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Navigating a liberal abortion law: The tug of war for nurses

Fragments: Unpacking the context of abortion care provision by (some) South African nurses

Sister Tendani

There was a day when I was sitting at the information desk in the hospital when a young girl approached me, wanting to have an abortion. As a nurse, I had my own objections to the termination of pregnancy, but I didn't want to convince her not to do it. Instead, I gave her some advice and asked her about her reasons for seeking an abortion. She told me that she wanted to terminate her pregnancy because her friend had done it before. I questioned her further about why she had sex before marriage and why she didn't want to keep the baby. She didn't seem to have any valid reasons, so I proceeded to tell her about the potential complications that could arise from having an abortion. I explained that while the procedure itself might be safe, there could be long-term consequences that would affect her ability to have children in the future. I urged her to consider the implications of her decision, especially if she wanted to have a family later in life. The girl was surprised to learn about the possible complications associated with abortion, as she had been told that it was completely safe. I emphasised that while she wouldn't be physically hurt like those who undergo unsafe abortions, there were still risks involved. In the end, the girl decided not to go through with the abortion and instead started attending the antenatal clinic. She eventually gave birth to a healthy baby, and I felt grateful to have been able to offer her some guidance and support during such a difficult time.

Nurse James

In my personal experience, my baby girl was born healthy in December 2018. However, the mother of the child initially wanted to have an abortion despite my objections. She even asked me to accompany her to the facility where the termination would take place. Despite my opposition, I decided to support her and secretly hoped that something would go wrong, and the termination would not be possible. To my surprise, the facility kept postponing the procedure until the baby reached the point of viability, which was at 26 weeks, rendering the termination impossible. In addition to my objections, I secretly informed her family members about her pregnancy since she had not told them. They made sure to keep her from going anywhere and she was constantly supervised. Despite the challenging situation, I am grateful that my baby girl was born healthy and happy.

This chapter endeavours to illuminate the multifaceted ways in which nurses in South Africa exert their right to conscientious objection, interpret ethical guidelines, and construe their professional responsibilities as compassionate healthcare providers. Using a critical African feminist perspective, I explore the attitudes, opinions, and practices of nurses regarding abortion. The chapter draws on empirical data obtained through semi-structured interviews and focus group discussions with nurses. The study assesses how nurses interpret and implement abortion laws and their perceptions of women seeking abortion. Additionally, it examines the factors that shape nurses' motivations for conscientious objection related to termination of pregnancy services.

Nurses were asked about their views on abortion and women's reproductive rights, their perceptions of women seeking abortion services, their professional backgrounds, including their training, and their understanding of conscientious objection. The goal was to examine the legal, professional, moral, ethical, and religious factors that shape their work in abortion services. The following excerpt provides a representative summary of the narrative patterns that emerged from the research, while maintaining anonymity. The selection of data is based on how effectively the quotes expand our understanding of conscientious objection practices. It is important to note that while this account offers insight into nurses' beliefs and actions, it does not reflect the experiences of women seeking abortion services, which has been studied elsewhere.[1]

1 Practices of conscientious objection

In South Africa, healthcare providers can exercise conscientious objection to providing abortion services based on their religious or moral beliefs, even though it is not provided for in the Choice on Termination of Pregnancy Act. This is allowed under the constitutional provision on freedom of thought, belief, and opinion. However, providers still have a duty to inform women seeking abortion of their right to access these services and refer them to another provider or facility. It's important to note that healthcare providers cannot refuse to provide abortion services in case of a medical emergency, as stated in section 27(2) of the Constitution.[2] Therefore, nurses are obligated to provide assistance in such situations.

1 See for example, J Harries et al 'Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study' (2014) 11 *BMC Reproductive Health* 1.

2 See also Human Rights Committee, General Comment 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life, 3 September 2019, UN Doc CCPR/C/GC/36 (2018).

There is a lack of available data regarding the prevalence of conscientious objection to abortion. However, it has been estimated that in 2013, less than half of the approximately 260 designated facilities in South Africa provided abortion services.[3] In 2018, this number was estimated to be only 264 out of the 505 designated health facilities.[4] As a result of this shortage of health workers providing abortion services, some women may resort to informal or unsafe abortions.[5]

It is important to clarify that the research did not aim to determine the prevalence of conscientious objection to abortion. However, the data gathered sheds light on how conscientious objection is practiced. Out of the 33 nurses interviewed, seven stated that they do not support the provision of abortion as outlined in the law, while seven were uncertain, as their decision-making was ongoing and non-linear.[6] In private facilities, there were no objections, possibly due to their nature as abortion clinics. Particularly, I found that there was a general lack of understanding of the concept and practice of conscientious objection. A similar study conducted by Jane Harries and colleagues in Western Cape reported similar findings, highlighting that health professionals also did not have a clear understanding of conscientious objection.[7]

3 'Provincial Data: Tri-provincial workshops 2010 data National Department of Health South Africa' as cited in KA Trueman & M Magwentshu 'Abortion in a progressive legal environment: the need for vigilance in protecting and promoting access to safe abortion services in South Africa' (2013) 103 *American Journal of Public Health* 397.

4 Amnesty International 'Briefing: Barriers to safe and legal abortion in South Africa' (2016) 8 https://www.amnestyusa.org/files/breifing_barriers_to_safe_and_legal_abortion_in_south_africa_final_003.pdf (accessed 10 January 2018). See also Committee on Economic, Social and Cultural Rights, Concluding observations on the initial report of South Africa, 29 November 2018, UN Doc E/C.12/ZAF/CO/1 (2018) para 65.

5 R Hodes 'The culture of illegal abortion in South Africa' (2016) 42 *Journal of South African Studies* 79. See also KE Dickson et al 'Abortion service provision in South Africa three years After liberalization of the law' (2004) 74 *Studies in Family Planning* 374.

6 The data of 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 researcher). 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 health care 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.

7 Harries et al (n 1) 3.

The nurses generally showed a lack of familiarity with the concept and practice of conscientious objection. When they chose to absent themselves from performing the procedure, they did not use the term 'conscientious objection'. A nurse shared:

> Well initially I didn't know anything about people objecting to performing any services to patients or the community, but recently, I am back at school, so we have learnt about management and everything that has to do with medicine. So, it was brought to light that as a professional nurse, we all have rights, as like any other patient [sic]. So, we have the right to conscientious objection, with the meaning that we have the right to refuse to carry out duties or tasks that we feel we are not competent enough to perform, or we feel that they are not in line with our values or our beliefs. But then we have to make it in writing, where we notify our supervisors or a manager in writing, also stating the reasons why you don't want to perform a specific duty that is assigned to you, or that is part of your scope of practice.

Other nurse colleagues responded to the comment above:

> No [we have not heard about conscientious objection]. The reason being, [nurse above] has recently enrolled in her [Bachelor of Nursing Science] degree study, so we, in the hospital, we don't have a standing policy that has stated what she has just said. So, we're not aware of that in the hospital. Only, because she is from school, in her books and stuff, but here in the hospital, we don't have that. We don't have a standard policy that specifically states the reasons that she said to us now.

