to do abortion so it's not (1) you must leave them (1) just like that' (.) 'You must go to theatre and save lives there in theatre (1) instead of doing these people who have just come to abort' (.) So I decided to go there but (1) I think I'm rectifying the mistake (.) If this clinic is not essential to this institution I rather quit (1) And I rather close women's clinic totally and go to assist in theatre (.)*

In extract (16), Bonga resisting being marginalized by the manager for providing abortion services. The manager instructed her to provide assistance to theatre services because they did not recognize abortion services as an integral part of women's reproductive services. However, the provider was adamant that if the manager continues to not acknowledge abortion services as another vital aspect of reproductive service, she would discontinue working as an abortion provider.

As indicated previously, however, lack of managerial support was not universal.

*Extract 17 [Trans. 4 Mary]*

*[...] my manager is so supportive like (1) very supportive (1) As a result I had a query because I was short-staffed (.) So on the coming change-over in April (1) I will be getting a sister and also a staff nurse (.)*

The provider in the above extract (17) had a different experience from the providers in the latter extracts because her manager was being supportive and provided solutions to reported problems. This indicates that managerial support can promote quality accessible abortion services and increase willingness of abortion providers to continue offering abortion services.

### 3.3. Support buddy program

Before training commenced, the main researcher (Ms Yamini Kalyanamaran) created a WhatsApp group for the providers to liaise about any technical glitches, reminders, updates and as a platform for the nurses to offer each other support as abortion providers. The following are extracts from the providers sharing how the support buddy system has been helpful since receiving training.

*Extract 18 [Trans. 4 Beauty]*

*Yes (1) yeah it is helpful because sometimes when I have a challenge (1) we just ask in the group and discuss a way forward (.) Like the other one was saying that they are going to refer me (1) to someone that's going to help me with the situation I am facing right now (.)*

*Extract 19 [Trans. 4 Lilly]*

*It does help a lot (1) because when I am experiencing any problems with the program (1) it is easy for me to talk to the ladies and the gentleman (1) they are so helpful I don't want to lie (1) it makes the job to be easy (1) because at least you have someone to talk to (.)*

The providers in extract 18 and 19 above both reported that continuing with the support buddy system has been helpful in assisting them when they encounter challenges. Being part of the support buddy group has afforded them to access referral information, how to deal with certain work-related challenges and made it easy for them to do their job because they have someone to talk to. This indicates that providers are able to promote and render quality abortion services when they feel supported and have access to a platform that allows debriefing.

While the intention of the support buddy system was for providers to support each other around particular cases, providers indicated that it also helped them deal with workplace related challenges.

*Extract 20 [Trans. 4 Peter]*

*Yes (1) it has been very much helpful (1) because there is information that I didn't know about the province (1) and what is happening in the province (.) So being a part of such a group (1) it helps because obviously the abortion service delivery problems that we are facing (1) there is no one I can speak to who understands what problems I am facing (1) and how I should deal with it (.) So when I have people in my corner that understands (1) and give me tons and tons of advices (1) it helps because it broadens my mind (1) and it has been one thing that has also been motivating me to continue with TOP (.)*

Another provider (extract 20) reported that they find the support buddy programme helpful because it allows them to access information that increases understanding in relation to the work challenges they face. Furthermore, continuing with the buddy programme also awards them the opportunity to access information that broadens their knowledge and motivates them to continue working as an abortion provider.

#### **4. Conclusion**

This chapter analyzed data from four different sources, namely, reports of prior counselling practices, and the reflective activity conducted in the first part of the course, case presentations in the second part of the course (after two weeks of fieldwork), and interviews conducted two months after the course. From their discussions around prior counselling practices, negotiating with third parties, poor gestational outcomes, and lack of managerial support were reported to be challenges affecting nurses' practice of quality abortion services. Recommending suitable referrals was mentioned as practice that enabled quality access to abortion services. During the reflection activity, confusion created by the institution, structural issues of space and time were reported as hindering quality practice. Ceasing asking for reasons for abortion and maintaining confidentiality were seen in this exercise as practices that informed quality practice within the abortion services. From the case presentations after two weeks of fieldwork, providers reported being non-judgemental, being observant during counselling sessions, the continuous practice of non-mandatory counselling, were practices that added quality to the services provided. Also, it improved the manner in which providers speak and conduct themselves during abortion counselling. The support buddy programme was also reported to be beneficial to the improvement of quality in the abortion services because of the debriefing space it offers providers whenever they face work challenges. However, continuous challenges of not receiving adequate managerial support still pose an impediment to the practice of quality abortion services.

## Chapter Six: Interpretation

### 1. Introduction

In this chapter, I summarize the analytical findings of the preceding chapter in a table format. In line with the grounded theory analysis, I highlight certain themes that cut through across different categories under two headings: represented realities and represented meanings of the course. I reflect on the findings from this research and discuss how the course confirmed or altered nurses' understandings and practices of abortion counselling. I situate my reflection by looking at the research question that steered this study, and the theoretical framework that underpinned the research and enabled the entire process.

Through this study, I sought to explore nurses' experiences of an abortion counselling training course using a symbolic interactionism framework that places experiences at the centre of thinking about abortion counselling. I formulated the following main research question: How does participation in a women-centred abortion counselling training course alter or confirm participants reported practices and understandings of abortion counselling? Sub-questions were: (1) What understandings and practices are reported at the beginning of the counselling course? And (2) How does these reported understandings or practices change (if at all) two months after completion?

### 2. Representations of practices that promote or hinder quality abortion counselling practices over the four data collection points.

In the previous chapter, I examined the participants' experiences of participating in the women-centred abortion counselling training course. I now present tables with the themes that emerged under each point of data collection. They are demarcated under two columns, the first containing factors that promote quality abortion services and the second containing those that hinder it. It should be noted that in a few cases, nothing appears under the headings. This is because the narratives did not reveal any data relevant to those headings.

#### 2.1. Represented realities prior to the course

The following table highlights themes that nurses shared from their prior counselling practices.

*Table 3: Reported counselling practices prior to course*

<b>Prior Counselling Practices</b>	
<b>Promotes quality abortion counselling practice</b>	<b>Hinders quality abortion counselling practice</b>

Referrals as supportive	Difficulties in negotiating with third Parties
	Lack of managerial support as Challenging
	Poor outcomes for gestational limits

Under prior counselling practices, “referrals as supportive” was the only practice represented as promoting quality abortion counselling. The providers made referrals due to lack of capacity to provide assistance to clients with particular needs. They referred the cases because they were aware that they would not be able to meet the clients’ needs. Successful referrals can promote quality access to abortion services when providers are aware of their incapacity to assist a client and are respectful of clients’ needs.

