

**NURSES' RELIGIOUS AND CULTURAL
BELIEFS AND ITS INFLUENCES ON
HEALTHCARE PROVISION FOR WOMEN
SEEKING TERMINATION OF
PREGNANCY: A CASE STUDY OF
GREY'S HOSPITAL**

By

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November 2014**

DECLARATION

As required by University regulations, I hereby state unambiguously that this work has not been presented at any other University or any other institution of higher learning other than the University of KwaZulu-Natal, (Pietermaritzburg Campus) and that unless specifically indicated to the contrary within the text it is my original work.

HONEST MANGENA

28 November 2014

As candidate supervisor I hereby approve this dissertation for submission

DR. F. G. SETTLER

28 November 2014

CERTIFICATION

We the undersigned, declare that we have abided by the College of Humanities, University of KwaZulu-Natal's policy on language editing. We also declare that earlier forms of the dissertation have been retained should they be required.



GARY STUART DAVID LEONARD

28 November 2014

HONEST MANGENA

28 November 2014

DEDICATION

I dedicate this study firstly to my mother and my father who have passed on. I continue to cherish the love, nurturing and inspiration you both shared with us as a family. I will always remember you saying to us “Go to school and learn more.”

I am grateful also to God for the wisdom and power granted me in order to carry out and complete this study.

Last, but not least, I dedicate this work to my wife-to-be and my family, for their appreciation, kind-heartedness, love and care that has provided me with much confidence and inspiration to work hard for further academic achievement.

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ABSTRACT

The political liberation of South Africa in 1994 gave its people the right to freedom of expression, thought and religion. This has led to the promulgation of the Choice of Termination of Pregnancy Act of 1996 (Act No. 2 of 1996) in order to promote the freedom of women and give them agency over reproductive health. The Choice of Termination of Pregnancy Act not only promoted reproductive health among women, but it also shaped the outlook of nursing practice to ensure that the termination of pregnancy service is translated into good nursing practice at public hospitals across the country.

This study, which is qualitative in nature, explores nurses' religious and cultural beliefs and its effect on healthcare provision to women seeking termination of pregnancy services at public hospitals. Six nursing professionals involved in termination of pregnancy services at a public hospital were interviewed as research participants in the study with the aim of obtaining individual opinions regarding its provision and the significance and impact of their religious convictions in service delivery at a public hospital.

The thematic analysis method was used to interpret and analyse the data received and to reach conclusions and recommendations for the study. The major themes that emerged from the research participants were as follows: (i) personal conviction and preferences in addressing issues such as an ethics of care and a human rights discourse in public health; (ii) social attitudes about termination of pregnancy, covering issues such as affirmation, acceptance or stigmatisation in regard to termination of pregnancy; (iii) the religious convictions of nurses and the termination of pregnancy and the extent to which religion is a deficit or asset in its provision at public hospitals in South Africa.

Key Terms: *Agency; Backstreet abortions; Choice of Termination of Pregnancy Act; Cultural beliefs; Ethics of care; Gender; Gender and health; Gender and religion; Registered nurse; Religion and health; Religious beliefs; Reproductive health; Social responsibility; Termination of pregnancy; Unauthorised hospitals; Unsafe abortion.*

GLOSSARY OF ACRONYMS AND ABBREVIATIONS

ARHAP	African Religious Health Asset Programme
ATR	African Traditional Religion
CTOP	Choice of Termination of Pregnancy Act (1996)
HPCSA	Health Professions Council of South Africa
KZN	KwaZulu-Natal
MSF	Médecins Sans Frontières/Doctors Without Borders
RN	Registered Nurse
TOP	Termination of Pregnancy
UKZN	University of KwaZulu-Natal

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CHAPTER ONE

BACKGROUND INFORMATION AND LOCATION OF THE STUDY

1. Introduction

This introductory chapter presents a concise background and motivation for the study. I introduce the study by locating it in a particular context and spelling out the objectives and research questions. I also present the significance of the study and provide definitions of the key terms used within the text. The purpose of the study is to explore how nurses' religious and cultural beliefs influence the provision of healthcare services to women seeking termination of pregnancy [TOP]. With regard to my research topic, I locate TOP as the main axis of reproductive health for women. Due to the nature and sensitivity of the study, I use the terms 'termination of pregnancy' and 'abortion' interchangeably. That said, I am aware that 'termination of pregnancy' is a much less judgmental term than 'abortion.' I conclude this introductory chapter by providing an outline of each of the chapters of the study.

2. Background Information, Motivation and Location of the Study

This study is conducted in one of the hospitals located in the Midlands region of the Province of KwaZulu-Natal (KZN). This province has the largest population of women as compared to the other South African provinces (Harrison, *et al.*, 2000:224). Researchers like Constant (2014:303) and Harrison (et al 2000:425) acknowledges that within KZN province there is strong opposition to the termination of pregnancy (TOP) as a medical procedure. According to a research conducted by Constant there is a high number of women seeking TOP services from traditional healer in KZN (2014:302). According to Harrison many healthcare professionals choose not to work in service related to assisting women seeking TOP in public hospitals (Harrison 2000:224). The reasons for not healthcare professionals choosing not to work with

TOP are multifaceted, ranging from cultural and religious beliefs, to that of personal opinion or preference.

In South Africa, the majority of people are aligned to religious faith groups. While adherents of the Christian religion make up 79.8% of the population, devotees of the other religious groups number as follows: Islam 1.5%; Hinduism 1.2%; Judaism 0.2%, and African Indigenous Religion 0.3%. The rest of the population are classified as follows: No religion 15.1% and Undetermined 15.1% (Pocket Guide to South Africa 2011/12:11). These statistics suggest that the majority of people living in KwaZulu-Natal are of a religious persuasion. The Demographic Population Census conducted between 1996 and 2001 revealed that the people in KwaZulu-Natal were religious, where the majority were adherents of the Christian faith. According to Statistics South Africa (2001:24), “in 1996, approximately 5,6 million people in KwaZulu-Natal were classified as belonging to a Christian religious group of one kind or another, compared to 6,8 million in 2001.” The position of any of the religious traditions on the provision of TOP is indirectly and directly responsible for the shaping of nurses’ understanding of TOP, as well as their attitude towards women seeking TOP in public hospitals.

