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Nurses' agency and power in abortion care: Personal stories and perspectives

Nurses are a crucial group of health service providers in South Africa,[1] with over 271 000 registered nurses according to data published by the South African Nursing Council in 2023.[2] The majority of these nurses are women, currently 242 280 are registered, and many work in the public health sector.[3] Despite the central role they play in the promotion and provision of essential health services, including safe abortion care, the nursing profession in South Africa faces shortages and conflicts between the needs of nurses and the communities they serve.[4]

As earlier noted, an amendment to the Choice on Termination of Pregnancy Act in 2008 expanded the pool of people who can perform abortion to empower nurses who receive appropriate training to perform first trimester services. Consequently, the implementation of the liberalised abortion law heavily depends on nurses as they are often in control of the provision of the services.

Although nurses play essential roles in abortion provision, research on the changing nature of their work within the broader health system context is scarce. This chapter seeks to address this gap by examining the power relations and medical discourses that shape the experiences of nurses who provide abortion services. Using primary research with nurse providers

1 P Barron & A Padarath 'Twenty years of the South African Health Review' in P Barron & A Padarath (eds) *The 20th edition of the South African Health Review* (2017) 4. See also, LC & A Padarath (eds) *The South African Health Review* (2018) http://www.hst.org.za/publications/Pages/SAHR2018 (accessed 20 June 2019).

2 South African Nursing Council 'Persons on the Register: Stat 2/2022(b)' (2022) NRSCSTAT71 1-3 https://www.sanc.co.za/wp-content/uploads/2023/01/Stats-2022-2-Registrations-and-Listed-Quals.pdf (accessed 15 January 2023). The number on the register includes all categories of nurses on the register. It also includes those professionals who are retired, overseas, working part-time, working in other sectors or not working at all.

3 Health Systems Trust *South African Health Review* (2017) 306.

4 See L Rispeli & J Bruceii 'A profession in peril? Revitalising nursing in South Africa' in Health Systems Trust *South African Health Review 2014/15* (2015) 117-227. See also Health Systems Trust (n 3) 306.

and observational data, I explore range of nurse providers' experiences in both public[5] and private healthcare settings.

This chapter is divided into two main sections. The first section explores the challenges that nurses face when providing abortion services in public health facilities. The second section provides an analysis of the obstacles that nurses encounter when running their independent abortion clinics. These clinics are not associated with government facilities or private clinics like Marie Stopes South Africa. By examining these two areas, we can gain a deeper understanding of the unique experiences of nurses in both settings and the barriers they face in providing abortion care.

1 Nurses' abortion work: An overview

Nurses in South Africa are able to conduct the whole abortion procedure in the first trimester when they are eligible abortion providers. Only doctors can perform abortions after 12 weeks. As one nurse described:

> As trained nurses, the Act allows us to do termination up to 12 weeks and above that (13 weeks up to 20 weeks), it is done by the doctor. So, in most of our facilities we don't have second trimester termination of pregnancy. We only have first trimester that is being offered by us nurses.

While nurses are not allowed to perform abortion procedures beyond the first trimester, they still play a crucial role in the provision of abortion services. They are responsible for administering medication and managing care during the procedure. This includes preparing patients for the procedure by taking medical histories, drawing blood, providing counselling, and administering drugs to examine the cervix. Additionally, nurses are responsible for post-abortion care.[6] A majority of the nurses

5 The data of the public sector was collected as part of a larger three-country study on conscientious objection led by Ipas in South Africa, Mexico, and Bolivia. This includes the six focus group discussions conducted in public facilities in Gauteng and Limpopo by the Centre for Aids Development, Research and Evaluation (CADRE) on behalf of Ipas South Africa (transcripts on file with author). The author was a consultant and served as a member of the innovation team to provide technical guidance related to developing and testing interventions to address the use of conscientious objection among public sector healthcare workers to deny women's access to safe, legal abortion services in Bolivia, Mexico and South Africa. The views expressed by the author in the analysis do not necessarily reflect those of Ipas.

6 Currently, Misoprostol alone is the standard of care for medical termination of pregnancy in public health sector: See D Constant et al 'Assessment of completion of early medical abortion using a text questionnaire on mobile phones compared to

interviewed were trained and knowledgeable about the manual vacuum aspiration but were not necessarily trained on medical abortion procedure (including Misoprostol and Mifepristone used as abortifacients).

Generally, the training provided to nurses is often incomplete or outdated. Some nurses only receive theoretical training, while practical training is limited due to a shortage of instructors. This has resulted in some nurses being unable to practice and having to work in other areas of healthcare. For example, an older nurse recounted how she attended the theoretical training in 2000 but was never given the opportunity to complete the practical due to shortage of instructors. So even though she was willing, she was unable to practice and thus went to theatre instead.[7]

In some cases, the training provided to abortion providers in public health facilities also includes a values clarification and attitude transformation (VCAT) component. Organisations like Ipas South Africa[8] conduct VCAT trainings in Gauteng and Limpopo, which engage participants in open dialogue to explore their values and attitudes about abortion and reproductive health issues.[9] These workshops aim to move providers through a progressive scale of support for abortion and reproductive rights. One nurse who previously provided abortion services until she was transferred to a different department noted the usefulness of these value clarifications:

> You cannot come to be a service provider when you have negative attitudes towards the service. I'm going to misinform the patient or whatever, so I have to not impose my beliefs and views on the patient. If the patient comes and says 'I want an abortion' I must give

a self-administered paper questionnaire among women attending four clinics, Cape Town, South Africa' (2015) 22 *Reproductive Health Matters* 83. For an analysis of the legal regime on medical abortion see, P Skuster 'How laws fail the promise of medical abortion: A global look' (2017) XVIII *Georgetown Journal of Gender and the Law* 379.

7 Participant observation during Ipas whole site orientation in Limpopo, May 2019.

8 Ipas South Africa is part of the international non-profit organisation that works globally to improve access to safe abortion and contraception. Ipas South Africa partners with health departments in two provinces, Gauteng and Limpopo, to increase women's access to safe, high-quality abortion services.

9 Ipas 'Abortion attitude transformation: A values clarification toolkit for humanitarian audiences' (2018) 3. On the impact of the VCAT trainings, see, EMH Mitchel et al 'Accelerating the pace of progress in South Africa: An evaluation of the impact of values clarification workshops on termination of pregnancy access in Limpopo' (2005).

> the service that they require, irrespective of how I feel about it and not being judgemental.

According to one nurse interviewed, the 2008 amendment that extended eligibility to nurses to provide first-trimester abortion services elicited mixed reactions among their colleagues. While some supported the amendment and saw it as a way of expanding access to safe abortion care, others were resistant to the idea. A nurse shared her own initial reaction:

> Before abortion was legalised, we were questioned, and we had discussions of our views towards what we think about the legalisation of abortion. For me I was pro-abortion since then because of what I had seen people going through. I used to work at … where every day we would be having patients going to theatre for evacuations and some of them with complications and we were saying if there was a safe abortion services that are provided for these women, we wouldn't be having these complications or having people or young girls and women dying of that. So that's why I was pro-abortion.