The practices that were represented as hindering quality abortion counselling were “difficulties in negotiating with third parties”, “lack of managerial support”, and “poor outcomes for gestational limits”. The involvement of third parties for clients seeking an abortion can hinder access to quality abortion services, particularly when they strip away the client’s right to fully exercise their reproductive rights and body autonomy. However, in all experiences reported the nurses were able to educate the third parties involved that abortion is every woman’s right and can be accessed at any given time provided it meets the legal criteria stipulated by the CTOP Act.

Providers reported that they are unable to efficiently provide quality abortion services due to a lack of support from their superiors. Some managers are not in support of abortion as a mandatory reproductive service, some restrict access to equipment or reduce days on which the service is offered.

Women presenting with late gestation is another factor that prevents providers from practicing and rendering quality abortion services. This is because the institutions at which the participants work only offer abortion services for clients presenting with pregnancies of 12 weeks and less; thus, providers can only refer clients coming with 12 weeks and above gestation. As a result, these clients mostly resort to back street abortion and present in casualty with incomplete abortion. Thus, the lack of second trimester clinics can be detrimental to the services being effectively accessed and rendered.

## 2.2. Reflective activity

Table 4 outlines the practices reported on in the reflective activity that took place.

*Table 4: Themes in reflective activity*

<b>Counselling practices reported on during reflective activity</b>
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<b>Promotes quality abortion counselling practice</b>	<b>Hinders quality abortion counselling practice</b>
Ceasing asking for abortion reasons in first trimester	Space and time limiting effective Counselling
Not practicing mandatory counselling	
Maintaining confidentiality	

Positive abortion counselling practices in this section of data consisted of “ceasing asking for abortion reasons” and “maintaining confidentiality”. Ceasing from asking reasons for requesting an abortion and refraining from practicing mandatory counselling were practices reported to promote quality abortion counselling. This was indicated by providers when they realized that using reasons for requesting an abortion as a gauge to qualify access to the service, disregarded women’s legal right to exercise autonomy. Also, providers realized that asking clients if they needed or required abortion counselling services was a better approach to adopt instead of conducting mandatory counselling.

The providers reported that they understood confidentiality to be of essence when providing abortion counselling. This is an aspect that all providers agreed to continue effecting in their practice. They indicated, however, that confidentiality was sometimes difficult owing to a lack of space, which hinders quality abortion counselling.

Other than the lack of space limiting confidentiality, providers referred to the confusion caused by the institution, and space and time constraints in general. All the providers in this study reported that they were required by the institution to inquire from the clients the reason for requesting an abortion. This requirement is detrimental to provision of client-centred abortion counselling because it can be used as a gauge to measure who “most requires” abortion. Furthermore, it forces clients to justify why they deserve to exercise a reproductive right that is legal and free. In line with the sentiment of the CTOP Act (that abortions can be requested in the first trimester of pregnancy), providers decided to stop requesting the reason for abortion from their clients.

Three out of nine providers reported that the lack of space and time prevents them from rendering quality abortion counselling. The lack of sufficient space in the providers’ facilities makes it difficult for them to maintain privacy during counselling sessions because there is not enough room for individual counselling sessions. Furthermore, this lack of adequate space causes some providers to resort to group counselling, and group counselling was reported to not give clients the freedom to openly express themselves or ask further questions regarding the abortion procedures or related concerns. Time was another factor reported to hinder effective abortion counselling because the

providers felt there was not enough time for abortion counselling; hence, clients returned for repeat abortions. The providers reported that having sufficient space and adequate time for conducting abortion counselling can promote effective abortion counselling and increase the quality of the service.

### 2.3. Case presentations

In Table 5, the themes emerging from the case presentations after two weeks of fieldwork are presented.

*Table 5: Counselling practices after practical period*

Case Presentations	
Promotes quality abortion counselling practice	Hinders quality abortion counselling practice
Being non-judgemental	Handling third parties
Observant	
Referral	
Providing beneficial information	
Listening	
Ensuring counselling is not Mandatory	

Under the non-judgemental theme, the providers reported being able to practice controlling their emotions even when they were not in agreement with the client’s decision. They recognized that they should render abortion counselling in a non-judgemental manner, and with the understanding that the client has a right to exercise autonomy over their bodies. Being non-judgemental towards clients during counselling is characteristic of a women- centred approach that enables clients to feel comfortable and be open during counselling sessions. This can enable the provider to tailor sessions that meet the client’s needs and provide a satisfactory service.

Providers indicated that they had learned to pay attention to verbal and non-verbal cues during counselling session as part of the training course. Paying attention to these cues helped them to be observant of their clients’ mannerisms and to gauge comfortability during certain facets discussed in counselling sessions, so that they could assess which aspects to focus on and which ones were less of a priority. Also, successfully referring clients to relevant parties for further assistance indicated the promoting of abortion quality practice. Participants spoke about referrals in their presentations.

Providers reported encountering clients who had inaccurate information regarding pregnancy. They thus indicated a willingness to educate their clients and provide information so that clients are able to make informed decisions regarding their bodies.

The providers reported that in their two weeks field work they affected listening skills in their practice and were able to notice how this improved the quality of services they were providing. Through the practice of listening, the providers reported that clients have become more open during counselling sessions and talk about reasons they resort to having an abortion without the provider requesting to know. In other words, when clients felt like the space created was a safe and trusting one, they volunteered certain information without being coerced into divulging intimate details.

The providers previously offered mandatory abortion counselling to clients without finding out whether clients were in need or/ want of the service. In the two weeks of fieldwork, the providers were able to put into practice the habit of asking their abortion seeking clients whether or not they wanted counselling during consultation. In putting this practice to effect, the providers found some clients are sure of their decision to have an abortion upon arrival at the designated facilities, and are aware of the abortion procedures being offered. Therefore, they do not prefer to be counselled. This allows providers to treat clients as knowing individuals who are capable of making informed decisions regarding their bodies, and as a result promotes quality access and rendering of abortion services.