In South Africa, unlike other countries in Africa, TOP services are made available to women in terms of the Choice on Termination of Pregnancy Act of 1996 (CTOP). In the post-Apartheid era following the first democratic elections in 1994, about 4,500 South African women per year are admitted to public hospitals mainly due to incomplete or unsafe illegal abortions. As a result, the South African Government legalised abortion in 1996, where “prior to this change in the law, abortion had been legal in very limited circumstances under the Abortion and Sterilization Act of 1975, requiring the approval of three physicians” (Stephanie, *et al.*, 2012:154). In this regard, many women who would have benefited from the 1975 Act resided in rural areas where only one or two doctors were present in outlying hospitals, while the law required at least two or three doctors to approve and make a decision for women to have abortion (Mhlanga 2003:116). Such restrictions could not totally promote women in rural areas to have access to TOP and in the context where one or two doctors are working in a hospital abortion therefore could not be permitted (Mhlanga 2003).

The Choice of Termination of Pregnant Act of 1996 (Act 92 of 1996) (CTOP) replaced the previous Sterilization and Abortion law of 1975 which not only criminalised abortion but legislated that it was only available in cases where a pregnancy threatened a woman's life or physical wellbeing, or that of the baby (Stephanie, *et al.*, 2012). The CTOP Act of South Africa aimed to govern the provision of TOP on request for women who were up to twelfth weeks pregnant. Under certain circumstances, it also allowed TOP on demand for women who were thirteen to twenty weeks pregnant (Trueman and Magwentshu 2013:397). The Act also allows nurses and midwives to be trained to provide TOP services in public hospitals and clinics, its aim being to increase the level of accessibility of TOP services to women. In addition, the aim of the CTOP Act was to improve women's health by curbing unnecessary abortion health-related diseases and deaths caused by unsafe abortion in unauthorized clinics (2013). However, there is still tension in the religious, medical and political discourse on how to implement TOP in public hospitals.

Although the CTOP Act provides women with the choice to terminate unwanted pregnancies, the law also provides medical practitioners with the right to recuse themselves from providing TOP services. According to Harries, *et al.*, "conscientious objection as it relates to the law in South Africa raises issues of competing constitutional rights in relation to women's right to exercise reproductive autonomy and a healthcare worker's right to freedom of conscience, belief, thought and religion." As a result, while the CTOP Act of 1996 does not spell out the right to conscientious objection, it nevertheless provides guidelines (Harries, *et al.*, 2014:2). The Act thus gave nurses the option not to provide TOP services based on conscience or religious belief and thereby created the space for nurses who are religious the right to object to provide services to women seeking TOP in public hospitals.

The Choice of Termination of Pregnancy Act of 1996 (Act 92 of 1996) legalises abortion and allowed the procedure to take place in certain hospitals and clinics across South Africa (Meel and Kaswa 2009:1). According to Banwari, *et al.*, (2009:1) about 69,894 abortions were performed in public clinics in South Africa between 1996 and 1999. About 500,000 women and girls died of complications worldwide and about

99% of these deaths occur mostly in developing countries such as South Africa (Meel and Kaswa 2001:1). Mbele, Snyman and Pattinson (2006:1196) have noted that in South Africa about, “one hundred and twenty maternal deaths were reported from 1999 to 2001 and 114 were reported from 2002 to 2004.” They also point out that, “if the maternal mortality ratio is calculated using the live births reported by Statistics South Africa in their Recorded Live births-the maternal mortality ratio was 4.77/100,000 live births in 1991-2001 and 4.91/100,000 live births in 2002-2004” (2006:1196). It has also been shown that the maternal mortality rate in South Africa was directly caused by complications due to abortion, contributing to about 10% of these deaths. Furthermore, TOP is also the most common cause of severe maternal morbidity in South Africa (Mbele, Snyman and Pattison 2006).

From the above statistical information clearly suggests the importance for the South African Department of Health to implement TOP to promote women’s reproductive health in order to address the challenges of unsafe abortion mortality and the related morbidity rate in South Africa. Accordingly, access to TOP service was seen to be one way to minimise death and disease associated with unsafe termination of pregnancy procedures in South Africa.

It is important to note that unsafe abortions contribute greatly to maternal mortality and morbidity in South Africa (Meal and Kaswa 2009; Mbele, Snyman and Parttison 2006). Despite a lack of healthcare professionals and hospitals offering TOP it is estimated that:

About 6% of female high-school learners reported having had an abortion, and 9.8% of male learners reported that their female partners had done so...Of these, only 51.5% reported that abortion had been performed at a hospital or clinic; 20.5% of respondents had consulted a traditional healers, 10.2% went to another place and for 5.4% the providers setting was unknown (Constant, *et al.*, 2014:1).

These statistics reveal the possible dangers and health problems that women in developing countries might face when accessing TOP outside of hospitals. In other words, allowing women the autonomy to control their reproductive health and especially the right to accessing professional TOP services, would be one way of reducing abortion-related complications and possible death among women in South

Africa. Harries, *et al.*, (2014:1) has thus noted that since the legalisation of TOP services in 1996, there has been a 91.1% decline in morbidity and mortality associated with abortions in South Africa. Nevertheless, it has also been noted that there is still resistance among nurses who are supposed to assist women in accessing TOP services based on religious, or moral beliefs, stigma associated with the provision of TOP services (Harries, *et al.*, 2014; Lipp 2011).

The implementation of TOP services in public hospitals in South Africa has been an important tool in providing women with control over their reproductive health and in improving access to quality healthcare services. However, research conducted by Harrison, *et al.*, (2000) and Jaine (2007) has highlighted that in KwaZulu-Natal, professional nurses are reluctant to provide TOP services to women seeking healthcare services in the public hospitals. Nevertheless, scholars such as Harrison, *et al.*, (2000), Jaine (2007), Natan and Melitz (2011), Walker (1996) and Potgieter and Andrews (2004) seem to agree with each other that the provision TOP services are contrary to many nurses' cultural and religious beliefs. TOP therefore remains unsupported, whereby nurses are willing to provide TOP services to women in the case of rape or incest, or in the case of a physically deformed foetus.

The implementation of TOP services in public hospitals remains a challenge in addressing health inequalities in South Africa. These challenges exist at both the provincial and national level, due to different views and understandings of TOP services among nurses. Nurses' opposition to TOP often relies on religious or moral beliefs, such as unregulated practices of conscientious objection (Harries *et al.*, 20014). As a result, some nurses object and do not provide healthcare to women seeking TOP (Harries, *et al.*, 2014:1-2).

Although it is not the aim of this research project to examine all the factors that act as barriers to the provision of TOP services, it does not overlook the shortage of professionally trained nurses that specialise in rendering TOP, poor access to resources, and the lack of information among women in rural areas. All of these aspects add to the challenge of implementing TOP services at the provincial and national level.