> So, that is why we have so many staff members refusing to perform the service, because of our own culture, we have different cultural beliefs and backgrounds and values. So, it's not to say, and we are not oppressed by the management, but the majority of the staff are refusing to perform the service, due to their own reasons.

There were no formal procedures or policies reported on the withdrawal or non-support of termination of pregnancy by staff. For example, some facility managers mentioned that nurses would refuse to engage in abortion services, but there was no official system for recording objections. Nurses who object to performing abortions were not required to register as conscientious objectors. There was also confusion between what constitutes obstruction of abortion services and conscientious objection.

> People have undergone training; the government spent a lot of money for training and when they come back, they do not want to provide the service ... No, not in this facility, but where I come from. I worked somewhere before. Two were trained but they do not want to implement the services.

When asked about how those who object to termination of pregnancy express their objections, respondents gave vague and unsubstantiated answers. It seems that if someone, including an abortion provider, wants to be excluded from providing or supporting TOP services, they inform their department head, facility manager, union representative, or the District Department of Health in an informal manner. There appears to be a lack of formal policies or procedures for conscientious objection, as indicated by an exchange with a facility manager:

> Interviewer: Do you have an Ethics Committee?
>
> Respondent: Not really. I'm trying to establish committees. I have started with the Quality Assurance Committee. So, we still have a long way to go.

There was a common understanding among the participants that individuals who are trained to provide abortion services but later refuse to do so, usually do it on religious grounds. One facility manager mentioned that some nurses who were sent for advanced training that included termination of pregnancy, later declined to offer abortion services due to their religious beliefs. The manager recalled that these nurses said they had found 'God' and could no longer support abortion services. This suggests that religious beliefs play a significant role in the decision-making of healthcare providers when it comes to the delivery of abortion services.

> Others have started to do this procedure on the line ... in the middle of the year, they just said they cannot continue with this anymore because they have taken God.

The data presented above suggests that the understanding and implementation of conscientious objection is uncertain. In some cases, it appears that conscientious objection is being used to resist abortion laws and the provision of legal abortion. Additionally, there is no formal process for recording objections or reasons given for objections, and there are no standardised policies or procedures for managing the practice. As a result, it is difficult to estimate the number of objectors or the grounds for objecting, but it is clear that poor knowledge of laws and regulations

plays a key role in nurses' perceptions of abortion, even in cases where the law is liberal.

2 Discourses on practical decision-making regarding the provision of abortion services

2.1 Professional duty and responsibility in relation to abortion services

Nurses who provided or supported abortion services considered it their professional duty, often based on personal experiences. They believed that legal termination of pregnancy was necessary to prevent unsafe abortions and save women's lives. According to a nurse in the public sector, her involvement in providing abortion services was crucial to prevent women from resorting to unsafe abortions:

> For a client to say, 'Sister I don't want this baby', you must listen to her. She will even tell you that 'if you don't terminate this pregnancy, I will see the outsiders who will give me medicine that will kill me'.

Nurses also stated that their motivation to provide abortion care was largely driven by the devastating consequences of unsafe abortion, which can result in morbidity and mortality. This sentiment was echoed by several respondents, as seen in the following quotes:

> My township experience and seeing black young women die from backstreet abortions motivated me to get trained and become a provider.

> I was going to say what makes [us] happy, as providers, we are the first, the number one prevention of maternal deaths in South Africa.

A number of nurses also reported that their personal beliefs and experiences played a role in their decision to provide abortion care. Many felt strongly about the right of women to make decisions about their own bodies and reproductive health. One private abortion clinic owner, for example, spoke about how her personal experience with an unwanted pregnancy led her to open her own clinic and provide safe abortion services:

> My 32-year-old friend had backstreet abortion and passed away. I set up a clinic dedicated to her life and safeguarding others to not experience the same.

These nurses are committed to saving lives and providing safe abortion services, as they are aware of the devastating consequences of unsafe abortion methods used and abortion pills sold by street vendors. They have witnessed the use of dangerous methods such as insertion of sharp objects into the vagina, physical manipulations of the womb, and drinking of herbal concoctions to induce abortion. These practices have been used in South Africa for over 150 years and are still prevalent today.[8] Health providers view their work as critical in addressing the consequences of unsafe abortion and are motivated by the desire to give women the right to make decisions about their bodies and reproduction. A nurse narrated:

> A 23-year-old lady from Zimbabwe was brought to casualty 3 weeks ago. She had a history of vaginal bleeding and abdominal pain. She tested positive for pregnancy. However, when we did an ultrasound, the uterus was empty, and the abdomen was flat. As we were not sure what happened, she was admitted for observation. She couldn't explain what happened because she could not speak any local language or English. The person who dropped her off mentioned that she was from Zimbabwe and later left her here. Few hours later due to abdominal and respiratory distress, a sonar was done again thereby leading to the discovery of accumulation of blood. She was then stabilised and transferred to the main hospital in Polokwane. During the operation, they found out that the uterus was perforated with a sharp object and she had bowel injury. She later passed away.

Another nurse also shared:

> A young girl came, it was two or three years back. So, she went through the queue and stuff, and she had big clothes on. You can't see anything is wrong with her, no pink nose or cheeks or anything. She stood up, the patients just move, thinking okay, the queue will move now. She went to the toilet. She went unnoticeably to the male toilet instead of the female. I guess when she sat down everything came out: big head and placenta. After that, she didn't even get into the consulting room, but luckily, she registered at the security gate. On night duty, no taxis, she walked, she fainted along the road somewhere. A patient came and asked whether we had torches. So, I think the patient went in and peed on top of the baby. There is no light, you know, because our poor maintenance also. We found her the next day. We had to call the mortuary.

8 H Bradford 'Herbs, knives and plastic: 150 Years of abortion in South Africa' in T Meade & M Walker (eds) *Science, medicine and cultural imperialism* (1991) 120-147.

In addition, abortion providers recognised the influence of the political and legal landscape on their perception of reproductive rights, as guaranteed by the South African Constitution. They understood the medical norms that required them to serve their clients, and they viewed women seeking abortion services as having agency and the right to make reproductive healthcare decisions.

2.2 Religious and cultural beliefs about abortion

From conversations with nurses, I find that the religious convictions and belief systems of nurses were found to have an impact on their decision to not engage in abortion procedures. Providers who objected to providing abortion services cited their Christian beliefs that abortion is against the ethics of killing:

> I'm against it because you will go and abort, you find that also because of my Christian belief, that's the main thing, my Christian belief … The belief is you are killing, and the Bible says you don't kill, because that person is a human being. According to the Bible, there is nothing such as a mistake. Everybody was a child, who has been conceived, God has got a purpose with that child, and you go, irrespective of the manner, you have conceived that child. God has got a purpose for that child.

> Well, I won't give advice to terminate the pregnancy. I will just speak to the parent, that they must decide what would be best for them, for the child, remember. Ja, but for advising a parent to terminate a pregnancy for a child, I can't also. I still feel religious and not comfortable.