#### 2.4. Individual interviews

In Table 6, themes emerging in the interviews two months after the course are outlined.

*Table 6: Changes, learnings and challenges in the practice*

<b>Changes, learnings and challenges in the practice</b>	
<b>Promotes quality abortion counselling practice</b>	<b>Hinders quality abortion counselling practice</b>
<b>Changes and learnings</b>	<b>Challenges</b>
Boosted morale	Continuous lack of managerial support
Improved language and conduct	Lack of equipment
Being empathetic and providing choices	Lack of adequate staffing
Support buddy program	Abortion stigma
	Ambivalence regarding rights in relation to repeat abortion & contraceptives

The nurses reported that the way they conduct counselling for abortion seeking clients had changed. Participating in the abortion counselling training course uplifted and boosted their confidence because they were able to render counselling that enabled them to successfully meet their clients' needs. Providers were able to observe the changes in their practice by how clients now felt more comfortable during sessions to talk and ask questions freely regarding their reproductive health. This indicates that

when providers feel confident in doing their job, they perform their best which increases the quality of service provided.

Another reported change effected from participating in the abortion counselling training course was language and conduct. The providers reported that there have been changes in the language use when offering counselling and when explaining abortion procedures to clients. Instead of using explicit images and risk-related language to explain abortion processes, providers reported that using neutral language during counselling sessions makes it easier for clients to open up and ask questions freely, which indicates that quality abortion services were being rendered. Therefore, being mindful of language use and their own conduct during counselling sessions can promote quality abortion practice and services.

Providers also reported that being empathetic and providing choices for clients during abortion counselling promoted the practice of quality abortion counselling. Empathy is another characteristic that forms part of the client-centred approach to counselling and helps the provider to better understand where a client is coming from when seeking the abortion service. Tailoring an abortion counselling session in an empathetic manner, allows clients to feel welcomed and to express themselves freely during sessions. This encourages clients to participate in pre-and-post abortion counselling options without the providers' coercion, and providers are able to respect the clients' decision which allows for quality abortion service to be rendered.

In their learnings, providers reported that participating in the abortion training course had taught them to view abortion as a woman's reproductive right, which can be accessed as many times as a client requires it. Moreover, they have learnt that being judgemental towards repeat abortion clients is discriminatory and hinders quality abortion services. Another thing the providers reported learning from the training course was prioritizing the client's needs by being supportive during counselling sessions towards their decisions on whether to continue with an abortion or use contraceptives. This promoted access to quality abortion services because clients were open to asking more information due to the provider's display of support.

All providers reported that being part of the support buddy whatsapp group had helped educate and increase their knowledge on cases and issues that they respectively encounter in their practice. They also indicated that this group alleviates some of the challenges they come across through recommended referrals that other providers suggest for them, and this has been helpful. Lastly, they reported that they continue to be part of this group because it is relieving to have a space to debrief and talk to people who understand what they might be going through because they do the same job.

Thus, this indicates that when nurses have a space to debrief and feel supported in their work, they are encouraged to continue working effectively. This feature can help ensure that improved quality in abortion services is maintained.

Within the continued lack of management support, other challenges such as lack of equipment and adequate working staff affect the quality of abortion services in the participants' practice. The lack of equipment in the abortion facilities has been reported to hinder quality services because it prohibits the providers from working efficiently when the need arises. For instance, one provider reported that they were unable to work because the scanner broke. If such hurdles are not addressed hastily, the service is prevented from being rendered and accessed, and the nurses' practice is negatively impacted because the standard of quality also decreases.

Furthermore, the lack of sufficiently trained abortion providers limits quality access to abortion services because trained providers experience fatigue and burnout due to being overworked and under-staffed. During the individual interviews, two providers reported that working alone is strenuous and affects services; when they have taken an abuse of leave, the services comes to a halt because there is no one to take over from them. This lack of trained providers hinders quality practice and access of abortion service; thus, it is important for training to be scheduled for other willing providers in order to alleviate the existing working burden.

### 2.5. Themes across categories

This section consists of two tables that illuminate practices that promote or hinder quality abortion counselling across the four data sources.

*Table 7: Practices that promote quality abortion counselling across the four data collection points*

<b>Prior counselling</b>	<b>Role plays</b>	<b>Case presentations</b>	<b>Interviews</b>
Referrals as supportive	Ceasing asking for abortion reasons	Being non-judgemental	Boosted morale
	Maintaining confidentiality	Observant	Improved language and conduct
	Not offering mandatory counselling	Referrals	Support buddy program
		Providing beneficial information	

		Listening	
		Ensuring counselling is not mandatory	

The providers in this study described encountering cases that allowed referrals to be suggested where necessary, thereby creating a theme of openness. This is an aspect of counselling that was found to be practiced prior to the counselling training. Being open to making referrals is enabled through the providers' ability to gather enough information during counselling sessions and to make referrals when they feel incapacitated to further assist their clients. The ability to know when to refer a client can promote the practice of quality abortion practice, because the provider is able to recognize when they are not equipped to assist with a case. Therefore, it can be concluded that recommending supportive referrals during abortion counselling sessions can be beneficial to both provider and client because it enables tailoring the course of treatment to the client's needs.

The practice of listening during counselling sessions enables the promoting of quality abortion practice; it improves the provider's understanding of each abortion case, helps build rapport and allows trust to be established between provider and client. In addition, not demanding reasons for the abortion helps promote the quality of abortion counselling practice, as women are more likely to be open and honest with providers during sessions.

Participating in the abortion counselling training course helped alter provider's practice and understanding that an abortion counselling session should not be mandatory, but should follow the client's lead. This allowed client-participation during session and acknowledged client's autonomy over their bodies. In addition, to demonstrate that providers put clients' needs first during counselling sessions, they maintained confidentiality. Maintaining confidentiality promotes quality of abortion counselling practice because clients are assured that their privacy will not be infringed upon nor be invaded. Therefore, this practice increases the quality of abortion counselling practice.

Partaking in the abortion counselling training course helped providers to be aware of their behaviour during counselling sessions when clients chose to make certain decisions regarding their bodies. This enabled providers to support clients, put aside their feelings of judgement and disapproval and practice quality abortion counselling that met clients' needs. Data collected showed that when providers pay attention to clients' body language and mannerisms during counselling sessions, providers are able to tailor a session that best suits the client because they are able to recognize and gauge which areas during the counselling sessions the client is comfortable to discuss. Therefore, this

increases the quality of abortion counselling practice because the sessions are tailored to ensure that all the client’s needs are met. Another factor that promotes quality abortion counselling practice is the provision of beneficial information to clients who come in seeking abortion services with inaccurate information regarding procedures and processes that takes place during an abortion. When clients have myths regarding pregnancy, this is an opportunity for providers to administer reproductive information to clients to promote informed decision-making. This practice increases the quality of abortion counselling.