Accordingly, the provision of TOP services in public hospitals remains a critical challenge among healthcare providers. Research conducted by Natan and Melitz (2011); Abdel-Aziz, Arch and Al-Taher (2004); Mclemore and Levi (2011); Jaine (2007); Harrison, *et al.*, (2000); Harries, *et al.*, (2014); Mokgethi (2006), and Sibuyi (2004) in countries such as South Africa, the United Kingdom, Israel and the United States of America, religious beliefs are mentioned as one of the factors influencing the attitude of nurses in providing TOP services in public hospitals. None of these researchers however, explain how an individual's religious and cultural views influence the attitude and behaviour of nurses regarding the provision of TOP services, nor the implications of this for women seeking TOP services.

In order to fill this seeming gap in the research, this study will seek to understand and examine individual nurses' religious and cultural beliefs and how these might influence them in providing TOP services in public hospitals in Pietermaritzburg. While TOP is still a contested issue, especially among different religious groups and healthcare professionals, there is the possibility that religious and cultural beliefs play an important role in shaping the way nurses understand the provision of TOP services. However, it is also important also to note that religion may also have a role to play in discouraging nurses from providing healthcare services to women seeking TOP in public hospitals.

In recent years, while research carried out by William and Sternthal (2007), van Ness (1999), Oman and Thoresen (2002), and Levin, Chatters, Taylor, Kansas and Michigan (2005) identify the link between religion and health and its benefit on the wellbeing of patients, these same researchers underestimate the contribution of nurses' religious and cultural beliefs and the contribution it might make in improving the level of service delivery in public hospitals. In this research study therefore, my aim will be to explore nurses' religious and cultural beliefs in relation to TOP services in public hospitals in the Midlands region of Pietermaritzburg. Although religious and cultural traditions have often been seen as barriers to the provision of reproductive healthcare services among women, these same religious and cultural traditions and belief structures may also act as assets in advocating for the provision of TOP services among nurses in South Africa.

3. Research Focus and Rationale

This study focus specifically on the influence that religious and cultural beliefs have on nurses who are required to provide women access to TOP services in public hospitals.

As a post-graduate student studying at the University of KwaZulu-Natal (UKZN), I have lived in various parts of Pietermaritzburg and have found that abortion is still considered a social ill that needs to be looked into. I have seen abortion advertisements on sidewalks, street poles and public spaces throughout the city, indicating that much still needs to be done to address the problem of access to TOP services. In the discipline of theology, HIV and AIDS, gender and gender inequalities and religion governance are among the other social problems that are the subject of research at the School of Religion, Philosophy and Classics, yet very few religion scholars have examined the challenges of TOP and its effects on women's reproductive health. The challenges of access to TOP services are an aspect of women's experiences of inequality in the provision of health that in the academy remains an under-researched subject.

The CTOP Act of 1996 allows for abortion to be legally carried out in South Africa. The aim of the law was to promote and address gender inequalities in the provision of healthcare in South Africa, especially among women (Meel and Kaswa 2009:1). Moreover, the legalisation of TOP services in South Africa also aimed to help women access quality healthcare services in designated State hospitals. Nevertheless, illegal backstreet abortions are still a phenomenon in provinces such as KwaZulu-Natal. The question therefore remains whether it is lack of knowledge among women which influences them to access TOP services in authorised clinics, or whether the problem is related to healthcare professionals such as nurses who provide TOP services to patients in public hospitals.

In the Zimbabwean context that I come from, termination of pregnancy remains illegal, even after thirty-four years of political independence. Women are left with no choice except to find help from backstreet abortionists, a fact that has contributed to greater maternal morbidity and mortality rates in the country. Having been influenced

by this context, I have asked myself why advertisements of unauthorised abortion centres still exists in public places, particularly in South Africa where termination of pregnancy is legal. What are the reasons why some women in South Africa are still seeking TOP in unauthorised clinics?

Generally, in any hospital setting, nurses are the first to encounter patients, such as women seeking TOP services. If nurses develop a negative attitude towards TOP and tend to blame women for unwanted pregnancies, this might influence women to prefer to get help in unauthorized clinics (Constant, *et al.*, 2014:302). The aim of this study is therefore to explore the impact of nurses' religious and cultural beliefs and how this can be used as an asset to promote women seeking TOP services in public hospitals.

Nurses represent the majority of primary healthcare professionals in clinics, private and public hospitals in South Africa. The negative views on patients seeking TOP services might influence their behaviour in providing access to termination of pregnancy. According to Partners in Health,¹ nurses make up 80% of the global healthcare workforce, where they deliver 90% of healthcare services and comprise 82.5% of the clinical staff. It is important therefore to investigate whether nurses' religious and cultural beliefs act as a deficit, or whether they can be harnessed as a health asset in nurses' provision of healthcare services to women seeking TOP.

Moreover, among nursing professionals, including midwives, the majority of workers are women (Hellman 2000:112-113). According to Solidarity Research Institute (2009:3-4), in KwaZulu-Natal, about 21,188 nurses are women and 1,280 are men. This suggests that services provided by nurses in public hospitals are of greater significance to patients seeking TOP services. Female nurses experience difficulty in providing TOP services to women as they might identify themselves as women, mothers, homemakers, sole wage-earners, and single-parents, responsible for the well-being of their spouse and children. Across most cultures in Africa, women are seen as child-bearers and caregivers in society (Deepa 2000:175). Nurses also identify themselves as caregivers as well as child-bearers, mothers, and wives; hence, these sentiments might also influence their attitudes and behaviour regarding the provision

¹ See, <<http://www.pih.org/send.a.note/>>.

of TOP services in public hospitals (Walker 1996:43). To support this claim, Walker (1996:59) states that:

In their discourse, motherhood entails a series of obligations and responsibility towards children who are unable to care for themselves...They 'mother' their patients in claiming the authority and wisdom to judge and to discipline their behaviour.

Accordingly, African women nurses who terminate a woman's pregnancy take away the opportunity of being the mother, thus the provision of TOP might be in direct conflict with nurses' cultural expectations of women as child bearer and caregivers (Walker 1996:43).

As I have mentioned earlier in this chapter, the religious and cultural beliefs of nurses may play an important role in the health-seeking behaviour of patients who need care and support to terminate pregnancy in public hospitals. Many women, for reasons of economics or discrimination, seek help outside of the public sector through 'backyard' or illegal abortionists. These abortion services are often harmful to women's health and have been argued to be a frequent cause of death or serious injury in South Africa. According to the WHO (2010) and Osman and Thompson (2012) abortion is a challenge to public health, yet the implementation and provision of TOP services in South Africa remains contested and sometimes inaccessible. According to a research conducted in Cape Town in South Africa, the WHO (2010) found that:

Despite induced abortion being legally available in South Africa after a change in legislation in 1996, barriers to accessing safe abortion services continue to exist...These barriers include, but are not limited to, provider opposition, stigma, poor knowledge of abortion legislation, a lack of healthcare professionals trained to perform abortions, and a lack of facilities designated to provide abortion services, particularly in the rural areas.