One reported issue is that some nurses who have been trained to provide abortion care end up not doing so, which is seen as problematic. A Facility Manager noted this and stated that some individuals 'reverse' their decision to provide the service. Nurses may have different reasons for this, as reported by one nurse:

> Yes, there is one, but she's a Christian. She did practice, but not for long, and then she went to work in maternity. Apparently, the husband became, you know, superior, and she had to stop practicing.

The failure of trained nurses to provide abortion care poses a significant challenge to the availability of safe and effective abortion services. Inadequate uptake of training opportunities contributes to the shortage of qualified abortion providers, leaving designated facilities unable to provide essential services. As a result, women may resort to private or illicit abortions, risking their health and wellbeing.

In the private healthcare sector, medical abortion is the preferred method for terminating pregnancies, with appointments made online or via telephone. However, in public health facilities, surgical abortion is the primary method, resulting in disparities in access to services. The complex and disjointed nature of abortion provision, which often takes place in hidden spaces, is not integrated into the everyday life of medical clinics, further complicating the client's pathway to accessing abortion services as shown in Figure 1.

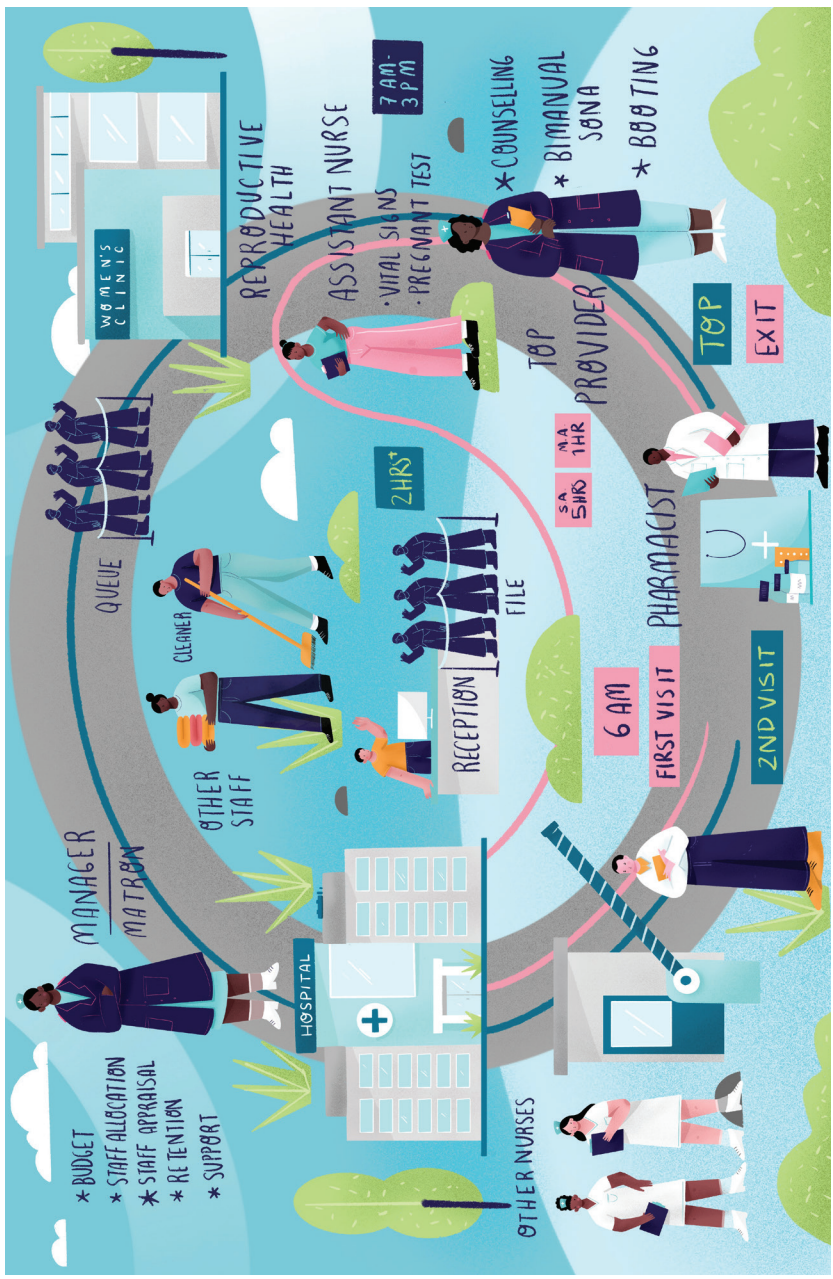


Figure 1: Client pathway for abortion access in a public health facility

This fragmentation of services, compounded by variations in providers' preparedness to offer comprehensive care, remains a prevalent challenge in South Africa's healthcare system. Thus, ensuring the availability of qualified and willing healthcare providers is crucial to guaranteeing effective and accessible abortion services.

The role of nurses in providing abortion care can vary widely, and this has important implications when it comes to conscientious objection. The first level of involvement consists of nurses who have undergone training as termination of pregnancy providers and are directly involved in performing the procedure for first trimester abortions. These nurses perform manual examinations or use ultrasound[10] to determine gestational age and they may administer medications like Cytotec or perform procedures like manual vacuum aspiration to terminate the pregnancy within the first nine weeks. They also assist in the operating room during surgical procedures.

The second level of involvement includes registered nurses who are not specifically trained to provide abortions but who still provide abortion-related services. These nurses may refer patients to authorised facilities for abortion, provide pre- and post-abortion counselling, and perform tasks such as taking vital signs, conducting pregnancy tests, and scheduling appointments.[11]

The third level of involvement includes nurses who do not participate in any aspect of abortion care and only perform general nursing duties. Some of these nurses may provide post-abortion care and contraceptive counselling, while others choose to abstain from these activities. Overall, the varying levels of involvement of nurses in abortion care demonstrate the complex dynamics of power and responsibility within the healthcare system.

The rest of the chapter is divided into two parts that provide an in-depth look at the challenges that nurses face in providing abortion services. Part 1, titled '"Dirty work": Experiences of nurses who provide abortion services in the public sector', sheds light on the experiences of nurses who work in public facilities and the difficulties they encounter while providing abortion services. Part 2, titled 'Shifting construction of nurses' abortion

10 Given that not all facilities have a sonar (ultrasound machines), clients would need to be referred to another facility that provides ultrasound services.

11 Services are provided within specific time frames during the day and not necessarily on a daily basis in some facilities. Patients are usually required to book an appointment based on the availability of the provider and the capacity of the facility.

work', delves into the multiple barriers that nurses face when running their own independent abortion clinics.

2 'Dirty work': Experiences of nurses who provide abortion services in the public sector

Through interviews with nurse providers on their experiences with providing abortion services, a recurring theme that emerged was the absence of an environment that fosters support and enables effective service delivery. This overarching theme was further expounded by three inter-related sub-themes: unsupportive management and inadequacies in the health system; lack of specialisation in abortion services; and negative attitudes of colleagues and pervasive stigma.

2.1 Unsupportive facility management and health system deficiencies

Generally, there were nurse providers who felt that they sometimes receive support from management and other staff:

> From my perspective where I am working, there is a lot of support. There is a few that I may not even know that are objecting but most of the people are supportive, even the manager is so supportive. So, I know in the beginning when we started around 2013 there was a lot of objection but now, I think people are beginning to accept it … but it depends on facilities, it depends on people, but at my facility to tell the honest fact, there is too much support.