During the interviews, the providers reported that participating in the abortion counselling training course helped them gain confidence in administering counselling services because they are now more equipped, and know what they are doing. Being trained has improved their counselling skills and increased their confidence.

Providers learned to refrain from using non-neutral language when conducting abortion counselling and to be mindful of their body language during counselling sessions. This practice of mindfulness increases the quality of abortion counselling because clients feel more comfortable to open up during sessions, and feel less judged for their decision to terminate their pregnancies.

Participating in the abortion training course helped providers to adopt a different understanding of practice, which includes accepting women’s decision to not discuss contraceptives if necessary. This level of recognition for women to have control over their bodies and choices increases the quality of abortion services.

When providers feel supported and acknowledged for the work they provide, their work performance increases and the motivation to continue working as abortion providers is encouraged. The support buddy program was reported as a space that enables providers to debrief, and acquire knowledge on how to handle some of the challenging cases they encounter in their work. Therefore, a support group for providers that allows for an outlet of challenges faced in their work promotes quality practice of abortion counselling.

*Table 8: Practices that hinder quality abortion counselling across the four data collection points*

<b>Prior Counselling</b>	<b>Role plays</b>	<b>Case presentations</b>	<b>Interviews</b>
Difficulties negotiating with third Parties	Space and time limitations	Handling third parties	Continuous lack of managerial support

Lack of managerial Support			Lack of equipment
Poor outcomes for gestational limits			Lack of adequate Staffing
			Abortion stigma
			Ambivalence regarding rights in relation to repeat abortion and contraceptives

Although the providers reported having learned to provide better counselling since participating in the training course, it not without challenges. The involvement of obstructive third parties during abortion services consultations tends to prevent quality abortion counselling. This is because third parties could be parents, guardians, and partners etc. who have different perspectives and beliefs from clients and try to influence clients' decision regarding their pregnancy. Such positioning can prevent the client from making an informed decision being imposed upon, which therefore hinders the provider from effectively putting the client's needs first. In some cases, providers were able to advocate on behalf of their clients by educating the third parties involved of the abortion legal procedures and processes. However, in some cases they were not successful; thus, clients' needs were not met and qualities of abortion counselling practice were hindered.

Providers find it challenging when clients present with late gestational pregnancies. Due to several facilities offering first trimester abortions only, providers are unable to render abortion services to clients above this gestational age. Thus, they must refer them, often to distant facilities for second trimester procedures. As a result, clients may resort to illegal abortion routes and the quality of abortion practice is hindered.

The providers are unable to practice quality abortion counselling because they have to constantly defend abortion as a significant reproductive health service to their facility managers. This was spoken about repeatedly in the data. This lack of support hinders quality abortion practice and overwhelms providers from effectively doing their job.

Participating in the abortion counselling training course improved the providers' counselling skills and enhanced their confidence of offering the services. However, systematic issues such as the imposed institutional rule of requesting reasons for abortion from clients presenting in their first trimester of pregnancy hinder quality of service. Asking clients to justify their reason for seeking an abortion contradicts abortion on request being a legal right. It also appears as a scale to gauge the suitability of who should access abortion. Thus, this practice can hinder quality abortion counselling practice.

Also, since providers are now equipped in their counselling skills, they are able to practice counselling that meets clients' needs. However, the lack of space to allow privacy and time to provide counselling care, providers are unable to offer satisfactory services to their clients. Therefore, the abortion services remain hindered due to these kinds of facility systematic challenges.

The reported continued lack of managerial support poses a threat to the quality practice of abortion counselling. This deficiency also allows for the continuance of other deficiencies such as lack of equipment, adequate staffing and abortion stigma, because providers do not receive any support from their superiors. Working under management that fails to recognize abortion as a reproductive legal right can hinder providers from efficiently providing quality abortion services, and make it challenging for women seeking abortion to access these services. Therefore, it is essential for these facility managers to recognize abortion as an important aspect of reproductive services so that women seeking an abortion can freely exercise this right without discrimination. Lastly, insufficient trained abortion providers, limits quality access to abortion services because trained providers experience fatigue and burnout due to being overworked and under-staffed. Thus, the shortage of trained abortion providers has been reported to be a challenge that prevents quality abortion counselling practice.

### **3. Conclusion**

In this section of the analysis, the data were interpreted in an attempt to answer the research questions. Several themes that cut across categories were highlighted to represent nurses' experiences of participating in the training course to confirm whether or not participating in the course altered their understanding or practice of abortion counselling. In an attempt to explain how nurses experience rendering abortion services, the data revealed that nurses became aware that being non-judgemental, observant, non-directive, listening and maintaining confidentiality during abortion counselling session promoted access to quality abortion services. They became aware that coercing clients into using contraceptives, asking for reasons for abortion, mandatory counselling, being judgemental towards clients seeking repeat abortions, and imposing their beliefs on abortion seeking clients hinders the

provision of quality abortion services. Despite their altered understanding and practice of abortion services, data revealed that lack of managerial support, shortage of trained abortion providers, insufficient working equipment and second-trimester abortion facilities prohibit nurses from efficiently rendering quality abortion services due to these institutional challenges. However, participating in the abortion counselling training proved to be essential to the understanding of what quality abortion services (at least in terms of abortion counselling) are, and therefore positively showed how effective it is in the nursing practice.

## **Chapter Seven: Conclusion**

### **1. Introduction**

Prior research studies have shown that sexual reproductive services, including safe abortion services, require a trained, empathetic and enthused health workforce that is sensitive to women's needs in order to render satisfactory services (Teffo, Levin & Rispel, 2008). Indeed, the availability of trained and willing abortion providers remains the most valuable determinant of safe abortion at designated facilities, especially in rural areas (Harries, Gerdt, Momberg & Green Foster, 2007). The lack of trained and willing providers poses as a barrier and challenge to quality services and trained providers (Kumar et al., 2009).