All these factors may influence women to find an alternative unauthorised clinic to terminate their pregnancies.

Unauthorised clinics, particularly those that are poorly resourced, expose women to numerous complications and infections and may lead to an increase in morbidity and mortality rates among women in developing countries such as South Africa. Research

conducted by Elis and Moore (2013) and Osman and Thompson (2012) has illustrated that most of these unauthorised clinics are not well equipped and that they are unsafe for women seeking TOP services.

In a report published by the Solidarity Research Institution (2009), as well as research completed by Elis and Moore (2013) and Osman and Thompson (2012), it has been shown that patients experiencing complications after receiving healthcare services from unauthorised clinics increases the work load of nurses in public hospitals. As public hospitals in KwaZulu-Natal (KZN) province are experiencing a shortage of qualified health personnel, this might have a particularly negative effect on access to healthcare services in public hospitals. This study aims to investigate whether nurses' religious and cultural beliefs have an effect of how they provide healthcare services to women seeking TOP service. In this regard, the study is guided by the following objectives and questions.

4. Research Objectives and Questions

The main research question for the study is as follows:

How do Nurses' Religious and Cultural Beliefs Influence their Attitudes towards Provision of Healthcare Services to Women Seeking Termination of Pregnancy?

The sub-questions for this study are as follows:

- i. What religious and cultural beliefs about TOP undermine the healthcare provision of nurses towards patients seeking termination of pregnancy services in public healthcare facilities?
- ii. How do nurses' religious beliefs and cultural beliefs about TOP find expression among the healthcare workers in public hospitals?

The main objectives of the study are as follows:

- i. To ascertain whether nurses' religion and cultural beliefs help them to provide healthcare services to women seeking TOP services in public hospitals.
- ii. To describe the relationship between nurses' religious and cultural beliefs and their understanding of the implications of TOP to women's health.
- iii. To investigate the relationship between nurses' commitment to work and to religious and cultural beliefs and how this influences them to provide quality healthcare services to women seeking TOP services in public hospitals.

5. The Significance and Contribution of the Study

As a researcher it is critical to look at whether religion and culture has an effect in helping nurses offer TOP services to women in public hospitals. It is also important to avoid making generalisations regarding the role of nurses' religious and cultural practices on the provision of TOP services.

Scholars such as Harrison *et al.*, (2000), Lipp (2012), Mhlanga (2003), and Mokgethi, *et al.*, (2006) have argued that nurses' religious and cultural beliefs are a hindrance to implementing TOP services. This undermines the role of religion and overlooks the fact that religion and culture might benefit nurses in caring for patients seeking TOP services in public hospitals. Moreover, presenting one-sided views on abortion, such as interpreting it as murder, neglects other dimensions of TOP, such as a woman's right to autonomy over her own reproductive health as well as her own experiences of emotional stress and psychological challenges in relation to TOP. Some women seek TOP services due to their financial inability to care adequately for their babies. Others terminate their pregnancy to pursue their educational careers. The fact that TOP is often upheld as a form of murder even among nurses themselves who are supposed to provide healthcare and support to women seeking this service is a severe blow to women's health (Mamabolo 2006: 22; Walker 1996:51).

This research aims to contribute to the body of existing literature regarding individual nurses' understanding on the influence of religious and cultural beliefs of women seeking the provision of termination of pregnancy in public hospitals. It particularly

aims to inform healthcare professionals (nurses) how to improve healthcare services to women seeking TOP services. What appears to be a missing in existing research studies is the focus on which religious and cultural beliefs might yield some benefits or asset to nursing professionals that provide TOP services to women.

6. The Definition of Key Terms and Concepts

The following key terms and concepts are relevant to the present study:

- i. **Authorised or Designated Hospitals, Clinics, or Health Facilities:** These are hospitals and clinics that are given permission by the government to provide termination of pregnancy services.
- ii. **Unauthorised Hospitals, Clinics, or Health Facilities:** These are hospitals and clinics that are not given permission by the government to provide termination of pregnancy services.
- iii. **Termination of Pregnancy (TOP):** This refers to “the separation and expulsion of the foetus by medical or surgical means of the uterus of a pregnant women” (Mamabolo 2006:17, 21). There are many different ways of defining and understanding termination of pregnancy and abortion, particularly from religious, philosophical, and medicinal perspectives. For example, the termination of pregnancy is “commonly known as abortion....Abortion may be defined as the intentional ending of pregnancy through evacuation of the uterus before the foetus has reasonable chances of survival” (Mamabolo 2006:2). The CTOP Act of 1996 specifically defines abortion as the “termination of pregnancy,” meaning, “the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman” (1997:48). In this study, I will limit myself to the above definition of TOP as a guide. I am aware that there are others ways of defining TOP. One of the mains reasons for using this definition is that it is the standard legal definition. It is also less stigmatising towards women seeking TOP services and also healthcare professionals who are providing these

services. Again, this definition does not pre-empt the understanding of TOP as the killing of babies as compared to the use of abortion.

- iv. **Religion:** In the context of this study, I will understand religion as that “system of religious attitudes, beliefs and practices held with ardour of faith...faith is defined as a firm belief” (Chamberlain and Hall 2000:4). Shutte (2006:xx) states that, “understanding religion in a scientific and secular culture, defines religion as our concern for the fulfilment of our most fundamental needs, especially those that seems to be beyond all human power.” One can interpret his definition by showing that religion can be used as a tool to liberate the community and not to glorify oppression. My understanding of religion is not limited to Christianity alone, but also to other religious groups and faith traditions such as ATR (Zulu and Xhosa), Islam, and Hinduism and the possibility of encountering devotees of other religious groupings among those working at Greys Hospital, Pietermaritzburg.
- v. **Culture:** In the context of this study, this refers to “the integrated patterns of human behaviour that include thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups” (Bosek 2008:100).
- vi. **Registered Nurse:** A Registered Nurse (RN) is a registered nurse or midwife in terms of the Nursing Act (Act 50 of 1978) (Mamabolo 2006:17). In this study, a registered nurse refers to a professional nurse who is working with patients seeking or undergoing TOP (gynaecology and obstetrics) services at Grey’s Hospital, Pietermaritzburg.

7. Chapter Outline of the Study

The chapters of this study are organised as follows:

Chapter 1 outline the background and motivation of the research, as well as identifying the research problem, objectives of the research and research questions of

the study. Finally, I provide a definition of the terms and concepts used in the study and a brief chapter outline.