Another nurse stated:

> There is a support, but they support you from a distance – they don't want to involve themselves in it.

One of the main challenges faced by nurses providing abortion services in public facilities is the lack of support from facility management. Many nurses who were interviewed highlighted this as a significant barrier to effective service provision. In fact, a nurse who previously worked in the public sector and later became an independent provider recalled her experience on her first day, where she felt unsupported:

> The matron in the hospital called me in her office and asked what was wrong with me? She advised that I should read the Bible as I was

> committing a sin. However, few months later, the same matron came to me for help regarding her pregnant daughter.

Others noted:

> You know, if they care, they will give us more support. They will check, even not on a daily basis, weekly, once a week to check, are you okay? How are you coping? There is anything wrong? So, they didn't bother about that. You only see them when there is a complaint that the people didn't get help at the facility. So, the thing that they are pushing is that the department is running. That is how they don't care.

> It's because they don't care. They are less concerned about these people of TOP … They don't know how important this is. I think if they will get that information, how important it is for a person to do a TOP, then that will make them feel that if you don't have equipment to work, you don't have someone to help, and you need someone to relieve you, because I have to work from Monday to Friday, you see. When I am going for leave, there is no one who is relieving me. When you come back, a lot of people are waiting for you, some of them not qualifying.

Although a prescribed training is required in line with the Choice on Termination of Pregnancy Act for a nurse to be able to perform abortion procedures and which is vital for broadening access,[12] nurses generally felt that there was a lack of proactive effort on the part of the facility managers to facilitate the training for willing nurses.[13]

> I know of a colleague who was willing, it's a guy actually. He was willing to be trained for the service, and he would always come and see [the facility manager] maybe for information and find out if there is any training that is being provided. He never got the training.

The lack of support from facility management is compounded by significant shortcomings in the public health system, such as the failure to retain nurses as abortion providers, inadequate space within the facilities,

12 WHO 'Health worker roles in providing safe abortion care and post-abortion contraception' (2015).

13 This is contrary to the position of the Democratic Nursing Organization of South Africa (DENOSA). See 'Submission by the Democratic Nursing Organization of South Africa (DENOSA) regarding the Choice on Termination of Pregnancy Amendment Bill 21 of 2007' (2007) http://pmg-assets.s3-website-eu-west-1.amazonaws.com/docs/2007/071113denosa.htm (accessed 20 May 2019).

and a general lack of prioritisation of the services by facility managers, particularly as it relates to staff shortage. A nurse who was interested in getting trained shared her experience.

> [The facility manager] told me that I can't go for training. They can't send me because they are short-staffed. If they take me this side from antenatal, who will be working in this place?

There has also been reports that this might be age-related as well:

> Again, I have heard an incident whereby they go according to your age. Where does that affect the service? You are a [professional nurse] at the end of the day, and then you find management telling you that you are too young to be providing such a service, or you do not have a child yet, and so you do not go and provide the service. I was willing to do it, I was told I am too young, that I will be traumatised and stuff. But personally, I don't mind.

According to the nurses' accounts, there seemed to be a prevalent sentiment of dissatisfaction and difficulty in retaining trained nurses, which they attributed to a lack of support and appreciation from facility management:

> The other one [previous provider], they said she got sick, because she was so traumatised about the place where she was working. Even now, she is on sick leave, for almost a year.

The inadequate prioritisation of abortion services is reflected in the small, uninviting and 'dingy' workspaces, which negatively impact women's experiences of seeking such services. Nurses expressed their frustration:

> The way the building is, it's like there is a lack of privacy, a lot of judgement, because you will find more of them gossiping that she is here to do abortion, just look how young she is. How can she sleep with a boyfriend? Even those pregnant women who are there for our service, they look at them, like seeing that maybe they are talking, they know that if you follow this Sister, they even know the Sister. If you follow this Sister and you come this side for the sonar, you are here for abortion. They know that. I think maybe if they can provide it somewhere else, so that they can have their own privacy. Because yes, they have their own privacy that side where they do.

> [T]he equipment, last time I asked them to order some instruments. From January [2019] till now, I never received it. I never received even a report that we are still waiting for your instruments or whatever

> … But if you go to the office and said: 'I don't have this, I don't have this', they said: 'You must compromise. You must use whatever you have.'

As highlighted above, public facilities are inundated with the unavailability of medication and equipment and human resources challenges, which exacerbates nurses' workload as shared by this nurse:

> Respondent: At my facility, for now I am a professional nurse, working with TOP. At TOP, I am working with an auxiliary nurse who is assisting me with the instruments. But for me, I think it's very hectic, according to the number of patients that I am seeing per day.
>
> Interviewer: How many do you see on an average day?
>
> Respondent: They come as large numbers, so I can't provide more than seven people per day. So sometimes you find that there are more than 50 or 100.
>
> Interviewer: Really?
>
> Respondent: Yes. So, I will only do sonars by myself. After sonar, I book them. I used to do the sonars on Mondays. On Mondays maybe I will take 30, as an example. So, when I took 30, I will book them according to days. Maybe on Tuesday I will book five, like that. So, it's so hectic, because I have to provide, as me alone and myself. No one is helping me, assisting me in the department. Then the other thing, the family planning is also done by me. I do family planning, I do counselling, pre and post, the observations, to observe the patient, that they are okay after the procedure.

A non-provider had this to say:

> I feel that okay, I am actually looking at it from the perspective of abortion provider. I feel like for her to be the only person that works there, it's a disadvantage. It's a disadvantage in the sense that she has to do all the procedures by herself. She has to prepare and clean the instruments and prepare the room as well, by herself. She has to do all the sonars for every patient that comes in here. Looking at the fact that also with the paperwork that is involved in the service that is provided.

Facility managers emphasised their efforts to reinstate termination of pregnancy services and provide necessary equipment despite financial

limitations, as they were aware of the negative impact of the lack of services on women seeking abortions. Facility managers shared:

> The [TOP] services were not running when I arrived, but in the past, as I understand, they were running. I don't know what happened, but people resigned, people are no longer here. So, we thought we needed the services, based on the statistics, people who do backstreet abortions, unwanted pregnancies, no family planning. Then we spoke to the DEM, which is District Executive Manager. Then he decided, let's go to X [name removed] and do research. The Sister who was providing services there was seconded here. Then we opened the clinic there to run even at night ... but here we only do services from seven to four during the week, and seven to one on Fridays. So, there is only one trained professional nurse, who is working with an enrolled nursing auxiliary, who is not trained, but is willing.

> [T]hose people need support, and they are dealing with something that's not so simple.

> I was surprised, because with us, Treasury, we are hiring not only CTOP Sisters, even any other personnel; we are waiting for April due to budgetary constraints. But once we are given the go-ahead, I think it wouldn't be a problem.

However, nurses had a contrary view about the support received from facility managers, noting that:

> Like for instance, [facility managers] are denying people who want to do it. They don't want to take [nurses] to training. They said they are short-staffed, whereas they are prioritising other departments like other than TOP … they make sure that there is only one person who is doing termination of pregnancy. She doesn't have any support from any staff members. So, this person, she can come back tomorrow and say I'm tired, I need early pension, then the TOP department will be closed.