The CTOP Act specifies that providers should refrain from practicing mandatory counselling when conducting abortion counselling. However, there has been little research done on abortion counselling in South Africa. In addition, training that focuses on abortion counselling specifically is limited if not non-existent. As such, this study sought to explore the ways in which nurses' understandings and practices of quality abortion counselling services changed after participating in a client-centred abortion counselling training course. Before addressing the findings of the present study, I briefly outline the research process of this study.

### **2. Overview of the research process**

Recognizing that abortion is a time restricted reproductive service, in the introductory chapter I discussed past and present abortion legislation in South Africa, outlining the circumstances under which abortion could be legally accessed and the process required in procuring the service in each case. Under the Abortion and Sterilization Act of 1975, unsafe abortion practices still remained high since women, especially black women from rural areas, were unable to fully access quality abortion services due to restrictions places on access. The CTOP Act replaced the previously restrictive Act with the aim to promote quality access to abortion services and for women to have early, safe and legal abortions. Despite this, several barriers to accessing (legal) abortion services continue to perpetuate unsafe abortion practices. These barriers, which include lack of trained and willing providers, lack of abortion counselling, nurses' negative attitudes to repeat abortion seeking clients and limited managerial support, form part of the context in which quality abortion services is hindered.

In the following chapter I reviewed relevant literature on abortion counselling. I began discussing the various aspects that form the context which shapes nurses' abortion counselling practices and

understandings. To conclude the discussion, I engaged with research that has been conducted in abortion counselling with regard to abortion and suggested that my research filled a gap in the research conducted in this area. My research is part of a broader project. This project started with research on actual, abortion counselling sessions, which were recorded; service providers and service users were also interviewed about their abortion counselling experiences. These findings were used to formulate a policy brief, a step-by-step guide to abortion counselling, and an in-service abortion counselling training programme using a women-centred approach. The aim of the course is to equip abortion providers with non-directive counselling skills. Thus, this research identifies the gap in abortion counselling training, and explores how participating in abortion counselling training alters or confirms nurses' understandings/practices of quality abortion services.

Through purposive sampling I managed to recruit 9 abortion providers to participate in the study. As the co-researcher of the abortion counselling training course, I collected data from four data recorded sources. The first recording was on the discussion around current counselling sessions, the second was from the nurses' reflective activity on what they would start, stop or continue doing in their practice, thirdly, data were collected through case presentations and lastly, I conducted (in English) individual interviews with only 5 research participants. These interviews were translated (where needed) and transcribed by me using Ian Parker's transcription conventions. Thereafter, I followed grounded theory informed analysis to analyze my data, whilst drawing on symbolic interactionism to illuminate the nurses' experiences of rendering abortion services.

Lastly, I presented a discussion of my analysis and interpretation in the two previous chapters. In the remainder of this chapter, I pull the two analytic chapters together and discuss the implications of my findings.

### **3. Grounded theory: How it informed my study**

Grounded theory informed this study because it is a theory that aims at capturing the worlds of individuals by describing their situations, thoughts, feelings, actions and by portraying the research participants' lives and voices (Charmaz, 1996). It was useful for this research because there is limited research done on abortion counselling training. Grounded theory is specifically useful in areas where there is little to no knowledge about a phenomenon or limited theories to explain an individual's or group's behaviour, in this case experiences of providing abortion counselling and of woman-centred abortion counselling training programme.

Through grounded theory and using symbolic interactionism lens, two over-arching themes emerged – interactions between clients and service providers; and interactions between service providers and health systems. The latter tends to undermine the former.

### **3.1. Interactive spaces between providers and clients**

Providers reported that before participating in the abortion counselling training course, they had no experience of what and how abortion counselling should be rendered. They had no confidence in their work due to limited counselling skills; however, participating in the training course helped boost their morale. It increased their confidence in the service they provided because they were knowledgeable in what they were doing. Firstly, through this approach (women-centred) providers were able to learn how to begin and end an abortion counselling session with confidence that the clients' needs were prioritized and met. Secondly, the women-centred approach taught the providers to refrain from coercing the clients into making decisions driven by their beliefs, but rather to ask open-ended questions that allowed the client to lead the direction of the counselling. Participants reported that adopting this aspect into their practice allowed clients to freely open up during abortion counselling sessions; this became evident when some clients admitted to engaging in risky sexual behaviour without being asked reasons for requesting an abortion. This is in sync with what Moore et al. (2011) found, that abortion providers should be knowledgeable about the abortion procedures, ask open-ended questions and to treat each case differently because each client is unique. Therefore, the women-centred approach helped the providers to identify what their role is and what it entails. It helped them to realize their position during abortion counselling is more of a facilitator than of dictatorship (Tabbutt-Henry & Graff, 2019).

Learning how to pay attention to non-verbal cues is another aspect of women-centered approach that helps providers to understand how to approach each case encountered and to know that each client is different, and therefore counselling needs to be tailored in a manner that best meets the client's needs. Providers reported that paying attention to body language during abortion counselling sessions helped them to identify which areas clients are most comfortable in discussing and allows client to openly express themselves. Furthermore, they have recognized that some clients do not require counselling because they are well-informed about what the abortion procedure entails. Providers were thus able to treat clients as knowledgeable and not naïve. Surman and Surman (2001) indicates that women seeking counselling, and that counselling ought to be centred on the client's needs and be focused on whatever the clients desires to discuss regarding their pregnancy. Thus, it can be concluded that participating in the women-centred abortion counselling training course illuminated the patterns of behaviours that are grounded in the realities of day-to-day practice of abortion providers, and that

adopting this approach in their practice can improve the quality and understanding of abortion counselling. Literature has shown that a trained abortion provider is able to display compassion, knowledgeable information and empathy towards clients seeking an abortion. Thus, undergoing abortion counselling training has had a significant impact in abortion providers' practice, the women-centred counselling approach was found to be beneficial in improving the reported quality of abortion counselling and access to abortion services. However, it was limited in terms of structural and systematic issues, continuous lack of managerial support and dealing with the involvement of third parties.

### **3.2. Structural and systematic issues hindering quality abortion counselling**

While abortion may be legal, South African providers report feeling stigmatized and isolated in their work (Harries et al., 2012). This is because abortion has been found to be a highly stigmatized reproductive service and nurses who provide this service have been subjected to name calling and mockery (Gallagher et al., 2010). In the data, providers reported that being overlooked for the services they provide prevents them from rendering quality services. Moreover, previous research conducted in South Africa has also shown that stigma continues to be a barrier in accessing safe abortion services in designated facilities.