In chapter 2 provide outline literature review consulted as well as demonstrating the link between religion and the nursing profession in connection with the provision of TOP services in public hospitals.

Chapter 3 I demonstrate the context of the termination of pregnancy and how the perception of religious nurses is shaped in the provision of TOP services at public hospitals.

In chapter 4, I provide a theoretical framework of social responsibility for nursing practice in the provision of TOP services to women at public hospitals.

In Chapter 4, I present an overview of the research methodology guiding this study. I particularly focus on describing the research design, covering the selection of criteria used in select participants, the sampling method, the collection of data and the method of data analysis. Finally, ethical considerations with respect to providing confidentiality are also discussed.

Here in chapter 6, I present the method of data presentation, interpretation and research findings of the study.

Chapter 7, provide concluding remarks of the research findings, recommendations and suggestions for future research.

Bibliography: I here present a comprehensive list of books, journal articles, conference papers, reports, on-line articles, unpublished dissertations and other research studies consulted in the study.

Finally I provide a list of appendices.

CHAPTER TWO

LITERATURE REVIEW ON TERMINATION OF PREGNANCY, RELIGION AND NURSING

1. Introduction

In this chapter, I will discuss the literature in relation to my chosen area and topic of study. According to Brink (1996) a literature review involves reading, understanding and forming conclusions about theory and the published research to address a specific topic under discussion. Burns and Grove (2003:55) note that a literature review is done so as to acquire knowledge for use in practice or to provide a basis for conducting a study. In this present chapter, I will discuss that body of academic literature that deals with the relationship between religious belief and health, especially in addressing the challenges faced by nurses in providing healthcare services to women seeking TOP services in public hospitals.

2. The Choice of Termination of Pregnant Act of 1996 (Act No. 2 of 1996)

In South Africa, there had been a sharp increase in the maternal mortality rate as a result of septic abortions which were unsafe for women at that time (Mhlanga 2003). Mhlanga (2003) has shown little could be done do address this problem because of the legal environment at that time and the abortion on demand was prohibited. Following the introduction of the Abortion and Sterilization Act of 1975 (Act No. 2 of 1975), the majority of women prohibited from seeking legal TOP services were those living in the rural areas of South Africa (Mhlanga 2003). As Mhlanga (2003:116) has pointed out:

The history of women is intimately linked to the history of the oppressed, in that women were not allowed to make any decision with regard to their lives, including their reproductive lives.

Following the introduction of the Abortion and Sterilization Act of 1975 (Act No. 2 of 1975), morbidity and mortality rates continue to escalate among women of all races (Mhlanga 2003:116). In support of that, scholars such as Mamabolo (2006) have indicated that the 1975 Act made abortion accessible under certain circumstances. However, the conditions laid down in terms of the Act were so stringent that only women in urban and well-resourced areas could benefit. Those women from rural areas who sought TOP services were prohibited because the law required two to three doctors to agree to provide legal abortion services. According to Mhlanga (2003) the Act was designed (at least in part) to benefit a privileged minority (most white population), while neglecting the majority of black women in rural areas. This influenced many women at the time to seek illegal TOP services in unsafe environments which lead to severe health complications and even death.

Following the political liberation of South Africa in 1994, it was important for the new democratic government to begin responding to the majority of South African women and their need to have their rights respected, protected and promoted (Mhlanga 2003). The CTOP Act of 1996 was therefore introduced in response to the sexual and reproductive health of women by tackling the most contentious of issues—abortion (Mhlanga 2003; Mamabolo 2006; Macleod 2014). Hoffman-Wanderer, *et al.*, (2013 cited in Mhlanga 2003:18) states therefore that:

Under the Choice on Termination of Pregnancy Act, 1996 any pregnant woman or girl can request termination of pregnancy [TOP] up to twelve weeks of gestation, without consultation or approval by a doctor or nurse. In support of that the Act also allows registered midwives to be trained to provide the service for women who are twelve weeks and below.

Even if the law did not necessarily wipe away illegal abortion in the country, the Act minimise high levels of morbidity and mortality caused by unsafe abortions in unauthorised places. The South African government establish hospitals and clinics in order to create safe space for women to have access to legal abortion. The Act was not necessarily aim to minimise the mortality and morbidity rate in the country, but also sought for women to have control over their reproductive health, especially with respect to TOP services and the need to deal with the burden of unwanted pregnancies.

3. Tension between Choice of Termination of Pregnancy and Nurses' Rights

Although the Act aimed at giving women full control over their reproductive rights, the 1996 CTOP Act also allowed doctors and nurses the choice whether they wanted to participate in providing TOP services. Regardless of the health rights and other benefits of the 1996 CTOP Act, some nurses chose not to be trained and involved in the provision of healthcare services to patients seeking TOP services (Mhlanga 2003). Such opposition to providing TOP services was influenced by “conscientious objection as it relates to the Law in South Africa raises issues of competing rights in relation to women’s right to exercise reproductive autonomy and health care worker’s right to freedom of conscience, belief, thought and religion” (Harries, *et al.*, 2014:2). Although the 1996 CTOP Act did not specifically mention the right to conscientious objection, it did set out guidelines on how healthcare professionals were expected to respond in terms of the legislation. In this, the Act states that healthcare providers who are not directly involved with TOP procedures cannot use their religious beliefs as reasons for refusing to assist a women seeking such services. In addition, healthcare providers cannot deny routine medical care and general assistance unrelated to the procedure (Harries, *et al.*, 2014:2). Ambiguity and inconsistencies regarding the interpretation of conscientious objection by healthcare providers [nurses] has had an impact on the provision of healthcare assistance to patients seeking TOP services. This might be one of the obstacles to women’s access to safe and legal abortion services in designated hospitals across South Africa.

Although nurses understand that they have a duty to care for patients seeking medical help in public hospitals, ambiguity and inconsistencies in the interpretation of conscientious objection might be barriers to obtaining TOP services. Mokgethi, *et al.*, (2006) note that the 1996 CTOP Act allows nurses the option to refrain from providing TOP services. Nurses who take this option nevertheless have the duty to refer their patients to other healthcare professionals who are willing to provide the service. Potgieter and Andrew (2004:26) suggest that because of this ambiguity, nurses provide care and support by choice. Moreover, they note that some nurses view TOP as a traditionally acceptable way of dealing with unwanted pregnancies.