A facility manager's description sets as forth:

> There are and others who have started to do this procedure on the line ... in the middle of the year, they just said they cannot continue with this anymore because they have taken God.

Another explained:

> What she is trying to say is some people [providers] don't want to be referred to as murderers, that's why they don't want to do it ... Yes, they believe it's killing.

Some respondents believed that pregnancy is a gift from God even in cases of rape:

> If it's an issue of rape, incest and things like that, I will advise that person to deliver the baby, give it up for adoption, rather than to kill.

The extracts suggest that the Christian discourse that considers abortion as a sin, aligns with the pro-life perspective that abortion is murder and violates the sanctity of life.[9] The religious arguments were not limited to Christianity but also included traditional African religions and mythologies, particularly in Limpopo province. One nurse provider acknowledged this difference and stated:

> We have been accused of being the reason why there is no rain, because we are doing abortion.

The Limpopo-based nurses highlighted a noticeable contrast in perspectives between individuals living in urban areas and those residing in rural areas, as they shared their experiences.

> They also don't believe like termination in their traditions … Abortion, they feel like it's not allowed in their traditions. We have got different kinds of traditions [sic].

> I think in also their cultures, because I think this thing of cultures and religion is one and the same thing, because they don't want to do the procedure. [They say]: 'My culture doesn't allow me to abort, or whatever.'

The quotes presented demonstrate how the objecting nurses used moral arguments to oppose abortion, drawing comparisons between it and religious and cultural taboos. The influence of cultural and traditional beliefs on attitudes towards abortion is evident. This aligns with the conclusions of a 2017 study, where the author noted a similar connection.[10]

> The African traditional epistemology views abortion as a taboo and its transgression is known to be punished by the earth spirit through shortage of agricultural products, famine, infertility, draught and illness. This punishment

9 See J Daire et al 'Political priority for abortion law reform in Malawi: Transnational and national influences' (2018) 20 *Health and Human Rights Journal* 225.

10 L Molobela 'Exploring black rural Bushbuckridge women's constructions and perceptions of the practice of abortion' MA thesis, University of South Africa, 2017, at 91 (on file with the author).

> may befall particular clan members, the whole family or everyone living in the village.

Although objecting nurses were of the belief that abortion was an unacceptable practice and often cited religion, abortion providers approached the issue from a different religious perspective. They argued that the Christian faith emphasises values such as compassion, humanity, and community, which align with providing access to abortion services. One of the nurse providers, who was also a pastor in her church, elaborated on this stance:

> Since I have mentioned that I am a preacher in my church, some of my colleagues at work they will say: 'But you are a preacher standing on the pulpit every Sunday. How do you feel?' I say: 'My conscience is very clear that I am not killing anyone. I am trying to serve the community, trying to reduce maternal death' and when they say to me: 'But it means you cannot see heaven' and I said: 'Have you ever been in heaven?' We cannot judge people. If somebody comes in and says she needs the service, if I can, I have to do that since I was trained, I have to do that.

Another reported:

> [B]efore I came for training I spoke to my reverend and he said to me because this thing is legalised and as a church we are sorry about what is happening outside, and each day the newspapers report that children are found wrapped in the plastic which it's trauma due to the public; then he said to me as long as you say you support this we are going to support you because this is a good work people are no more going to be traumatised by what we see on TV or what is reported on daily basis.

These two narratives demonstrate how discourse can be repurposed, as it is socially constructed and can be used to further different agendas. Here, the nurse providers used moral arguments to address the issue of unsafe abortions, which is typically associated with the pro-life movement.

Understanding different ideologies, whether political or religious, can help to illustrate how they are used to maintain power structures. Patriarchal societies are an example of such power structures which include institutions, belief systems, ideologies and behaviours that uphold

men's control over women's power of agency over their own bodies.[11] In patriarchal societies, women are often subordinated to men through the family structure, with men as the head of the household. This patriarchal discourse is often tied to traditional and religious beliefs and practices, which reinforces women's subordination.[12] This dichotomy between non-western and western states is illustrative of the differing views on gender roles and power dynamics.

The perspective of Marxist-feminism posits that patriarchal structures underpin the functioning of capitalism as an economic system.[13] Bell hooks employs the term 'imperialist white supremacist capitalist patriarchy' to refer to the interlocking political systems that serve as the foundation of politics and political structures.[14] In *The will to change,* she goes on to contend that the patriarchal system is sustained through various means, including the socialisation of men into dominant gender roles, the objectification and sexualisation of women's bodies, and the undervaluation of caregiving and other activities associated with femininity.[15]

The anti-essentialist perspective on patriarchy challenges the notion that the concept can be universally applied across cultures, which contests the oversimplified understandings of western feminism. This view recognises the interconnected and constantly evolving components of patriarchy as a system, rather than attributing it solely to individuals. Religious beliefs and practices play a significant role in reinforcing male dominance, particularly in relation to reproductive decisions, often through the authority of male religious and cultural leaders. For instance, the Catholic Church relies on priests, while some Protestant churches still regard fathers and husbands as spiritual heads.[16] In Islam, while all humans are viewed as equal before Allah,[17] gender roles are defined, with

11 T Braam & L Hessini 'The power of dynamics perpetuating unsafe abortion in Africa: A feminist perspective' (2004) 8 *African Journal of Reproductive Health* 45.

12 This resonates with the arguments of African theorists that African feminism did not come about as a reaction to patriarchal domination, which was central to western feminism. See G Mikell (ed) *African feminism: The politics of survival in sub-Saharan Africa* (1997) 5.

13 On how the patriarchal nature of the state allows for gender hierarchies to be reproduced, see C MacKinnon *Toward a feminist theory of the state* (1989) 161-162.

14 b hooks *The will to change: Men, masculinity, and love* (2004) 17-18.

15 As above.

16 KA D'Souza 'Abortion and the three bodies: An interpretive understanding of barriers to abortion access in South Africa' (2013) 1 *Journal of Undergraduate Anthropology* 8.

17 Quran verse 39:6 states: 'He created you from one being, then from that (being) He made its mate'.

men typically serving as heads of households and women responsible for child-rearing.[18]

Viewed through a feminist lens, religious and cultural arguments against abortion stem from traditional expectations about women's roles in reproduction and motherhood. Gender norms are rules that governs what is acceptable or unacceptable behaviours based on one's gender.[19] These gender norms constrain what behaviours are deemed acceptable based on one's gender, leading to social sanctions for those who do not conform. Motherhood is considered a key status symbol for women, making it the highest achievement in many societies. Consequently, when a woman decides to have an abortion, she is often perceived as rejecting this societal ideal.[20] This sanctioning of motherhood is part of patriarchal discourse and reinforces the belief that a woman's primary responsibility is childbearing and childrearing.