This research found that the shortage of abortion providers, coupled with the absence of a clear plan to train and replace retiring providers, results in a heavy workload for existing abortion providers and a high likelihood of burnout. The findings from the interviews and focus group discussions suggest that nurse providers often work in environments that lack essential equipment, are understaffed, and do not provide adequate support. This finding is consistent with previous research, which has highlighted that the challenging working conditions of providers make the provision of

abortion services difficult.[14] The shortage of human resources ultimately leads to burnout and high levels of stress.[15]

2.2 Non-specialty of abortion service

One of the major themes that arose from the research was the absence of incentives and recognition for abortion work. Based on the accounts of the interviewed nurses, some of them pursued abortion training with the assumption that it was considered a specialty and would offer career advancement opportunities. This perception was based on their understanding that the Department of Health had intended it to be so.

> Some of them they went for training thinking it is a specialty and they would earn from it. Since there aren't any incentives given, they say no, they can't do it. They would rather go to other specialties where they can be paid because we're working in an environment that really needs money, without money you can't do anything. So, they opt to go for specialties that pay rather than continuing to do a thing that does not pay. They don't want to do a thing that does not give them food because at the end of the day we have to eat, we have to take children to school, so and so, yes.

Another lamented:

> Yes. So, people are going for courses that are paying but termination of pregnancy is not paying so people are reluctant to do it and also, it's hard work but there's no incentive, nothing. Like with the department, they promised earlier on, but they made a U-turn immediately. They promised incentives, incentives, incentives, incentives.

When the Department of Health made the decision not to consider termination of pregnancy services as a specialty and declined to provide higher remuneration for nurses who provided abortion care, some nurses opted to stop providing this service. This lack of recognition and compensation was seen as a major disincentive to continuing to provide termination of pregnancy services.

14 LRC Mamabolo & J Tjallinks 'Experiences of registered nurses at one community health centre near Pretoria providing termination of pregnancy services' (2010) 12 *African Journal of Nursing and Midwifery* 73.

15 See similar findings in A Norris et al 'Abortion stigma: a reconceptualization of constituents, causes, and consequences' (2011) 21 *Women's Health* S49.

> And even those that were providing, they have stopped providing because it is hard work, you are working alone heavily so but nobody recognises that. I mean financially. We are working alone, you can check on our statistics, one person doing such a work per day, with so many patients alone. You admit, you give treatment, you counsel, when you go home you feel like if you can have a driver to drive you home.
>
> [T]he worst part is that as a TOP provider, you don't benefit anything. If you work Monday to Friday and over the weekend you don't work, you are only getting tired and saying not going to claim any overtime, no Sundays. Then you are only getting tired and others saying, 'oh you are complaining about backache, no one is forcing you to terminate'. Meanwhile people in the ward are getting money for working on Sundays.

Nurses reported that providers get transferred to other departments thereby leading to shortage:

> We even have providers who deserted the services because they were tired, they were not taken care of, because there's no incentive, monetary incentive and if they can bring an incentive into the service like any other specialty, people come back. We will see too many people going for training, we will see termination of pregnancy as [big as] any other service like TB or HIV.

2.3 Attitudes of colleagues, stigma and burn-out[16]

According to the nurses who provide abortions, their colleagues held negative and judgmental attitudes towards them, and they were often stigmatised and harshly judged. They were given derogatory labels such as 'baby killers', 'lucifer', 'mortuary', and 'murderers'. As one nurse provider put it:

> I am called 'professional murderer', friends no longer want to talk to me because I work in an abortion clinic.

Further, a nurse shared her experience of how she was insulted:

16 While this section focuses on public sector nurse providers, it is important to note that the insults and naming calling is also experienced by some nurses the private clinic as noted in the quote below: We are constantly harassed by hecklers calling us 'murderers' and 'baby killers'. But there is not much we can do except ignore them. It is frustrating.

> The last time [I was called names], it was from one of the security guards. In fact, he said to me: 'Sister, after doing what you are doing, because it's like you are murdering kids, you are killing babies. Do you go for cleansing, and who is cleansing you?' You know our rituals, you know, the black rituals, we always go after mourning, the funeral and everything, we need to be cleansed. I mean, it doesn't sit well with me. Some will say: 'Are you working there? Are you also killing babies?' Stuff like that, you know.

These comments were confirmed by a nurse objector who stated:

> Well, I think sometimes I'm unfair, because I blame them. I go like: 'Why you agree to do this? You are a murderess'.

In some instances, public sector nurses narrated that several of their co-workers were not supportive:

> Some of the staff members are negative especially in my facility. I'm working alone. I needed an assistant from at least a junior level or next to come and help on busy days. They all refused and said that they can't cope with seeing me killing babies; they don't even know, the doctor is not even interested to see what I'm doing and they're thinking it is as if I'm taking out babies and killing babies. They are so negative and then that leads to me working alone now.

Another explained how support staff including the cleaning staff refuse to clean the room where abortion procedures are performed:

> What I have observed is that some of the cleaners do not even want to see that room. If the person who is cleaning on that day has taken a day off, I will end up reporting to my manager that no one is coming to clean. They will say 'the bloody room, sister of blood room, no I do not want to see myself there' but now lately that I have tried to orientate them that what I need is only to clean and leave the room clean.[17]

The stigma and discrimination that nurse providers experience take a significant emotional toll on them, often resulting in burnout and a shift to other departments or the private sector. Negative comments and attitudes from colleagues leave nurse providers feeling isolated, victimised, and

17 See also Ipas 'Factsheet: Findings from in-depth interviews with abortion providers and health system managers' (2018) 2 https://ipas.azureedge.net/files/SAFAPE18-HowtoImproveSACSouthAfricaPublicHealthFacilities.pdf (accessed 19 April 2019).

stigmatised. Several studies have highlighted that even in places where abortion is legal, providers continue to struggle with stigma and a lack of support, making it challenging to provide high-quality abortion services.[18] Both women who seek abortions and those who provide such services are subject to stigmatisation.[19]

Stigma is defined as 'an attribute that links a person to an undesirable stereotype. leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one'.[20] Abortion stigma, as defined by Anuradha Kumar, Leila Hessini, and Ellen Mitchell, refers to the 'negative attributes ascribed to women who seek to terminate a pregnancy', marking them as inferior to ideals of womanhood.[21] Stigma operates within individual, organisational, and societal structures. In the context of nurse providers, abortion stigma is related to the negative attributes ascribed to those nurses who provide termination of pregnancy services. Colleagues stigmatise nurses who provide abortion services and often do not see them as lifesaving but as involved in unethical services.