Despite the changes that occurred through participating in the abortion counselling training course, structural limitations such as lack of space and time still pose a threat to quality access to abortion counselling and services. The data collected showed some facilities have limited space to conduct individual counselling sessions, and therefore providers resort to group counselling. This limitation poses a significant hindrance for abortion seeking clients to have quality abortion experience. This is because lack of counselling space can and does impose on clients' privacy and access to quality individual time with the provider, to ask or acquire information in case a client appears to be unsure or confused regarding their request to have an abortion. Thus, lack of or limited amount of individual time spent with clients is inadequate because there is not enough space for private one-on-one sessions. Hence, data collected showed that without addressing such structural issues of space and time, quality abortion counselling and services remain hindered.

Additionally, the reported consistent lack of managerial support in some instances creates a series of systemic issues that prevents access to quality abortion services. Issues such as lack of equipment, inadequate staffing and resources are left unaddressed when facilities' managers are not in support of abortion as a legal reproductive service. This is because providers are unable to report arising challenges affecting quality of service and, therefore, access and delivery of quality abortion services

continue to be mired. Not having support from superiors has proven to be a barrier to quality patient care. The data showed that when hospital managers are not supportive towards the willing and trained abortion providers, it is challenging for providers to efficiently offer abortion services without the backing up from their superiors. Sibuyi (2004) has also highlighted that lack of managerial support and supervision deters the legalization and provision of abortion services. This finding is consistent in the data and therefore it can be concluded that when providers are not supported in their workplace, their practice of quality client care deteriorates.

The lack of recognition that abortion is a legal reproductive right not only affects women seeking to use the service, but also the way in which providers render the service. The providers seemed to be affected when other colleagues viewed their work as unimportant and characterized the service as “murderous work”. However, providers reported that since participating in the training course they have been getting positive feedback from clients appreciating the manner in which they render their services, and this has motivated them to continue working as abortion providers. This suggests that the training course has helped the providers to feel recognized rather than being invisible for the services they render as abortion providers, and feeling seen and appreciated increases the quality of client care and provision of abortion services. Although participating in the abortion counselling training course helps providers feel recognized and improves quality of care, it remains ineffective if their managers remain unsupportive.

Despite abortion being a legalized reproductive service in South Africa, some women still find it challenging to safely access it when needed. This study was conducted to find out whether participating in the women-centred altered the nurses’ understanding and practice of quality abortion services. As discussed in the analysis chapters, the data show that participating in the women-centred abortion counselling training did alter the nurses’ understanding of what quality abortion counselling services are and, thus, also positively informed their practice. It can be concluded that abortion counselling training is essential to the quality of abortion practice, increases quality client care and the provision of abortion services.

#### **4. Limitations and strength of the research**

I identify the attrition of participants in the interview segment of data collection as a limitation in this study. In the methodology chapter, the possible reasons for attrition in the research sample were discussed. The experiences of nurses who initially showed interest but did not participate in the interview segment of data collection remain unknown, as well as their reasons to honour the initial

agreement for participating. It is possible that the participation of these providers in the interview segment may have led to different findings.

Using the Zoom application as point of contact to collect data for this study required an extensive amount of data bundles and unforeseen technical glitches (such as load shedding) that had the potential of dampening the quality of audio recording. These requirements could, in some way, have impeded on the interest to participate in the research study, as navigating through the different Zoom features appeared to be challenging for some participants, and therefore had the potential of limiting access to collect data from the providers.

I identify the symbolic interactionism theoretical lens and grounded theory as strengths in my study. Using symbolic interactionism and grounded theory provides a complex, nuanced and comprehensive account of nurses' experiences of participating in the abortion counselling training course. While it is important to acknowledge that several authors in the past have studied abortion and nurses' attitudes towards women seeking abortion services, these studies have typically focused on selective variables to the exclusion of others such as abortion counselling training. The symbolic interactionism lens, facilitated by grounded theory, has enabled a rich, vivid examination of the many ways in which women-centred counselling approach to abortion influence the delivery and access to quality abortion services. For example, applying women-centred counselling techniques in their practice after training, the providers received several appreciation and positive responses from clients for their outstanding services.

## **5. Recommendations**

The findings from this study reveal the importance of providers being trained to offer abortion counselling to women seeking abortion services using the women-centred counselling approach. Therefore, it could prove beneficial to normalize scheduling of abortion counselling training for willing abortion providers. It would be comforting for nurses to receive training about the range of counselling techniques that the women-centred counselling approach can offer. The current abortion counselling training for abortion providers seem to be insufficient, leading to directive and coercive counselling practices. As an example, abortion counselling training courses as the one offered by Rhodes University should be made available to more provinces and be adopted by the Department of Health as a course for designed facilities in all provinces.

Apart from offering abortion counselling training course, support from superiors such as facility managers is a strong component that promotes quality abortion services. The importance of the role of managerial support is reiterated in my research findings. Firstly, managerial support ensures that

providers have enough medical equipment, counselling space and co-workers' support which has the potential of promoting the delivery and access to quality abortion services. Secondly, the inclusion of managers in the abortion counselling courses needs to be part of the abortion counselling training. This would impact the quality of service for women seeking abortion services and give providers the confidence to continue providing abortion services.

Literature has shown that abortion training does not focus sufficiently on aspects of services such as counselling. The CTOP Act does not specify any details regarding abortion counselling training and, according to the participants in this study, during their abortion training, they did not receive any abortion counselling training. Thus, they reported not being sure of what they were doing during counselling sessions. Based on the findings from this research study, I would recommend the course be moved to face to face contact provided all COVID-19 restrictions are adhered to, to minimize the attrition created by the course being on Zoom application. This might increase the number of interested providers to participate in the training course. Also, the number of providers allowed to take part in the abortion counselling course could be increased to allow a high number of trained abortion providers, for quality abortion care. The women-centred approach in training abortion providers has shown to have a significant impact on the nurses' reported practice and understanding of quality abortion counselling.