Abortion is often framed as a transgression against the traditional idea of motherhood.[21] This notion stems from the idea that women are primarily viewed as mothers rather than individuals with reproductive choices. As Martha Fineman and others argue, motherhood has been defined and shaped by male norms and legal definitions.[22] In many African societies, the regulation and control of women's sexuality and reproductive capacity has been used to ensure that women conform to prescribed roles of childbearing and homemaking. However, some African scholars caution against solely viewing motherhood through a western lens and acknowledge that women's autonomy can be celebrated in both public and private spaces.[23] Women's role of wife or mother does

18 Quran verse 4:34. See SS Ali 'Women's human rights in Islam: Towards a theoretical framework' (1997) 4 *Yearbook of Islamic & Middle Eastern Law* 117.

19 GL Darmstadt 'Why now for a series on gender equality, norms, and health?' (2019) 393 *The Lancet* 2375.

20 See P*lanned Parenthood v Casey* 112 S Ct 2791, 505 US 833, 120 L Ed 2d 674, 1992 US LEXIS 4751, 60 USLW 4795, 92 Daily Journal DAR 8982, 6 Fla L Weekly Fed S 663 (US 1992) 168-169. See also KT Bartlett, DL Rhode & JL Grossman *Gender and law: Theory, doctrine & commentary* 5th ed (2009) 692.

21 K Cockrill & A Nack '"I'm not that type of person": Managing the stigma of having an abortion' (2013) 34 *Deviant Behavior* 975.

22 MA Fineman et al (eds) *The neutered mother, the sexual family and other twentieth century tragedies* (1995) 38.

23 S Tamale 'Gender trauma in Africa: Enhancing women's links to resources' (2004) 48 *Journal of African Law* 50.

not necessarily limit women's agency.[24] It is in this line that Ifi Amadiume in *Male daughters, female husbands* argues that motherhood is a sacred and highly regarded aspect in African societies, where women's maternal power is associated with the fertility of the earth, making them crucial producers and providers, thus resulting in their revered status.[25]

While acknowledging the usefulness of presenting African women's maternity as reproductive autonomy, caution should be exercised against romanticising precolonial times as such depictions fail to recognise the constraints that traditional gender roles could impose on women, leading to a double bind on women seeking abortions and contributing to conservative sexual morality that punishes women for non-procreational sexual activity. According to Fitnat Naa-Adjeley Adjetey, cultural norms in Africa subordinate women and limit their reproductive choices, as their responsibility for reproductive labour is seen as essential to keeping the family bloodline alive.[26] Examining motherhood as reproductive autonomy should involve acknowledging it as a means of oppressing women, which portrays abortion as a violation of gender norms. The South African Constitutional Court acknowledges that motherhood can be a source of inequality for women, as it imposes a significant burden.[27]

Nurses utilise the motherhood mandate as a benchmark to make moral judgments of women who decide to have an abortion. There is an overwhelming sense that all women supposedly want to be mothers. The narratives show that when women make a decision to abort, as an indication of their agency, nurses sought to prevent this, in effect reinforcing patriarchal norms of motherhood as an essential aspect of women's lives.

2.3 On women – and the reasons (justifiable or not) for seeking an abortion

While personal, moral, and religious beliefs are often cited by those objecting to abortion, the majority of nurses who object base their involvement in abortion provision on the reasons for women seeking an abortion, acknowledging the complexity of the decision-making process.

24 The recognition of women's special role as mother is reflected in the article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) adopted 11 July 2003, entered into force 25 November 2005.

25 I Amadiume *Male daughters, female husbands: Gender and sex in African society* (1987) 191.

26 FNA Adjetey 'Reclaiming the African Woman's individuality: The struggle between Women's reproductive autonomy and African society and culture' (1995) 44 *American University law Review* 1351 at 1352.

27 *President of the Republic of South Africa v Hugo* 1997 (4) SA 1 (CC) para 38.

Objecting nurses often noted that circumstances such as rape, incest, and risk to the woman's health justify abortion, while still holding their personal views on the matter. For example, quite a number of objecting nurses stated that there were indeed circumstances – such as rape and incest, as well as risk to the woman's health – that justify an abortion. As one noted: 'I only think when it comes to rape, and also when it's, to me, that's kind of acceptable.' Others added:

> Yes, I think with me personally, I was like if you were raped, that's when you can go for abortion. Then something comes to me and says no man, 'God can't give you a trouble which you can't carry'. Then I'm like how are you going to carry that pregnancy for nine months, and then like you were raped? You get my point?

> If you are raped, you have to go to ask for help. There [are] emergency contraceptives. That's where we are going. Yes, if you are raped, you have to go and get emergency contraceptives, and if the emergency contraceptives fail, there is this thing called termination of pregnancy.

Nurses were also more sympathetic and supportive if it was an unplanned pregnancy of a minor due to rape:

> I think when a young girl, of any age, if she is raped, or if she has been molested by a relative or something, I will recommend it, but I'm not 100 per cent recommending it. It will be due to the rape, only the rape.

The few providers who suggested that there should be an exemption when it is 'affecting the health of the mother' observed:

> If it concerns your health, your health is at risk, then go through with it. That's the only reason for me, that I feel it's okay.

> It's medically indicated. I can support that one, because you are terminating the pregnancy because you are trying to save life. It's not that maybe you just want termination of pregnancy, it's not medically indicated, you just don't want the baby.

A critical feminist analysis of *situational objecting nurses*, nurses who object to abortion but make exceptions for certain circumstances, such as rape or risk to physical health, reveals underlying gender stereotypes about women and their perceived roles, with the implication that women without exceptional reasons for seeking an abortion are being put in their place. It is also important to note that these nurses' consideration for justifiable

reasons only extends to physical health and not mental health. In this case, if women do not have exceptional reasons for having an abortion, they would be put in their place.[28]

What is found from the types of arguments advanced by nurses as to *who deserves an abortion*, points to discursive constructions of women who seek abortion. Discourses produce interpretative lenses which shape nurses' beliefs, opinions and understandings.[29] The underlying premise of these discursive positions is also premised on the construction of women as mothers, as highlighted earlier. The reality is that nurses are human beings who live and reproduce norms of the societies in which they live and work.[30] They are not just norm-abiding rule followers or self-interested actors, but rather, their behaviour depends on the *individual,* on the *context* and on the *rules*.[31]

The nursing profession involves specialised knowledge and clinical practice that gives rise to actions of power, which aligns with Foucault's notion that power and knowledge are interdependent.[32] Nurses' knowledge and perspectives shape their attitudes towards women seeking abortions, and gender stereotypes influence their evaluation of which circumstances justify access to abortion services. For example, women who have experienced rape or have medical conditions are often portrayed as *deserving* and as victims, revealing the influence of societal norms on nurses' decision-making.

As deduced from the quotations, narratives of victimhood were common as a justifiable reason for women to access abortion services. The study shows that even if nurses object to abortion generally, they are willing to support abortion provision if a woman seeks an abortion that does not seem to be about demanding reproductive autonomy. Objecting or non-supporting nurses view reasons for abortion not valid unless they pertain to rape or sexual abuse. This has resonance with both the discourse used to support the enactment of the Choice on Termination

28 M Sullivan 'Stereotyping and male identification: "Keeping women in their place"' in C Murray (ed) *Gender and the new South African legal order* (1994) 187.