For these nurse providers, stigma is driven from the context in which they operate. The experience of stigma by a nurse who provides abortion services is acutely different from that of a woman seeking abortion, or who has had an abortion. Nurses who provide abortion services are stigmatised based on their work in abortion services, which is viewed as 'dirty work' and not in line conceptions of what it means *to be a nurse* and *a member of the nursing profession*. This is because abortion work becomes closely tied to the professional identity of these nurses resulting in continuous exposure to stigma.[22] Abortion provision becomes *an isolating and stigmatising profession.*

Despite this, the nurse providers have coping mechanisms to deal with the stigma and negative attitudes from colleagues. They view their work as helping women and providing respectable nursing care, and their sense of professional responsibility outweighs the judgmental attitudes of

18 LA Martin et al 'Abortion providers, stigma and professional quality of life' (2014) 90 *Contraception* 581; LA Martin et al 'Measuring stigma among abortion providers: Assessing the abortion provide stigma survey instrument' (2014) 57 *Women Health* 641.

19 See A Kumar et al 'Conceptualising abortion stigma' (2009) 11 *Culture, health and sexuality* 625.

20 E Goffman *Stigma: The management of spoiled identity* (1963) 11.

21 Emphasis added. Kumar et al (n 19) 628.

22 On professional responses addressing stigma, see, RJ Cook & BM Dickens 'Reducing stigma in reproductive health' (2014) 125 *International Journal of Gynaecology and Obstetrics* 89.

their colleagues. They express this through their conscience-based claims. Nurse providers describe their conscience-based claims as follows:

> I've never been so comfortable in my life as a nurse working in the reproductive services doing termination of pregnancies. It's not an awful feeling, you know helping women to go on with their lives with no conscience being free and you know something that you don't know, if a woman has an unwanted pregnancy that woman is bad news. That woman can kill herself if she doesn't reach the services of termination of pregnancy. If a woman doesn't want a pregnancy, she wants that pregnancy out like in a week. She wants to close her eyes and when her eyes are opened, the pregnancy is no longer there. So, helping women to get back to themselves, it's so fulfilling and very comfortable.

> To maintain woman's dignity because you know previously women, we were much oppressed, physically, emotionally and otherwise. You find that you have a boyfriend then he sleeps with you and after you tell him that you are pregnant, he tells you: 'With whom have you decided to make that baby? That is none of my business, that baby is not mine, it's yours.' Then that woman gets frustrated and whatever then when she comes, I remove the thing because it's not wanted rather than leaving that particular woman under that particular stress and unhappiness. That offspring will be born being stressed. I think she will just be a naughty person, fighting with everybody at school, crèches and wherever. She won't be a controlled person because she has developed from a human being that would always be angry and she won't even get love from the beginning, or conception, from the first trimester, formation until the end. So, what do we expect the offspring will be like?

In order to counter the stigma and negative attitudes that nurse providers of abortion services face, support systems are crucial. These systems include group get-togethers with fellow providers to discuss their feelings and experiences, as well as support from family, partners, and friends. It is worth noting that the youngest nurse interviewed, who only worked in the private sector, reported that she had not personally experienced any stigma related to her work. This was in contrast to the experiences of older nurses, particularly those working in public health facilities. The young nurse attributed her lack of stigma to her work environment in the private sector and the pro-choice attitudes of her family and friends.

For nurses working in public facilities supported by Ipas South Africa, debriefing and social engagement sessions are also available as coping

mechanisms. As one provider described, these sessions have been helpful in dealing with the stress and challenges of their work:

> Debriefing by Ipas. That makes us free and understand, and gives you that energy again, that I can go back and do 1, 2, 3.

The lack of support for public hospital nurses in coping with their work conditions is concerning, as highlighted by the Democratic Nursing Organisation of South Africa (DENOSA). While Ipas South Africa organises debriefing sessions for nurses in Gauteng and Limpopo, this is not widely available in public hospitals despite the challenging work environment.[23]

The difficulties faced by the health system in providing termination of pregnancy services are not new, as raised during the early years after the Choice on Termination of Pregnancy Act was passed. Rachel Rebouché notes that the Act's ineffective implementation is indicative of broader issues in the healthcare system.[24] In 2002, the Reproductive Rights Alliance, a coalition of NGOs working in the abortion field, expressed concerns about the reluctance of facility staff and district management to offer or support termination of pregnancy services despite the legal mandate.[25] Similarly, Ames Dhai commented on this issue during the National Parliamentary Health Portfolio Committee's 2002 hearing on abortion services: [26]

> Social justice is called into question when access to safe termination of pregnancy is limited by negative attitudes of staff and the failure of training programmes to prepare personnel for performing termination of pregnancy.

The South African case study reveals that negative societal attitudes towards abortion persist even when it is decriminalised, resulting in ostracisation and discrimination of those who provide and seek abortion services.[27] The implementation of termination of pregnancy services is hampered by the

23 M Lekgetho 'Nurses need debriefing & counselling – Denosa' *Health-E News* 20 April 2017 https://health-e.org.za/2017/04/20/nurses-need-debriefing-counselling-denosa/(accessed 28 August 2019).

24 R Rebouché 'The limits of reproductive rights in improving women's health' (2011) 63 *Alabama Law Review* 4.

25 J Merckel 'Comment from Judith Merckel of the Reproductive Rights Alliance' (2002) *Women Health Project* 7. See, CE Hord & M Xaba 'Abortion law reform in South Africa: Report of a study tour 13-19 May 2001' (2001).

26 As cited above.

27 Guttmacher 'Making abortion services accessible in the wake of legal reforms: A framework and six case studies' (2012) 11.

exercise of conscientious objection by health professionals, unsupportive hospital management, lack of information on services, and inadequate investment in public health services. Access to healthcare is thus dependent on one's social status and financial capacity.

Despite the negative attitudes that nurse providers face from their colleagues, they often come to them for support when they or someone they know has an unwanted pregnancy. This indicates a dualistic morality in which opposition to abortion dwindles when it affects them directly. A similar study in Brazil reported a drastic change in the attitudes of health professionals towards abortion when it affected them personally.[28]

3 Shifting construction of nurses' abortion work

3.1 Why it is so hard to run an abortion clinic

Here, I highlight two nurses who run their own private abortion clinics and draw on personal experiences to illustrate the changing nature of nurses' abortion work. These nurses, sister M (a pseudonym) in Gauteng and sister K (also an alias) in Limpopo, shed light on emerging issues such as difficulties with certification, lack of support, and victimisation. Although independent abortion clinics play a crucial role in providing access to abortion, they still face challenges in maintaining their operations.

28 A Faúndes et al 'The closer you are, the better you understand: The reaction of Brazilian obstetrician-gynaecologists to unwanted pregnancy' (2004) 12 *Reproductive Health Matters* 47.

3.1.1 Sister M

As long as I can remember, I have always wanted to be a nurse. I started working in a general hospital in a farming area in Mpumalanga more than 45 years ago. I later became a nurse for reproductive health from 1988. I used to serve in the mobile clinics which would come to the countryside every three months, where black women could get an injection, sometimes without knowing what the injections were for.[29] Generally during those times, women working in the factories were not allowed to come to the mobile clinic for check-up. Employers did not give them adequate time. During apartheid, I remembered how abortion was done considering that it was highly restricted, especially for black women. 80 per cent of cases we saw were at night, which were mainly for evacuation or post-abortion care.

Before the legalisation of abortion, we as nurses had conversations. We were encouraged to attend workshops and come back and teach others. I was recommended by my fellow sisters when they chorused that 'Sister M should go. She is pro-choice. She does not have a problem with abortion'. Despite my family's resistance as my in-laws were priests in the church but leaning on the strength of Desmond Tutu who came out to support abortion rights, I attended the workshop and then got trained as a provider. My fellow sisters refused on the ground of being 'born again', though most of them just refused because they feared the stigma associated with such work.