Since this research study illuminated some of the experiences that promote or hinder quality access to abortion counselling and services, it could be used by the abortion counselling researcher as a guide to improve aspects of the course. My recommendation would be for the training course to include a segment on the ways providers can advocate with facility managers for support abortion providers, using their legal roles in providing non-discriminatory services in line with the law (in this case the CTOP Act) as leverage. This will help managers to understand and perceive abortion services as a part of reproductive health services to be offered. Training should also be extended to facility managers. Since there is a shortage of willing trained providers, the displayed support of competent facility managers has the potential to motivate and encourage other providers to be willing to train and provide abortion services, thus, enabling quality abortion services.

The Department of Health should make coalitions with research institutions that focus on improving the access of reproductive services and aim at educating women of the legal reproductive services offered at public health facilities. Rhodes University and the CSSR research unit were able to establish a women-centred abortion counselling training course that aimed at offering abortion counselling training to abortion providers around the Eastern Cape Province. My recommendation is

that the Department of Health should adopt/associate with such initiatives in their abortion training programmes, and make it accessible to all provinces. If more providers are exposed to a course like this, the better the quality of counselling will be and the more supported and enthusiastic the providers will feel. This could have the knock-on effect of making more providers willing to volunteer for the service, seeing those who provide finding it fulfilling. It will increase human resources, and relieve qualified abortion providers from high workload levels. As highlighted in my findings, recruiting willing abortion providers enables designated facilities to offer quality abortion services to women seeking abortion.

Not being remunerated and certified for providing abortion services was a reported concern for nurses providing abortion. All participants reported that after being trained as abortion providers, they were promised to receive certificates indicating that they are qualified abortion providers; however, none of them received any certificates to the date of conducting this research. After participating in the women-centred counselling abortion training course, the providers received a Rhodes University accredited certificate, and they expressed being recognized for the first time for the services they provide. Being acknowledged for the services nurses provide was highlighted as enabling quality services and leading to providers feeling confident in rendering abortion counselling. Furthermore, the participants reported that being a qualified trained abortion provider adds to the qualification they already uphold as qualified nurses thus, it would be befitting to be remunerated for the services they render. Therefore, for the reasons mentioned above, my recommendation would be for the Department of Health to issue certificates to trained abortion providers and consider remunerating them fairly for the services they provide as this promotes the access to quality abortion services. It might be useful for facilities to schedule workshops that allow providers to raise queries or suggestions that could improve future quality access to abortion services because they are at an advantage of interacting with women seeking these services, and therefore can recognize the gaps that need improvement or termination in terms of service provision.

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## Appendices

## Appendix A: Consent form



### CRITICAL STUDIES IN SEXUALITIES AND REPRODUCTION

Tel: (046) 603 7329 - Email: [cssradmin@ru.ac.za](mailto:cssradmin@ru.ac.za)

#### DEPARTMENT OF PSYCHOLOGY

#### AGREEMENT BETWEEN RESEARCHERS AND RESEARCH PARTICIPANT

I \_\_\_\_\_ (participant's name) agree to participate in the action research project of Yamini Kalyanaraman, Laura Magonong and Catriona Macleod. The aim of this project is to develop, conduct, document and improve an online abortion counselling training course for nurses. The course aims to support nurses in developing skills in the area of face-to-face and telephonic abortion counselling.

#### I understand that:

1. This research is under the supervision of Distinguished Prof. Catriona Macleod in the Psychology Department at Rhodes University, who may be contacted on +27(0)466037329 or [c.macleod@ru.ac.za](mailto:c.macleod@ru.ac.za).
2. The researchers are students conducting the research as part of the requirements for a Doctoral/Master's degree at Rhodes University. The researchers may be contacted on
  - Yamini: 079 706 3020 or [yamini.arts@gmail.com](mailto:yamini.arts@gmail.com)
  - Laura: 079 161 8195 or [laurahmagonong@gmail.com](mailto:laurahmagonong@gmail.com)
3. The research project has been approved by the Rhodes University Ethical Standards Committee (RUESC) [Review Reference: 2020-1337-3489]. For any queries regarding ethical clearance please contact the RUESC Manager, Siyanda Manqele at [s.mangele@ru.ac.za](mailto:s.mangele@ru.ac.za).
4. The Abortion Counselling Certificate Course has been approved by the Department of Health, Eastern Cape (EC\_202008\_008) and the Rhodes University Short Application Course Division (SCA 5520).
5. My participation in the research will enable the development of an online abortion counselling course that will contribute to nurses' professional development; and lead to the development of training manuals for which my expertise input is highly valued.
6. I am participating in a 5-week online course which, if I meet the criteria, will result in my being issued with a *Certificate of Competence in Abortion Counselling* and a *Letter of*

*Attendance.* I am free to participate in the research component or not, without my decision affecting my participation in the course.

7. I agree to a contract of confidentiality amongst the participants, facilitators and researchers in this training course. As a group member, I acknowledge that any information shared about oneself, cases or field-work experience should be considered personal and private information. Information gathered about other participants in this training course cannot be shared, without prior consent, outside of this space.

8. As part of the research, I agree to:

	YES	NO
Allow some sessions of the training course to be recorded. The facilitator will alert me to these sessions.		
Allow my inputs during recorded sessions to be used as data.		
Allow the reflective journal that I submit as part of the course assessment to be used as data.		
Allow my case presentation to be used as data.		
Provide feedback on the course through completing feedback forms.		
Participate in an interview lasting 45 minutes – 1 hour, two months after the completion of the course; and to allow the interview to be recorded.		
The tape recordings may be transcribed by one or more nominated third parties		
The data may be retained after the study for the sole purpose of research and information will remain anonymous.		

9. If at any point I am asked to answer questions of a personal nature for the research study, I can choose not to answer any questions about aspects of my life, which I am not willing to disclose.

10. I am invited to voice to the researcher any concerns I have about my participation in the study, or consequences I may experience as a result of my participation, and to have these addressed to my satisfaction. *Should I feel uncomfortable or at risk at any point, details of an appropriate counselling service (telephonic or face-to-face) will be provided to me.*

11. The report on the project may contain information about my personal experiences, attitudes and behaviours, but the report will be designed in such a way that it will *not* be possible to be identified by the general reader. My name will not appear in any research reports or presentations, and all effort will be made to disguise my inputs.

12. I am free to withdraw from participating in the research component (this will *not* affect my participation in the course or issuing of the Certificate and Letter) at any time during data collection. However, I commit myself to full participation unless some unusual circumstances occur, or I have concerns about my participation, which I did not originally anticipate.