4. General Discussion of Termination of Pregnancy

The Health Professions Council of South Africa (HPCSA) Code of Conduct (2008) make provision for conscience objection and thereby allows nurses to recuse themselves from providing TOP services on the basis of their religious and cultural beliefs. Although this protects nurses from entering into morally or ethically compromising situations, it nevertheless has a negative impact on women seeking TOP. In order to improve the level of healthcare services to women seeking TOP services in public hospitals, the concept of social responsibility as outlined by Tyer-Viola, *et al.*, (2009) and the understanding of the ethics of care as proposed by Groenhout (2004:2) this might be a useful instrument to help nurses to deliver TOP service to women in the Midlands region of KwaZulu-Natal.

Research conducted by Lekwetji Redibone and Catherine Mamabolo in 2006 on the experiences of registered nurses providing TOP services at the Soshanguwe Community Health Centre, north of Pretoria, raised an important point that abortion worldwide was criticised on the basis of understanding it as killing in many different disciplines. As a result, TOP/abortion was considered morally wrong even among nursing professionals (2006:22). In many different academic disciplines, including, philosophy, religious studies, health, women's studies, theology, morality and ethics, abortion is a widely researched area addressing different issues such as the reproductive choice of women (Dollar 1997:47). The aim of this present research was to address the challenges that women face within many communities to enjoy the freedom to make their own decisions regarding reproductive health, especially in the light of septic abortions which is the cause of many deaths each year in South Africa.

5. Religious Beliefs and the Health of Patients

Substantial research has been conducted in the role of religion in relation to the physical and mental health and wellbeing of women. Research has indicated that religion has an important role to play in promoting the healthcare of patients, especially in reducing the high morbidity and mortality rate of women who associate

themselves with a religious faith (William and Sternthal 2007; van Ness 1999; Oman and Thoresen 2002; Levin, *et al.*, 2005). Scholars mentioned above indicated that people who are religious have a long life span as compared to people who are not religious, for instance Seventh Day Adventist and Jehovah's Witness do not allow their members to smoke and this reduces the risk of heart diseases and lung cancer. Central to the argument raised by most of these scholars is to demonstrate how religion can be of benefit to patients accessing public health services. The study by Levin, *et al.*, (2005) argues that religious epidemiology suggests that religious participation on average was associated with less illness and with better health. This demonstrates the significance of how religious participation can be of a benefit to the health of patients, although this is not always the case.

Although religion may have health benefits for patients, other scholars such as van Ness (1999), Chatters Levin, and Ellison (1998) and William and Sternthal (2007) claim that religion also has the potential to generate undesirable health outcomes. For example, William and Sternthal (2007) note that even though religious participation creates social networks and social relations, it can also be a source of stress and thereby create a higher risk of mortality. As a consequence, religious and cultural beliefs not only provide healthcare benefits to patients, but can also create undesirable health outcomes for patients as well.

6. Religious Beliefs and Healthcare Professionals

Research conducted by Oman and Thoresen (2003), suggests that religion has not only important benefit to patients, but is also of significance to motivate healthcare providers such as clinicians, doctors, patients and psychologists, because it can empower individuals by connecting them not only to religious community, but also to a Supreme Being that might in turn give psychological strength in the working environment. Potgieter and Andrew (2004:25-26) has argued that although some nurses opt not to provide healthcare services to women seeking TOP services in public hospitals in KwaZulu-Natal based on their religious affiliations, religious affiliations nevertheless motivated nurses to provide care to fulfil women's health needs in public hospitals. If that is the case among nurses in public hospitals, religious

beliefs might be a beneficial tool to provide care to women seeking TOP services and improve the ability to care for such women.

7. Religious Interpretations of Termination of Pregnancy

Regardless of religious faith, opinions and attitudes for or against abortion also contribute to the position of those in nursing profession. A significant portion of the literature consulted for this study has revealed that religious traditions have mixed feelings about TOP. Stephens, *et al.*, (2010), and research conducted by Manxaile (2000) have noted that Christianity has different opinions regarding TOP. According to the Roman Catholic tradition, for example, TOP is prohibited, and opposition to medical interventions that interfere with the life of an unborn child is informed by the ethical argument that even an unborn foetus has a right to life. Unlike the Roman Catholic stance, the Lutheran Church has a range of positions regarding TOP, yet leave room for women to exercise their reproductive rights as designated by the State in different contexts. Stephens, *et al.*, (2010:516) can thus state that:

The majority of theologians in the Evangelical Lutheran Church in America (ELCA), of Scandinavian Lutheran churches, as well as the majority of German Lutheran theologians, are of the view that termination of pregnancy is to be discouraged, while recognizing the necessity for a state to have a rational law on abortion allowing termination of pregnancy under certain conditions.

In the case therefore of pregnancy following rape or incest, or when a pregnancy threatens the health of the mother, TOP is allowed. In the Islamic tradition, TOP is not permissible and is condemned as being morally wrong (Stephens, *et al.*, 2009). Nevertheless, TOP is permissible under certain circumstances, for example, if the pregnancy jeopardises the mother's life, or in the case of rape, or if the foetus suffers from a condition incompatible with life. This is a similar position to that of the Evangelical Lutheran Church's policy regarding the health of mothers.

As in other patriarchal religious traditions such as African Indigenous Religions, manhood and womanhood in the Islamic tradition is determined in relation to their

reproductive ability, and therefore remains a hindrance to women's access to TOP services. In the Hindu traditions, however, there is allowance for TOP, whereby, "belief in the law of karma, Hindus do not believe in abortion, even in the case of rape or disability. Every life is sacred and has to fulfil its destiny."

African Indigenous Religions seem to condemn the termination of pregnancy due to their understanding of life. Scholars such as Sindima (1995), Mbiti (1969) and Shutte (2006) argue that African indigenous religions understand life in its totality or in community with one another. In this, life is defined as beginning at the moment of conception. Chidester (1992) and Conteh (2008) argue that rituals marking birth and death in African Traditional Religions (ATR) mark the beginning of life and the after-life. In line with this, Lauro (2011:18) also argues that:

Life and death are seen as cyclical in traditional African societies: a birth is the passage of a spirit from the world of the dead to the world of the living; the spirit goes back to the other world when a person dies, and will return to the world of living with the birth of another person.

The vision of life and death in African Indigenous Religion therefore suggests that terminating pregnancy is an act which sends back to the other world a spirit who wanted to return. Abortion is thus not seen as the final solution, but rather as murder (Lauro 2011:18). For Conteh (2008), human life begins at conception, where God is in existence with the unborn baby. Pregnancy within African Indigenous Religion is therefore viewed as being a blessing from God. It is from this perspective that the Limba people from Sierra Leone and the Zulu people from South Africa base their resistance to TOP. The diversity of religious beliefs and understandings of TOP among African Indigenous Religions might hold significant impact in promoting the behaviour and attitudes of healthcare professionals towards women seeking TOP services in public hospitals.