[I was motivated to become an abortion provider] when a woman came into the hospital at 28 weeks pregnant. She was given an injection to stop the cervix from opening. However, the woman then took the drips off and hid in the bathroom. We had to search everywhere for her. When we finally found her, the baby was out, and the woman had boiled the baby with the hot shower. This led to my training as a provider in 1999.

29 On the population control programme during apartheid as a way of addressing the epidemic of backstreet abortions, see SM Klausen *Abortion under apartheid: Nationalism, sexuality, and women's reproductive rights in South Africa* (2015) 198-200.

In this story, we learn about the history of abortion in Gauteng during apartheid and after it became legal in 1996. Sister M's interview shows how hard it can be for providers to get permission to run private facilities. Sister M is the eldest nurse I spoke to, being 65 years old. She began working as a nurse in 1974 and became a midwife in 1982. Years later, she left the public sector and worked for a private abortion clinic noting that:

> Lady politicians and celebrities who were publicly against the liberalisation of abortion would come to these private clinics.

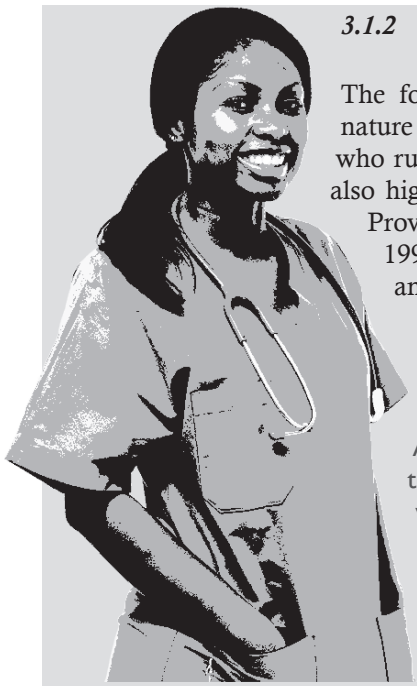
Despite knowing that she was doing great work at the private clinic, she felt that the prices were very expensive and unaffordable. She wanted to help women and girls and not necessarily make money. She noted:

> If a girl comes with ZAR 700 and the clinic says ZAR 900, they will be turned away. Let me catch these girls. I therefore see mostly black women and girls. But also, poor white women also come to me. But if they are rich, they go to the high -end abortion clinics.

On running her independent abortion nursing clinic:

> The Choice on Termination of Pregnancy Act empowered us. During apartheid, nurses could not even do drips. We were regarded as cheap labour. Hence, I decided to set up my own clinic. There is a lot of red tape with designation and the application process takes too long. Most nurses who run their own clinics are not cared for by the Department of Health. My clinic got designated in 2001 and due to restructuring of the office space for residential purposes, we had to move in 2015. Although, I am still in the system, but the clinic is yet to be re-designated since. The accreditors would not come, but they will threaten you with closure and still require statistics from you.

Sister M's description of the designation process and frustration over the designation process resonates with the other nurses running their own private clinics. There is a lot of red tape with the designation of facilities to offer termination of pregnancy services. It was noted that there are usually two Provincial Department of Health staff responsible for the whole province. They are overwhelmed and do not prioritise the process. One of the other problems is that when one moves from the designated site, they need to re-do the whole designation process again.



3.1.2 Sister K

The following narrative reflects the complex nature of abortion work for independent nurses who run their own clinic as the other narrative also highlighted. Sister K is based in Limpopo Province and started as an enrolled nurse in 1992, became a professional nurse in 1999 and midwife in 2002 respectively.

> I did mobile services for a while going to communities and offering services. But this was not challenging enough. As I am a practical person, I went back to maternity in 2005. One day when I was in casualty, a 16-year-old girl came in with a profuse vaginal bleeding with ruptured uterus and the cervix was out. She was apparently taken to a traditional healer. We could not do anything to help her, so we transferred her to the closest referral hospital. However, she stayed with me. I felt she was my daughter and needed to follow up. This motivated me to apply for TOP training in 2005. I wanted to save lives.

She recalled her experience working as an abortion provider in the hospital. She got called names, was over-worked and burnt-out. She finally left public service for private abortion clinic because she felt that she was unable to help women and girls because of the booking system and inadequate number of providers. Out of 60 nurses, there were only two trained abortion providers:

> It was devastating to me how due to the booking system; I was unable to provide timely services to a woman seeking abortion services. Few weeks later, I get called to casualty for the same woman suffering from the consequences of backstreet abortion.

Working as an abortion provider in a public hospital was a very difficult situation characterised by no performance bonus despite being the best performing nurse in the hospital, which was further worsened by an

incident with her unsupportive manager who was only interested in the statistics:[30]

> When I have personal problems at home, the manager will tell me that 'nothing will go right for you'. When my daughter had a miscarriage, she said, 'your daughter will never have a child because you are a baby killer'.

She eventually left the public sector to set up her own private abortion clinic. This also came with an array of problems:

> In May 2018, I was reported to the Department of Health as a result of false information given to them. I was accused of stealing hospital materials for my clinic and illegally operating an abortion clinic. Thirty police officers came to arrest me. There was no search warrant. I have applied for designation a year earlier and yet to hear anything back. I was targeted simply because of perception of being a threat. However, this is confusing, as government is supposed to support health professionals in providing services to women and girls.

These two narratives provide insights into how the identity of nurses in South Africa has evolved in relation to providing abortion services. The healthcare system in South Africa is largely composed of female nurses, which has its roots in the historical shortage of medical professionals during World War II.[31] The history of nursing in South Africa is marked by the emergence of black nurses as a majority in the field, starting with the registration of Cecilia Makiwane in 1908.[32] Makiwane, a product of a nurse training school for black nurses, became the first black professional nurse in the country. This was due to the need for Xhosa-speaking nurses in King William's Town, which led to the establishment of the experimental training school.[33] Over time, more black nurses were trained

30 Facilities are obligated to document and send monthly detailed accounts of procedures performed with disaggregated data for the clients in terms of age, group and gestational age. This is in line with sec 3(4) of the Choice on Termination of Pregnancy Act which obligates the member of the Executive Council to once a year submit statistics of any approved facilities for that year to the Minister.

31 See CE Burns '"A man is a clumsy thing who does not know how to handle a sick person": Aspects of the history of masculinity and race in the shaping of male nursing in South Africa, 1900–1950' (1998) 24 *Journal of Southern African Studies* 695.

32 South Africa Nursing Council 'Born to be a nurse – Cecilia Makiwane' (2019) 3 *#SANCNews* 4.

33 As above.

nationwide, reflecting the changing political landscape and the increasing role of women in the country. Today, black nurses make up the majority of registered nurses with the South African Nursing Council. This change of trend overtime also reflects the changing political landscape and the position of women in the country.

The nursing profession is characterised by a combination of specialised theoretical knowledge and practical experience.[34] As a result, nurses hold and exercise a considerable amount of power. However, it is important to note that knowledge is not neutral, as it carries particular viewpoints and therefore serves as a means for the exercise of power. Nurses further reinforce their power through the wearing of uniforms, which symbolise their status and authority.