29 M Foucault *The archaeology of knowledge* trans AMS Smith (2012) 209.

30 SW Salmond & M Echevarria 'Healthcare transformation and changing roles for nursing' (2017) 36 *Orthopaedic Nursing* 21.

31 Emphasis added.

32 M Foucault *Discipline and punish* (1977) 27-28. See also RR Sepasi et al 'Nurses' perceptions of the concept of power in nursing: A qualitative research' (2016) 10 *Journal of Clinical and Diagnostic Research* LC10.

of Pregnancy Act,[33] as well as the pro-choice movement's approach for abortion reform in restrictive settings.[34] From this perspective, women seen as victims of sexual crimes should be allowed to have an abortion since they are blameless and their request is *not a choice against motherhood*.[35] According to this position, these women must be granted limited access to abortion services because it is a painful choice for them to make in light of devastating events that occurred. Abortion within this trauma discourse becomes morally acceptable, which discredits abortion as a normal procedure in women's lives.

While it is understandable that the victimhood argument could potentially elicit empathy from nurses who do not support abortion, it ultimately perpetuates harmful stigmatisation of women who seek abortion for other reasons. It is important to note that the majority of women seeking abortion do not do so because of sexual assault or rape. In fact, research has shown that reasons for seeking abortion vary widely, including financial instability, inconvenient timing, relationship problems, lack of education, and contraceptive failure.

Furthermore, it is crucial to recognise that women who do become pregnant as a result of rape or sexual assault should not be reduced to mere victims, as they are exercising their agency and autonomy in making decisions about their reproductive health. The tendency of nurses to make exceptions based on medical indications may not necessarily support women's autonomous right to access safe abortion, but rather reinforces the societal expectation that women's worth is tied to their role as mothers.

The discourse of victimhood creates a framework that excludes women who have not experienced sexual violence or have medical reasons as not having a justifiable reason for seeking an abortion. This framework fails

33 As one Member of Parliament (MP) in expressing support painted this scenario for parliamentarians to keep in mind: 'Raped women, girls who are sexually abused by their fathers, divorced women who are still expressed and abused by their ex-husbands without realising that this is rape and the divorced independent woman, a woman with five children.' See Republic of South Africa 'Choice on Termination of Pregnancy Bill – Second reading debate' (1996) 16 *Debates of the National Assembly (Hansard) – Third session – First Parliament* (29 October to 1 November 1996) 4796.

34 T Feltham-King & C Macleod 'How content analysis may complement and extend the insights of discourse analysis: An example of research on construction of abortion in South African newspapers 1978-2005' (2016) 15 *International Journal of Qualitative Methods* 1. See also M Berer 'Abortion law and policy around the world: In search of decriminalization' (2017) 19 *Health and Human Rights Journal* 13.

35 Emphasis added.

to recognise that women have the right to make decisions about their own bodies and reproductive health, regardless of the reasons behind them.

2.4 On contraception and 'repeat abortions'[36]

The narratives gathered from nurses who object to providing abortion services consistently highlighted the connection between contraception and abortion. Nurses seemed reluctant to make concessions on their moral beliefs, largely due to how they perceived women who sought abortions.

> So, if you do unprotected sex today and you want termination of pregnancy, to me yes, it is like killing.

Nurses reported difficulty dealing with the lack of responsibility displayed by the patients.

> 'Do it because I made a mistake. I didn't use a condom, I don't want to be pregnant', I don't support that one, I don't think I can support it.

Another stated:

> I think people who should not be allowed to do terminations, for someone who is above 22 years, and that person knows about contraception. So why terminate the pregnancy? And for somebody who says ok I was in love with this person, and I discovered that this person is a gangster, what does that have to do with terminating a pregnancy? Yes, he is a gangster, but does that mean termination has to do with being a gangster and your baby will also be a gangster? This thing of saying the blood runs through the veins, no I do not believe in that. If you believe that your boyfriend is a gangster, why did you have unprotected sex with him instead of saying no my boyfriend is a gangster and I do not want to have a child with a man who is a gangster? No, that's not [right] and for a person who is having two kids and she is on the third pregnancy and decides to terminate, why? Because you went through all those two pregnancies and now you want to terminate, it's not fair. Just leave the people who were raped, those cases, allow them to have termination of pregnancy, not just that I wake up today and decide that I no longer want to keep

36 This study uses the phrase 'repeat abortion' where necessary, when nurses use it to describe women who are considered 'deviant' because they are having more than one abortion. This study uses it with no intention of harm. While this study acknowledges that using the plural 'abortions' is a valuable way to destigmatise the idea of having more than one abortion experience, at the same time phrases such as 'multiple abortion' might be useful to explain the needs of people with different experiences.

> this child, no that is not fair. But for the person who was raped, yes, I would also encourage that one.

The prevailing perception among nurses was that women who sought abortion were using it as a form of contraception, especially in cases of suspected 'repeat abortions':

> I am also of the same view because now since it's been legalised, and also the age, wherein you can start terminating pregnancy, young girls are using it as a means of contraception [sic].
>
> ...
>
> I think we have heard instances where we have had patients coming for antenatal booking and they had like five abortions before. Then you are asking, termination of pregnancy times five, what was happening? It's not like they are teenagers, or they did that when they were teenagers. They were well aware of what they were doing. In most instances, they will tell you, 'no, family planning doesn't go well with me'. So when you try to educate at that point that you know there are other types of family planning that you don't know that you are supposed to know about that could have helped you, then that's the only time they will understand. But even the attitude of the community towards family planning, that's why we are getting those termination of pregnancies that will be following each other every year.

Nurses often cited the example of young women who seek abortion services repeatedly and refuse education on contraception. These women were deemed to be sexually promiscuous, using abortion as a means of contraception.

> [T]hese young females, they love sex and they do not protect themselves and they are busy terminating pregnancies.

The belief that women seeking abortion are using it as a form of contraception was evident in the response of a nurse who objected to providing abortion services when asked if she would refuse to provide post-termination of pregnancy care:

> I think I will counsel that patient, because it will help not for her to go and fall pregnant again, come back again and terminate. I will talk to that person to make sure that will be the first and the last. Then I will counsel, give options of contraceptive methods that are there,

> so she can make a choice if she wants to continue having sex before marriage. I will counsel the patient.

Based on the narratives, it was a widely held belief that an increase in 'repeat abortions' was due to women's refusal to use contraception properly. This was seen as unacceptable by the nurses:

> Some patients come several times to do TOP. At first you can say it's a mistake, but the second time, the third time? You are just saying you are not protecting yourself. We are encouraging unprotected sex, which comes with HIV, which comes with STIs, you know.

> ---

> [I]t is just that I think you put it in different baskets, if I can say that, that there is that group of people that are terminating because they are using termination as a form of family planning. Those people are the ones that I would say I do not know if we are educating them. I am sure [nurse provider] is educating them after each and every time that they come here, but then four or five months later, those same people are here again. So, those people, I do not know what needs to be done or how they can hear us if we say there is family planning. Even if [they are given] family planning, they will use it for the time being, and then forget about it, to fall pregnant again.