13. The nature of the research and the nature of my participation have been explained to me verbally and in writing.


**I agree to participate in all or parts of the research component (as specified above) of the training course that I am attending:**

**Signed on (Date):** \_\_\_\_\_

**Participant:** \_\_\_\_\_

**Researcher:**

\_\_\_\_\_

 *If you have not agreed to be part of the research component, your voice will be deleted from the recordings taken during the course. Your reflection journal will be used for the assessment of your competence only and not for the research*

## Appendix B: Transcription form



**RHODES UNIVERSITY**  
*Where leaders learn*

### **CONFIDENTIALITY AGREEMENT:**

#### **Transcription Services**

I, Laura Mogonong agree to maintain full confidentiality in regards to any and all audio recordings and documentation received from the research study on exploring emerging themes from nurses' experiences in abortion counselling that promotes or hinder quality abortion services.

Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;
2. To not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by my supervisor and co-supervisor Professor Macleod and Ms Yamini Kalyanaraman.
3. To store all study-related audio recordings and materials in a safe, secure location as long as they are in my possession;
4. To store all audio recordings and study-related documents in password protected files.
5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality

agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audio recordings and/or files to which I will have access.

Transcriber's name (printed) \_\_\_\_\_

Transcriber's signature \_\_\_\_\_

Date \_\_\_\_\_

## Appendix C: Ethics clearance



Human Ethics subcommittee  
Rhodes University Ethical Standards Committee  
PO Box 94, Grahamstown, 6140, South Africa  
t: +27 (0) 46 603 8055  
f: +27 (0) 46 603 8822  
e: ethics-committee@ru.ac.za  
[www.ru.ac.za/research/research/ethics](http://www.ru.ac.za/research/research/ethics)  
NHREC Registration no. REC-241114-045

1 June 2020

Ms Yamini Kalyanaraman

Email: [g14K2501@campus.ru.ac.za](mailto:g14K2501@campus.ru.ac.za)

Review Reference: 2020-1337-3489

Dear Ms. Kalyanaraman

**Title:** Developing a women-centred abortion counselling training course

for healthcare providers: an action research project. Principal Investigator:

Distinguished Professor Catriona Macleod

This letter confirms that the above research proposal has been reviewed and **APPROVED** by the Rhodes University Ethical Standards Committee (RUESC) – Human Ethics (HE) subcommittee.

Approval has been granted for 1 year. An annual progress report will be required in order to renew approval for an additional period. You will receive an email notifying when the annual report is due.

Please ensure that the ethical standards committee is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators. Please also ensure that a brief report is submitted to the ethics committee on the completion of the research. The purpose of this report is to indicate whether the research was conducted successfully, if any aspects could not be completed, or if any problems arose that the ethical standards committee should be aware of. If a thesis or dissertation arising from this research is submitted to the library's electronic theses and dissertations (ETD) repository, please notify the committee of the date of submission and/or any reference or cataloging number allocated.

Sincerely,

A handwritten signature in black ink, reading "Arthur Webb". The signature is written in a cursive style with a long, sweeping underline for the first name.

**Prof Arthur Webb**

**Chair: Human Ethics Sub-Committee, RUESC- HE**

**Appendix D – IAN PARKER’S (1992).TRANSCRIPTION CONCENTIONS (ADAPTED)**

<b>SYMBOL</b>	<b>MEANING</b>
( )	Round brackets are an indication of uncertainty that emerges regarding the accuracy of material.
...	Ellipses are an indication of material that has been excluded from the transcript.
[ ]	Square brackets are used to explain something to the reader.
//	Forward slashes are an indication of any noises, words of assents and others.
=	Equal signs are used to indicate the absence of a gap between one speaker and another at the end of one statement and the beginning of the next statement.
e.g. (2)	Round brackets with a number inserted are an indication of any pauses in speech. The number in the brackets indicates the duration of the pause in seconds.
(.)	Round brackets with a full stop are used to show any pauses in speech for the duration of less than one second.
::	Colons are used as an indication of an extended sound in the speech.
_____	The underlying of words is an indication of anything that has been emphasized in the speech.
‘ ’	Single inverted commas are used to show words or phrases that have been quoted (research participants may either quote

	themselves or others).
--	------------------------

## Appendix E: Interview schedule

### Interview Schedule

Thank you for agreeing to participate in this interview.

1. You will remember that as part of the training course, we discussed participants' experiences and understandings of abortion counselling at the time. What is your memory of what you and others said at the time?
2. What are your thoughts about what was said in this session?
3. How did the course alter your practice in relation conducting abortion counselling?
4. I made on some of the challenges participants identified during the course. Please tell me how you have dealt with these following the course:
  - Clients being coerced to terminate a pregnancy
  - Women seeking late termination of pregnancy
  - Lack of support from managers
5. How have clients responded to the changes that you have affected in your practice?
6. What challenges are you still experiencing in conducting abortion counselling and abortion services?
7. Have you managed to continue with the support buddy system? If so, how has this helped, if at all?
8. If you were to talk to nurses who are thinking of undertaking the training, what aspects would you tell them are beneficial? How would the course change how they conduct their practice?
9. Is there anything else you would like to add?

Thank you for your time.

## Appendix F



**RHODES UNIVERSITY**  
*Where leaders learn*

# ABORTION COUNSELLING CERTIFICATE COURSE 2020

*For nurses*

## WHO CAN REGISTER FOR THE COURSE?

Nurses who have undergone TOP training, but wish to acquire and deepen their skills related to counselling.

## HOW MANY PLACES ARE AVAILABLE?

A maximum of 10 places are available on the course. Enrolment works on a 'first come-first served' basis.

## IS THERE A COST?

CSSR will cover all costs involved in this course, as there is a research component.

## WHEN IS THE COURSE?

13. Nov. 2020	2 - 3 pm
16. Nov. 2020	2 - 4 pm
18. Nov. 2020	2 - 4 pm
20. Nov. 2020	2 - 4 pm
25. Nov. 2020	2 - 4 pm
09. Dec. 2020	2 - 4 pm

CSSR IS OFFERING AN  
**ACCREDITED**  
SHORT ONLINE COURSE IN  
ABORTION COUNSELLING

## HOW DO I REGISTER?

Ask your facility manager for a registration form or you may contact Yamini at [yamini.arts@gmail.com](mailto:yamini.arts@gmail.com) for any queries.