The nursing profession is characterised by theoretical specialised knowledge and practical experience, which result in power being held and exercised by nurses. Knowledge is not impartial and signifies specific viewpoints and consequently serves as the vehicle for the exercise of power. In addition, nurses wear uniforms, which reinforces the status quo of having power. The nursing profession's invariable coupling of power and knowledge, as Foucault points out, is complimentary.[35] The dispensation of power through complex social networks includes not only 'agents but also instruments of power'.[36] These instruments of power may include documentation, infrastructures, equipment, and established ways of doing things, all of which are utilised to wield power.

Power is not a fixed entity but rather comprises power relations that are constantly recreated and reinforced over time. For nurses who provide abortions, empowerment came in the form of the Act which allowed them to perform first-trimester abortions, changing the way their professional identities were constructed and creating new opportunities for them.[37] By asserting their agency and moving between the margins and centres of their profession, nurses are creating their own social spaces and locations, as described by bell hooks.[38] This has led to the establishment of specialised abortion clinics owned and operated by nurses, independent of public hospitals, particularly in Gauteng and Limpopo, resulting in an increase

34 RR Sepasi et al 'Nurses' perceptions of the concept of power in nursing: A qualitative research' (2016) 10 *Journal of Clinical and Diagnostic Research: JCDR* LC10–LC15.

35 M Foucault *Discipline and punish* (1977) 27-28.

36 J Rouse 'Power/knowledge' (2005) 34 *Division I Faculty Publications* 11.

37 M Berer 'Provision of abortion by mid-level providers: International policy, practice and perspectives' (2009) 87 *Bulletin of the World Health Organization* 58.

38 bell hooks *Feminist theory: From margin to center* (2000) xvi.

in service provision. Private clinics have become a refuge for those who cannot access public services due to time constraints and booking systems. Some private clinics even offer abortion services outside of regular hours, making them more accessible to those who need them.

Yet, private nurse practitioners, who run their own abortion clinics, face significant challenges when it comes to complying with the designation process. This is because section 3 of the Choice on Termination of Pregnancy Amendment Act outlines a lengthy list of requirements that health facilities must meet in order to be designated to provide abortions. Termination of pregnancy may only take place at a facility which:

(a) gives access to medical and nursing staff;
(b) gives access to an operating theatre;
(c) has appropriate surgical equipment;
(d) supplies drugs for intravenous and intramuscular injection;
(e) has emergency resuscitation equipment and access to an emergency referral centre or facility;
(f) gives access to appropriate transport should the need arise for emergency transfer;
(g) has facilities and equipment for clinical observation and access to in-patient facilities;
(h) has appropriate infection control measures;
(i) gives access to safe waste disposal infrastructure;
(j) has telephonic means of communication; and
(k) has been approved by the Member of the Executive Council by notice in the Gazette.

Through the 2004 amendment of the Choice on Termination of Pregnancy Amendment Act, a member of the executive council (MEC) could designate facilities that could provide abortion services.[39] Additionally, the assigned member could exempt facilities from obtaining approval for abortion services if they provide 24 hours maternity services. While the amendment to the Act was aimed at making abortion more accessible through the removal of long designation procedures, as illustrated above, this has not translated into practice. The wide-ranging requirements that facilities have to comply with in order to be authorised to provide abortion is burdensome for the private sector, especially nurses with limited capital and social networks.

Private nurse practitioners who operate their own abortion clinics face significant challenges when it comes to complying with the designation

39 See, sec 3 of the Choice on Termination of Pregnancy Amendment Act 38 of 2004.

process. On the one hand, complying with the requirements outlined in section 3 of the Act is burdensome and time-consuming, making it difficult for these practitioners to provide abortion services. On the other hand, failure to comply with these requirements can lead to legal consequences and the loss of the ability to provide abortion services altogether.

Despite these challenges, the private sector has played a key role in complementing abortion services provided by the public sector. However, the high cost of private sector service provision means that it is not accessible to all. Moreover, the extensive bureaucratic process of accrediting facilities has resulted in a slow decentralisation of services, with many authorised public health facilities still not providing abortion services.

Nurses who operate their own abortion clinics have also faced continued abuse and disempowerment at the hands of public health officers responsible for designating facilities, particularly when compared to doctors who run their own abortion clinics. This highlights the ongoing power imbalances within the healthcare system, and the need for greater support and recognition for nurse providers in the field of abortion care.

3.2 Negotiating roles and power in the doctor-nurse relationship

Despite the potential of nurses to practice as private practitioners with their own abortion clinics and meeting the challenges of providing quality abortion care, they are faced with the power structures in the health system, which makes it difficult for them to do abortion work. As one nurse lamented:

> The problem is that termination of pregnancy has become commercialised and hijacked by doctors and the selling of pills in informal shops in the townships. For example, due to the influx of foreigners seeking the services, the prices have gone unreasonably up. There are doctors who charge ZAR 5 000, but they are not disturbed like us. They give their patients pills and tell them to go to the hospital when they bleed. We suffer unequal treatment as nurses running our own clinics.

Another one recalls:

> I used to have at least 500 clients per month. However, because we have a doctor in the same building, it has gone down to 100-200 clients per month.

In conversations with nurses, it becomes apparent that there is a tension and professional boundary between nurses and doctors that is often defined by labels such as: 'I am a doctor and you are a nurse.' This boundary is reinforced by gendered and professional hierarchies based on qualifications and licenses.[40] Professional codes and training further distinguish doctors and nurses as separate professions.

The global landscape of senior positions of power within various industries remains dominated by men, while front-line health professionals such as nurses are predominantly women.[41] Despite an increase in the number of women entering the medical profession, men still make up the majority. This has resulted in a patriarchal structure, with predominantly male doctors serving as the head of the team, which is primarily composed of female nurses. This hierarchical observation allows for power imbalances to persist.

The nursing profession, in particular, has been stereotyped as being feminine, perpetuating gendered divisions of labour within the health system that mirror those of society.[42] Nurses are conditioned by the health profession to play a deferential role, contributing to power relations being maintained through social and bureaucratic hierarchies in hospital settings.[43] These structures are designed to ensure that nurses remain in their place, conforming to traditional settings and dictates that preserve the status quo.[44]

Nonetheless, while speaking to the independent nurses, there was a clear sense of questioning of traditional occupational roles and hierarchy between nurses and doctors. They no longer viewed doctors, who are mostly men, as the ultimate authority on women's bodies, as exemplified

40 See S Porter 'Women in a women's job: The gendered experiences of nurses' (1992) 14 *Sociology of Health and Illness* 510; G Andrews 'Nursing as emancipatory practice' in JD Jansen (ed) *Knowledge and power in South Africa* (1991) 165.

41 See WHO 'The world health report' (2006) http://www.who.int/whr/2006/en/ (accessed 12 March 2018).

42 M Takase et al 'Does the public image of nurses matter?' (2002) 18 *Journal of Professional Nursing* 196.

43 CM Chapman 'Image of the nurse' (1977) 24 *International Nursing Review* 166; PM Manojlovich 'Power and empowerment in nursing: Looking backward to inform the future' (2007) 12 *OJIN: The Online Journal of Issues in Nursing* 2.