Despite the prevailing belief among some nurses that women seek repeat abortions due to their failure to use contraception, there were opposing views. Some nurses acknowledged the need to take into account the specific circumstances of women who seek multiple abortions. These nurses cautioned that factors such as frequent relocation, lack of access to reliable family planning methods, poorly trained healthcare providers, and negative attitudes from health professionals could contribute to women seeking multiple abortions. Such nurses advocated for a more comprehensive approach to reproductive healthcare that takes into account the complex realities faced by women seeking abortion services.

> Besides the fact that the community has attitude towards family planning, I partially blame our health services. Most people are denied access to family planning in some of the clinics. You will find a woman saying she went maybe, I am sorry to point out, but most clinics in Soweto. They deny most people access to family planning.

While another added that:

> You come at two o'clock, they tell you that it's late, come back tomorrow in the morning. In the morning you come there, it's a one-stop service. They will tell you that they are busy with immunisations, they are busy with a clinic, come back later. When they come back later again, it's the same story, that it's in the afternoon, or they are on long tea breaks and whatever. These are the actual formal complaints that we hear from the people in the community. So, that's why I'm saying I partially blame the health services as well. Or they will be saying they don't have stock of Depo or Noristerat or whatsoever, then they end up being resistant to go for family planning, or the attitude of our nurses in the family planning departments. So, I think that needs to be looked at as well.

One provider reported instances in which women seeking termination were not actually pregnant, possibly due to lower-ranked nurses not following proper procedures during pregnancy tests. An independent provider had to turn away a client who had come for the fourth time, despite being counselled on contraceptive use and referred to a social worker.

Furthermore, some providers expressed the belief that abortion was promoting promiscuity among young women, who were not taking responsibility for the potential consequences of unprotected sex, such as pregnancy and HIV. An objecting nurse cited this as her reason for objection:

> Yes, I'm objecting because it promotes the young kids to have sex at an early age, which will lead to early pregnancies, high rates of HIV. So, some of the young girls are using this as family planning. They just have sex, knowing that they will go to the government institution, it's free to do it … So, they have sex at an early age, knowing that there's nothing that can block them. So, they are no longer afraid of HIV, STIs and other health hazards. They just do it.

Others also noted:

> [B]ecause some, the reason is because it's not my husband's child. My husband works away, I was just cheating with another man, and I don't want him to find out.

> Some of them [trained TOP providers] when you ask them, it's their beliefs, they will tell you about their Christianity does not allow them to do that. They can only do that if maybe it's the emergency cases only, if they are forced to save a life but voluntary if the person just comes, just goes and sleeps with a man, and gets pregnant and comes and terminates, they won't attend to that. Even doctors, some of them don't want to do it.

Nurses expressed concerns regarding the impact of abortion on women's fertility and their ability to conceive in the future. They believed that abortion posed a threat to women's reproductive health and could potentially cause infertility.

> [Abortion] can be safe, but then later on it is possible that you might not fall pregnant, you will be married, and your husband will be looking to start a family, what are you going to do?
>
> ---
>
> Me, I won't think it's a good thing to kill a baby. Why, because you can find it's a firstborn, and then you kill that baby, then in the future you find somebody, then you want to marry him, then you can't make another baby.

A nurse shared her experience of stepping in to address future concerns related to abortion. She recounted a situation where a young woman came to the clinic:

> Nurse: I said how old are you, and then she told me. I said do you want to do it, or maybe you want to ask for anyone else. She said no, I want to do it. I was like okay, I didn't want to go further, but I became so emotional. I said: 'You are so young. Have you thought about this thing?'
>
> Interviewer: What did she say?
>
> Nurse: She said: 'Now Sister, you are scaring me off now. What should I expect?' I said: 'I don't know what's going on there. I have never done it before, but I'm asking you, have you thought about it, because when you are doing abortion, it's like the child is there, the foetus is there. You want to get rid of the foetus?' Then she said, 'I don't have a choice, because I'm at school, and then my boyfriend, I don't know where he is, so I need to do it'. She wanted to cry by that time, and then I said okay, let me not go further, and then I directed her. I said:

> 'But when you get there, please think about it. There are so many options; you can talk to your parents about it. Maybe they will say okay, we will accept the child, or maybe they will say to you, let's take the child to the social workers, and if you have got any other problems, you can even come to us, to me, I will refer you to the social workers and then you will make a good decision'. Then she said to me: 'But time is not on my side because there is a cut off period'. I said: 'Oh, I know about that, but please think about it', and then I directed her, and then she went.

The narratives primarily reflect arguments that focus on the consequences of contraceptive misuse and the potential implications of undergoing an abortion. Women who seek abortions for reasons other than contraceptive failure or who seek abortions multiple times are viewed as irresponsible and deviant. Such attitudes perpetuate negative stereotypes about women, who are often discouraged from engaging in non-procreative sexual practices of pleasure and desire. Consequently, nurses are less likely to sympathise with women who seek abortions for reasons related to contraceptive failure or who do not use family planning methods consistently and correctly.

The negative attitudes towards women seeking abortion services are especially pronounced for young, unmarried black women, who are deemed irresponsible and immoral for engaging in non-procreative sexual activities. These negative stereotypes reflect a belief that the availability of abortion services encourages promiscuity and irresponsible behaviour, which are deemed unacceptable, particularly for adolescents.[37] Those nurses who object to providing abortion services believe that teenagers should abstain from sexual activity until marriage as it is morally wrong. They also hold the view that young women should not have access to abortion services, as it could encourage early sexual activity and increase the risk of contracting HIV.

In addition, nurses perceived women who have had one or multiple abortions differently. The term 'repeat abortions'[38] creates a binary categorisation, leading to negative stereotypes and othering of women who have had multiple abortions. Nurses who hold this belief view these

37 A Müller et al '"You have to make a judgment call" – Morals, judgments and the provision of quality sexual and reproductive health services for adolescents in South Africa' (2016) 148 *Social Science & Medicine* 71; K Wood et al 'Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa' (2006) 14 *Reproductive Health Matters* 109.

38 Discussion on this, see L Hoggart, V Newton & L Bury '"Repeat abortion", a phrase to be avoided? Qualitative insights into labelling and stigma' (2017) 43 *Journal of Family Planning and Reproductive Health Care* 26.

women as irresponsible and deviant, often due to the assumption that they are using abortion as a form of contraception. A nurse is quoted as saying that there is no justification for abortion given the availability of family planning and emergency contraception.

There were different views regarding emergency contraception among the nurses. Some nurses couldn't understand why women wouldn't use emergency contraception as a preventive measure against unwanted pregnancies, while others were afraid that promoting emergency contraception would discourage women from using long-term contraceptive methods. This complicated debate over contraception goes beyond the portrayal of women seeking abortions as irresponsible and is likely influenced by the economic and structural challenges faced by these women. Additionally, the lack of widespread promotion and misinformation about emergency contraception may contribute to its perceived abortifacient properties.