Walker (1996:51) has produced similar arguments and illustrates the point by stating that some "nurses opposed abortion expressed the view that it was unacceptable and unjustifiable under any circumstances...significantly, their anger was directed towards the women who have unwanted pregnancies and who want abortion rather than

towards the men who place women in this predicament.” The main argument was in demonstrating the difficulties within African Indigenous Religious belief systems especially among nurses, who in associating themselves as mothers also find it difficult to provide TOP services in public hospitals. Hence, the religious beliefs of some nurses might contribute to their behaviour and attitude towards women seeking TOP services in public hospitals. Another example is that of the Karanga people, the ethnic group to whom I belong, where becoming pregnant outside of marriage is considered a shame to the family. As a result, private abortions are tolerated as a way of avoiding such shame.

8. Other Factors Affecting Provision of TOP Services

A study conducted by Benn Natan and Melitz (2011:69) claims that “research shows that nurses from gynaecology departments have a more negative attitude towards TOP than do nurses from other medical departments because of their personal involvement in the actual performance of the procedure.” The point here is that not only religious and cultural practices inform nurses on their attitude towards TOP services, but also other factors such as the working environment. In support of this argument, it is evidenced that most public hospitals in South Africa are experiencing shortages of nurses and other healthcare providers. This directly affects TOP services in public hospitals and makes it difficult for women to gain access (Harries, *et al.*, 2014).

9. Professional Nursing, TOP Services and Religious Faith

Research conducted by Berger (2006) has been used to show that both the age and religious affiliation of nurses has a significant impact on their attitudes and behaviour towards TOP. Berger (2006) maintains that nurses believe that divine control takes precedence over matters of life and death. Such nurses understand that the termination of a pregnancy cannot be used as a means for women to enjoy happiness. Accordingly, such nurses oppose the provision of healthcare services to TOP patients in public hospitals. Adding to this, Walker (1996) suggests that nurses who are mothers tend to view TOP as a practice that takes away the opportunity for women to

become mothers. Hence, they expressed negative attitudes toward TOP. This indicates that in addition to religious beliefs and age, the life situations and experiences of nurses also has a significant impact on their attitude towards the practice of TOP. However, Walker's (1996) argument overlooks the fact that male nursing professionals also participate in TOP services. Men were supposed to be consulted as part of the research, and included in the category of 'nurses.'

Scholars such as Potgieter and Andrews (2004) argue that TOP is a service available for women to exercise their reproductive rights. On the other hand, the participation of nurses in TOP helps women access safer health services. Feminist biomedical ethics also advocates for women to access quality health services in order to avoid undue suffering (Cahill 2005:169). However, it is important to note that even if TOP services are available for women to exercise their reproductive rights, some healthcare providers are reluctant to offer these services due to various reasons (Osman and Thompson 2012). Accordingly, Mokgethi, Ehlers, and van der Merwe (2006), raise similar concerns to that of Osman and Thompson (2012) when they note that:

Healthcare 'providers' are reluctant to be involved in different aspects of TOP and public sector nurses frequently chastise clients, particularly younger women, for being sexually active, for being 'irresponsible', and for choosing to terminate the pregnancy rather than give birth.

Such attitudes may have an impact on women seeking healthcare in public hospitals, influencing their choice to access TOP in unauthorised clinics that are not well equipped. This is likely to cause infertility, infection, and increase the rate of mortality among women in South Africa.

Although the Code of Conduct of the Health Professions Council of South Africa (2008) is very important for nurses to provide services to their patients. What is missing is the need to address the challenges of whether the religious and cultural beliefs of nurses might be harnessed as an asset or deficit in the provision of TOP services in public hospitals. It is also important to note that negative attitudes and behaviour of nurses, whether due to religious and cultural beliefs or other factors in the working environment are in direct contrast with the Framework of Social Responsibility and the Health Professions Council of South Africa's (HPCSA) Code

of Conduct (2008), which is a guideline for healthcare professionals in providing healthcare services to patients seeking support in public hospitals in South Africa.

10. Feminist Approaches to Women's Reproductive Health and TOP Services

Feminist theorists from the disciplines of theology, medicine, philosophy and religion hold a common understanding that women's experiences differ from one context to another. Within the discipline of theology, it is noted the diversity of negative experiences among women include women abuse, oppression and the challenges of reproductive health (Rakoczy 2011:32, 35). In the case of South Africa, women unable to seek TOP services in public hospitals may experience death or severe physical and psychological trauma associated with unsafe, illegal abortion clinics. Such suffering is the direct result of nurses' unwillingness to participate in the provision of TOP services at public hospitals and goes directly against the right of women to have access to good healthcare as a fundamental human need.

It is important therefore for nurses to classify the burden of an unwanted pregnancy as another form of women suffering. By so-doing, this will help them provide care and support to women seeking TOP services. In the context of women seeking TOP services in South Africa it is also important to note that such women in one way or another are suffering emotionally from unplanned pregnancies. It is thus unjust for nurses to refrain from providing such healthcare services or even to provide patients with referrals to other healthcare providers willing to provide the service especially in designated hospitals in Pietermaritzburg.

Reproductive health for women is a contested issue, especially with regards to the provision of TOP in public hospitals across South Africa, but particularly in KwaZulu-Natal, the province where my research is centred (Harrison et al 200 and Constant 2014). Feminist biomedical ethics such as those advocated by Cahill (2005:169) suggest that the choice of termination of pregnancy for women assists them to exercise their reproductive choices in order to have full control over their health, rather than other external influences to monitor their health. Nurses who provide TOP services to women should aim to improve the quality of life of their

patients that accords with basic healthcare access for all. Cahill (2005:171) further argues that “many polls over the last twenty years have shown that while most Americans, both Protestant and Catholic, support women’s legal right to choose abortion, they do not believe that all abortion decision are not morally the same.” For this reason, many feminist theologians view abortion as a tragic necessity in some cases. Roman Catholic feminists, however, are less likely to focus on abortion as a right, or as an item of primary importance, in working towards gender equality (Cahill 2005:172).

Making allowances for TOP not only improves the quality of life of women, but also supports women’s liberation and freedom to exercise their reproductive rights. If this position towards abortion could find expression among registered nurses in South Africa, it would provide access to healthcare for women seeking TOP services in KwaZulu-Natal.