44 Foucault coined the term 'biopower' to not only focus on the body as a site of subjugation, but also highlights how individuals are implicated in their own oppression through self-surveillance. See M Foucault *The history of sexuality, Vol 2* trans R Hurley (1980) 139.

by the character in Nawal El Saadawi's *Memoirs of a woman doctor*.[45] These nurses have gained their own expertise and experience through working outside of the hierarchical structures of public hospitals. An incident in May 2018, where a professional nurse's clinic was raided by the provincial Department of Health, serves as a clear example of the continued harassment and victimisation faced by private nurse practitioners running their own abortion clinics.[46] It highlights the discriminatory treatment towards nurses compared to doctors, who do not face such crackdowns.

Focus on fake Drs

Maseo Nethanani

THE MEC for Health, Dr Phophi Ramathuba, led a raid on an illegal women's health clinic in Ladanna on Thursday.

Department officials were accompanied by police officers to investigate and close the clinic that was operating without a licence. During the raid, a foetal scope, belonging to the Department of Health, was confiscated as well as other equipment belonging to the state.

Ramathuba said the clinic was ran by a professional nurse who was trained by the department but refused to serve the community in government healthcare facilities, rather opting to open her own practice for financial gain, not complying to the laws and bylaws.

"This clinic is illegal as it is not accredited by the Department of Health. Aside from the numerous complaints against the clinic made with the department, it was also worrisome to find equipment belonging to the state. This equipment was purchased by the department to help the people in communities but they were stolen by one of our own professionals, indirectly stealing from Limpopo's people, denying them their basic right to healthcare services," Ramathuba said.

She added the confiscated equipment was taken from Rethabile Clinic and has led to the clinic being unable to help patients due to the stolen equipment.

"We want to investigate what happens to the morals of the medical professionals we train as a department to care for our people. People who come to this illegal clinic have the money to pay for medical care which is essentially stolen from the poor when medical professionals steal state equipment to open their own practices for personal financial gain. We will continue to work with police to investigate the matter and bring the guilty parties to book, an example must be made."

Ramathuba added this was not the only success the department had on Thursday as they also arrested two young males masquerading as doctors at Mankweng Hospital.

"We lose too many women to illegal street abortions from fake doctors. Contraceptives are free at state medical facilities, make use of this service and look after your health. We will continue to root out these illegal medical practices and fake doctors. We will leave no stone unturned to ensure the safety of our people, it is our responsibility to protect them," Ramathuba said.

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Figure 2: News story (Raid on a women's health clinic)

The above discussion portrays the power dynamics at play in the healthcare system, particularly in the provision of abortion services. Nurses challenge the traditional power structures and assumptions about the quality of care provided by doctors. They argue that they offer high-quality services at a lower cost compared to doctors. This challenges the assumption that doctors are the only ones capable of providing safe and effective abortion services. The criticisms levelled against doctors also highlight the issue of accountability in the provision of abortion services. The power dynamics between nurses and doctors reflect larger societal power structures that need to be addressed in order to ensure access to safe and affordable reproductive healthcare for all.

45 The fictional book tells the story of a young woman's encounter during her studies as the only woman in the class in mid-century Egypt. She no longer sees men as 'gods' as described by her mother; due to the misogynistic experiences faced by the women patients she encounters. See, N El Saadawi *Memoirs of a woman doctor* trans C Cobham (1982) (originally published in 1957).

46 M Nethanani 'Illegal woman's health clinic raided in Ladanna' *Review* (Polokwane) 31 May 2018 https://reviewonline.co.za/263822/focus-on-fake-drs/ (accessed 5 June 2019).

4 Concluding reflections

The chapter reveals the intricate and challenging experiences of nurses who provide abortion services. It sheds light on the difficulties faced by nurses who support the right to abortion and carry out the termination of pregnancies. Despite the challenges, many abortion providers demonstrate unwavering dedication to their work.

Through these narratives, we see the dedication of these nurses to their patients, despite the hurdles that compromise the quality of their services. They confront power structures and societal norms that undermine the provision of abortion services. Michel Foucault's notion of resistance and opposition comes to mind, as the provision of abortion services has become 'a point of resistance and a starting point for an opposing strategy'.[47]

The nurses who provide abortion services must navigate complex and sometimes hostile environments. They face criticism and stigmatisation from some members of society and even their colleagues. Nevertheless, these dedicated healthcare providers continue to provide quality services to their patients, even in the face of adversity.

This chapter also brings a new perspective to the existing research on nurses who provide abortion services. Unlike previous studies that only focused on public health nurses, this research also sheds light on the experiences of private sector nurses. By doing so, it challenges the notion that all nurses are the same and instead acknowledges the diversity of their experiences. Through the insights, we can gain a better understanding of abortion service provision in the private sector, including stand-alone abortion clinics owned by nurses.

While previous research has focused on public health nurses, this study is novel with its additional focus on private sector nurses. This speaks to an anti-essentialist position, which does not assume that all nurses are the same. The experiences of nurses in this chapter cannot be encompassed in a single standpoint. The study gives unique insights into abortion service provision in the private sector including stand-alone abortion clinics owned nurses. I traced the career trajectories of two private nurse practitioners who own their abortion clinics to illuminate the complex barriers that they face which overlaps but also varies from that of nurses who provide abortion in public health facilities. Findings showing

47 M Foucault *The history of sexuality, Vol 2* trans R Hurley (1978) 102.

differential treatments between doctors and nurses is a good illustration of the role that power plays in constructing the discourse of competence and regulatory effects in limiting the skills and knowledge of nurses to challenge and uncover truths.[48] This contributes to the maintenance of hierarchies and solidifies the historically disadvantaged position of nursing viewed mostly as a female discipline as opposed to medicine as a male discipline.[49]

In the context of abortion service provision, there is a clear power dynamic between doctors and nurses that is based on their respective knowledge and expertise. This power dynamic reinforces historical hierarchies in the healthcare system, where nursing has traditionally been viewed as a female discipline and medicine as a male discipline. I argue that this power dynamic is further complicated by issues of race, class, gender, and other factors related to reproductive health. As the nursing profession continues to evolve and diversify, so too does the power and knowledge dynamic between nurses and doctors, highlighting the need for ongoing analysis and exploration of these complex issues. As we listen to the stories of nurses, it becomes apparent that their responses to their experiences vary. While each nurse's experience is individual, certain common themes, such as acts of resistance, emerge.

In contrast to this chapter, the upcoming chapter has a specific focus on conscientious objection and its impact on nurses' attitudes and motivations regarding termination of pregnancy services. This narrower scope allows for a more in-depth exploration of the factors that shape nurses' conscientious objection and how it affects their perceptions and understandings of abortion.

48 NJ Ford et al 'Conscientious objection: a call to nursing leadership' (2010) 23 *Nursing Leadership* 46.

49 A Lipp 'Challenges in abortion care for practice nurses' (2008) 19 *Practice Nursing* 326; G Andrews 'Nursing as emancipatory practice' in JD Jansen (ed) *Knowledge and power in South Africa: A critical perspectives across the disciplines* (1991) 163.