3 Implications of negative stereotyping and contradictory discourse

In this chapter, I begin with the premise that although legal changes may permit women to access abortion, healthcare professionals' attitudes, including nurses, can still create barriers. I aim to provide insights into the lives of nurses and the subjective experiences they navigate in the provision of legal abortion care. To achieve this, I integrate multiple dimensions of their realities, including their actions, feelings, and perceptions, as well as their relations of power.

The Democratic Nursing Organisation of South Africa (DENOSA) during its submission to the Parliamentary hearings on the Choice on Termination of Pregnancy (CTOP) Amendment Bill,[39] noted the role of nurses in abortion provision:

> As the major representative body of nurses in South Africa, who are mostly women faced with the same challenges that the Act is trying to address, it is right and proper that while we advocate as a union, we should not [lose] sight of the fact that these providers of health care, who form the majority of the health service providers, are women who also have the right to choice about their own reproductive health.[40]

39 Act 21 of 2007.

40 Submission by the Democratic Nursing Organisation 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).

The work involved in providing abortion care creates interactions that reinforce various power relations. Hospitals function as a space where different forms of power dynamics, including vertical and horizontal, are reinforced, thereby perpetuating social and bureaucratic hierarchies within the hospital setting. Nurses hold significant power, not just in disciplining patients but also in subjecting them to surveillance and normalisation. This behaviour can be seen as a manifestation of 'oppressed group behaviour', as described by Margareta Dahl.[41]

Judith Butler's theory on performativity is useful in offering a lens through which to explore power while putting gender at the centre of such analysis.[42] Nurses through the act of performance of their duties, enact the convention of reality. Butler explains this by stating:

> The act that one does, the act that one performs, is, in a sense, an act that has been going on before one arrived on the scene. Hence, gender is an act which has been rehearsed, much as a script survives the particular actors who make use of it, but which requires individual actors in order to be actualized and reproduced as reality once again.[43]

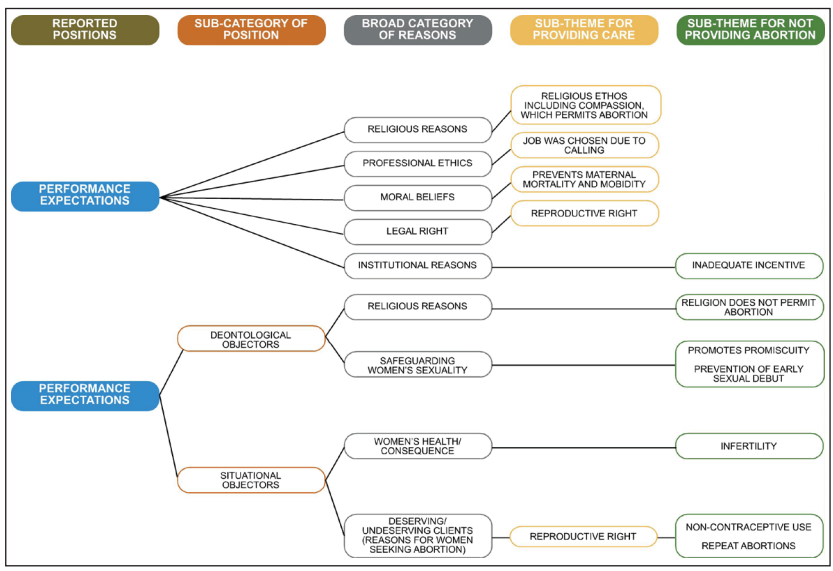
Insights from the aforementioned findings highlight how nurses mirror and perpetuate societal norms within their working and living environments, as evidenced by the differing discourses utilised by both providing and objecting nurses (and even within those groups). It is evident that power dynamics underlie nurses' articulation of these discourses. This chapter has elucidated the often-contradictory motivations and justifications behind non-providing nurses' decisions. Religious beliefs and perceptions of the 'good' or 'bad' nature of abortions based on women's reasons for seeking the service both influence nurses' willingness to provide abortion care. The themes and sub-themes identified in this study are summarised in Table 1 below.

41 M Dahl 'Nurses: An image change still needed' (1992) 39 *International Nursing Review* 12.

42 See J Butler *Gender trouble: Feminism and the subversion of identity* (1999).

43 J Butler 'Performative acts and gender constitution: An essay in phenomenology and feminist theory' in SE Case (ed) *Performing feminisms: Feminist critical theory and theatre* (1990) 272.

Table 1: Overview of deployed discourses



This research, despite having a limited sample size, sheds light on the intricacies of abortion practice. It reveals that the behaviours exhibited by nurses in relation to abortion provision cannot be solely attributed to conscientious objection. Instead, nurses who do not provide abortion services should be identified as 'non-providers' rather than 'conscientious objectors', as they hold distinct perspectives on abortion services. Since morality is not a fixed concept, the narratives of non-providing or objecting nurses can be characterised from two primary perspectives.

The first viewpoint among nurses who object to providing abortion services is that of a small group who hold a firm opposition to termination of pregnancy based on an absolutist doctrine rooted in religious beliefs. They believe that abortion is immoral, and their conviction is based on the notion that God forbids the taking of human life. Therefore, according to this perspective, abortion is a violation of the moral law, which states: 'Thou shalt not kill'. This perspective aligns with the stance of many of the world's major religions, which consider abortion as murder. These nurses view their moral obligation to respect this moral law as being rooted in deontological ethics that place value on human rationality.[44] In line with Kantian theory, nurses who hold an absolutist view against abortion

44 See HJ Gensler 'A Kantian argument against abortion' (1986) 49 *Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition* 83.

are only concerned with the nature of right and the moral content of actions.[45] These nurses believe that it is never morally acceptable to perform or assist in an abortion, regardless of the consequences. They ignore the outcomes of their decision not to provide abortion care. For them, abortion is always wrong, and the principle of universality applies, meaning that ethical judgments apply to every situation involving pregnancy, regardless of the circumstances. Thus, even in cases of rape, where a woman becomes pregnant, they believe that abortion is not justifiable, as the baby can be given up for adoption instead. They argue that there is no need to resort to abortion under any circumstances because it is intrinsically bad.

The majority of non-providing abortion nurses in this research take a different approach compared to the absolutist doctrine. Instead, they can be categorised as 'situational objectors' based on their narratives that exemptions should be made. Their decision-making is affected by contextual factors rather than their individual religious beliefs or cultures. These nurses apply situated moral judgments to determine when abortion is appropriate or not. For instance, nurses contextualise morality when deciding who deserves an abortion. They base their decision on a backward-looking stance or a consequentialist position. Women who have been raped or have a medical condition that is risky to their life or health are deemed deserving of support, while women with weak reasons such as contraceptive failure are not. This approach aligns with the relational ethics of care. A member of parliament (MP) expressed a similar sentiment during parliamentary debates on the Act, stating:

> The Bill challenges the legal rights of parents, guardians and husbands, it promotes promiscuity and irresponsibility amongst our teenagers. It destabilises trust between married couples, and I foresee a great degeneration in family life as we know it today.[46]

Interestingly, in this study, socio-economic reasons did not emerge as a significant factor in determining the willingness of nurses to provide or assist with abortions, although another study has shown that it can be a relevant factor.[47]

45 LC McDonald 'Three forms of political ethics' (1978) 31 *The Western Political Quarterly* 7.

46 Republic of South Africa 'Choice on Termination of Pregnancy Bill- Second reading debate' (1996) 16 *Debates of the National Assembly (Hansard) – Third session – First Parliament* (29 October to 1 November 1996) 4796.

47 See J Harries et al 'Health care providers' attitudes towards the termination of pregnancy: A qualitative study in South Africa' (2009) 9 *BMC Public* Health 1.

On the other hand, the consequentialist perspective on abortion suggests that it should be avoided due to its potential negative consequences. As seen earlier, some nurses expressed concerns about the alleged risks of abortion, such as infertility, which could contribute to a culture of fear around reproductive health. This undue focus on risks associated with abortion has an unwarranted impact on women's decisions about whether or not to terminate a pregnancy. It is also not consistent with the responsibility of healthcare providers to offer evidence-based and non-judgmental information and care regarding sexual and reproductive health.[48]

These nurses' display of paternalism reflects a return to the idea of medical professionals having all the knowledge and power.[49] Women seeking abortions are not seen as capable of making decisions for themselves, based on a gendered belief that they are not fully informed about the potential implications and consequences of their choice. The concern of these nurses is that unrestricted access to abortion can lead to undesirable consequences. As previously mentioned, one of their main worries is that women may use abortion as a form of contraception despite the availability of other family planning methods. This perspective is similar to that expressed by a member of parliament (MP) from the National Party (NP) during the deliberations of the Choice on Termination of Pregnancy Act:

> I, for one, and my party agree that the only way to improve living standards in South Africa us to improve our economy and introduce an effective system of family planning. However, we in the NP are totally opposed to the use of abortion as a method of birth control.[50]

Non-providing nurses believed that women who did not effectively use contraception were irresponsible and therefore turned to abortion as a solution. Most of these nurses considered abortion acceptable, but having multiple abortions was viewed as deviant behaviour that needed to be corrected.[51] However, it was unclear whether women were having multiple abortions due to reluctance, inadequate knowledge, or limited

48 African Commission on Human and Peoples' Rights, General Comments on Article 14(1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2012) para 26.

49 S Sheldon 'The decriminalization of abortion: An argument for modernisation' (2016) 36 *Oxford Journal of Legal Studies* 334.

50 Republic of South Africa 'Choice on Termination of Pregnancy Bill – Second reading debate' (1996) 16 *Debates of the National Assembly (Hansard) – Third session – First Parliament* (29 October to 1 November 1996) 4794.

51 M Nussbaum *Sex and social justice* (1999) 63.

access to contraceptives.[52] Some nurses admitted that younger providers lacked the necessary competency in family planning provision, delivery, and counselling. Others noted the limited role of the state in ensuring the provision of effective and comprehensive family planning services. Stock-outs of family planning products such were also a common issue in public facilities.[53] As a result, it is necessary to examine the quality and effectiveness of family planning and post-abortion counselling services.

The research shows that nurses' moral or religious beliefs have an impact on women's health, specifically their ability to access safe and legal abortion services. This is because their beliefs reinforce the stereotype that 'womanhood equals motherhood'. The value judgments made by these nurses reflect their exercise of paternalistic control, which can include influencing women not to have an abortion or using their own discretion to decide when to 'allow' women to terminate their pregnancies.

The evidence presented here supports the claim that social and institutional factors, in addition to legal ones, contribute to and shape nurses' perceptions of womanhood and its connections to abortion. This chapter's findings acknowledge the possibility for nurses (in this case, women) to act as agents of patriarchal power against other women.[54] Since power is dispersed and relational, any group or individual can wield it. The nursing profession, with its specialised knowledge and clinical practice, thus becomes a vehicle for the exercise of power. The patient-nurse relationship is already fraught with gendered assumptions based on the patient's presumed role as a mother, creating a situated power relationship. Nurses, through their performance of certain acts, reinforce the conventions of reality, such as the normativity of motherhood and the condemnation of pre-marital or transactional sex, making these seem natural and necessary.[55]

In a Foucauldian sense, nurses engage in discourses that do not solely belong to them. They deploy normalising techniques that create an ideal standard to which they and women seeking abortion services must conform. Through this process, as witnessed from the narratives, women who do not adhere to gender norms are penalised and sanctioned. Such

52 See F Lang et al 'Is pregnancy termination being used as a family planning method in the Free State?' (2005) 47 *South African Family Practice Journal* 52.

53 See Medical Brief 'Birth control stock-outs remain a problem in SA' (6 March 2019) https://www.medicalbrief.co.za/archives/birth-control-stockouts-remain-problem-sa/ (accessed 5 May 2022).

54 b hooks *Feminist theory from margin to center* (1984) 85-87.

55 J Butler *Gender trouble: Feminism and the subversion of identity* (1990) 28.

tactics of organised mentalities aim to domesticate women even when they choose not to exercise their perceived reproductive role of procreation within a framework facilitated by the law. Nurses construct women who seek abortion services as sexually irresponsible, adopting a punitive stance to punish them for their perceived promiscuity. These actions are at odds with the notion that women's access to abortion is grounded in free choice.

In summary, the way in which nurses perceived women and their motivations for seeking abortion services was based on an oversimplified view of the 'universal woman' that failed to consider the complex range of factors that contribute to a woman's decision. It is crucial to recognise the intersectionality of race, gender, and class, as well as other factors such as age, socio-economic status, sexual orientation, and disability. The influence of African mythologies and cultural norms on black women nurses, demonstrates the importance of contextualising intersectional effects.

4 Concluding reflections

In this chapter, I have delved into the practice of conscientious objection among nurses in Gauteng and Limpopo, South Africa, showcasing the discourses and practices that nurses rely on when making decisions about women's access to safe and legal abortion services. The discussion illustrates that the practice of not providing abortion services is indeed prevalent, but due to the lack of standard registers, it is challenging to determine the full extent of this phenomenon.

Unfortunately, the portrayal of women seeking abortions as victims and irresponsible individuals oversimplifies the complex realities of women's lives in South Africa. Moreover, nurses' objections are not solely based on conscience, but also on political beliefs, cultural norms, stigma and discrimination, and inaccurate medical knowledge and evidence. What is most concerning is that despite the liberalisation of abortion over two decades ago, nurses continue to act as gatekeepers, deciding who can and cannot access abortion services based on their own subjective views of whether the reasons for seeking an abortion are 'good' or 'bad'. This perpetuates patriarchal norms of motherhood and reinforces the paternalistic control over women's bodies.

While this chapter has focused primarily on nurses' attitudes towards abortion and conscientious objection, the next chapter will delve into the legal and ethical scope of conscientious objection. Drawing from international human rights law and comparative law, I will prescribe the approach that the courts should take in developing judicial interpretations

on the exercise of conscientious objection and reproductive rights. It is crucial to safeguard respect for women's reproductive autonomy and human dignity when they seek abortion services, and I believe that a clear and nuanced understanding of conscientious objection is essential to achieving this goal.