Nursing is a profession in which women still dominate. According to the Solidarity Research Institute (2009:3-4), within KwaZulu-Natal there are about 21,188 female registered nurses and 1,280 male registered nurses. It is therefore important to accredit the voice of women when exploring issues related to healthcare for women seeking TOP services in public hospitals. Women in secular societies are seen as primary agents of care, as compared to men, hence it is crucial to analyse the phenomenology of care as a central issue and social responsibility in nursing. According to Tong (1997:37), “feminine at present refers to the search for women’s unique voice and most often, the advocacy of an ethics of care that includes nurturance, care, compassion and network of communication.” In this sense, providing healthcare for women seeking TOP services in public hospitals plays an important role in allowing women to exercise their reproductive rights in South Africa.

11. Chapter Summary

In this chapter I have briefly surveyed the literature consulted and drawn upon in the development of this research project. I have demonstrated the need to examine individual nurses’ religious and cultural beliefs in the provision of TOP services in

public hospitals. Moreover, I have sought to demonstrate the relationship between nurses' religious and cultural beliefs and their understanding of the implications of TOP to women's health and reproductive rights.

CHAPTER THREE

TERMINATION OF PREGNANCY SERVICES IN SOUTH AFRICA

1. Introduction

At the global level, TOP remains a contested issue. TOP is difficult to implement as communities, religious groups, theologians, politicians and even healthcare institutions and workers find it difficult to address its perceived challenges. Generally, registered nurses have mixed feelings towards TOP. In North America, for example, it was found that “gynaecological nurses often have stereotyping and lamenting attitudes towards TOP's and patients undergoing abortion” (Miya 2008:6). In South Africa, it is evidenced that nurses who have a negative judgmental attitude towards women seeking TOP services in public health facilities are unlikely to provide the service and others have even refused to provide TOP services or work in public hospitals and clinics offering such services (Mokgethi, Ehlers, and van der Merwe 2006:33). Not only nurses working in public hospital opposed the provision of TOP, a research conducted by Mncwango and Rule found out that “nine out of ten South African are of the view that abortion is wrong where family has low income and cannot afford more children...A similar sentiment among three-quarters of south Africans, even if there is a strong chance of the baby being born with a defect²” (2003-2006:7). This might suggest that opposition to TOP is strong among South African citizens, therefore might make difficult to offer TOP service in public hospitals.

2. The Context of Termination of Pregnancy in South Africa

The dialogue concerning TOP began immediately after the democratisation of South Africa in 1994 (Sibuyi 2004:76). Constitutional reform was adopted in 1996³ which

² <http://www.hsrc.ac.za/en/review>

³ The Constitution of the Republic of South Africa, 1996 was adopted on 08 May 1996 and amended on 11 October 1996 by the Constitutional Assembly.

allowed all its citizens to exercise their rights such as the “freedom of religion, thought, belief and opinion” (Sibuyi 2004:76). This constitutional reform provided a platform allowing for the passage of the Choice of Termination of Pregnancy (CTOP) Act No. 92 of 1996. The CTOP Act was promulgated on 31 October 1996, and became law on 01 February 1997 (2004:76). Although the 1996 Constitution provided opportunities for the reproductive freedom for women, TOP remains a contentious issue among nurses and politicians. Accordingly, it has been well-documented that South Africa has experienced a huge shortage of abortion-care providers who are willing to work in abortion clinics. According to the Pulitzer Centre this is mainly because, “nurses who oppose the procedure often elect not to work in their clinic’s abortion wing...[and] willing nurses, meanwhile, may be discouraged by peer pressure⁴.”

TOP is related to women’s reproductive health and remains a contested topic in religious faith and even among health professional such as nurses. The implementation of TOP services in South Africa introduced new tasks for nurses and with it caused a lot of tension among those healthcare professionals who were to be the providers of TOP services in public hospitals. Constitutional amendments and reforms gave all South African citizens the freedom of speech, religion, thought, and the freedom of choice. Nevertheless, community members and nurses continue to find it hard to deal with the reproductive freedom for women when faced with TOP services at public health institutions.

Another important barrier to the implementation of TOP is an unwillingness to engage and discuss TOP as a reproductive health benefit for women, not merely as a moral issue. Nurses remain silent regarding TOP, mainly due to how the apartheid constitution criminalised TOP (McGill 2006:196). It could also be a result of the cultural and religious beliefs of nurses (Mokgethi, *et al.*, 2006). But this does not necessarily mean that all nurses of a religious persuasion are against the provision of TOP services. According to Potgieter and Andrew (2009:26) nurses who provide TOP services are often of the view that TOP was always practiced in religious and cultural settings even if it was not called TOP.

⁴ <http://pulitzercentre.org>

In Apartheid South Africa, TOP was not considered to be an issue that secured women's freedom and power to control their own reproductive health; instead, it was criminalised. According to McGill (2006:196), "prior to 1975, abortion was understood to be a common law crime." The Abortion and Sterilization Act of 1975 (Act No. 2 of 1975) indeed discouraged women to have control of their lives including their reproductive health, this even after the Act introduction in 1975 as an attempt by the white National Party to stem the increase in morbidity and mortality rates among women from all races (Mhlanga 2003:116).

The Act of 1975 allowed the termination pregnancy to be performed under certain circumstances and women who benefited from it were mainly from urban and well-resourced areas, while many women who should have benefited from the Act were mostly from rural areas where only one or two doctors were present in the rural-based public hospitals and clinics (Mhlanga 2003:116). The Act of 1975 specified that abortion should be permitted when at least three doctors gave their agreement that a women should undergo a legal abortion. Hence, as Mhlanga (2003:166) has observed, "the Act therefore was part of the response to the need to protect the lives of the privileged (mostly white population), while neglecting the welfare of the many women who were in the rural areas, and who did not know of the facilities that could be available for legal abortion." The act thus directly benefited but a few women, particularly those in urban and well-resourced areas and marginalised the majority of women in the rural areas.

The Choice of Termination of Pregnancy Act of 1996 (Act No 92 of 1996) aimed to allow women to exercise their own reproductive rights. Despite the controversies and debates raised by CTOP among South Africans, the introduction of TOP services at public health institutions aimed to minimize the rate of morbidity and mortality among women by reducing the number of illegal abortions performed (National Department of Health 2000; Osman, and Thompson 2012). According to Osman and Thomson (2012), in addition to death, illegal abortion causes illness and other immediate health complications such as severe bleeding, uterine perforation, tearing of the cervix, and infection of the abdomen and blood poisoning, risk of infertility and

premature delivery⁵. Due to a number of disease affecting women improvement in service delivery especially TOP in public health care services will help to minimise morbidity among women in South Africa.

Despite the controversies and debate on TOP in religious circles, the legal framework and the provision of medical healthcare in terms of women seeking TOP services sought to reduce the rate of maternal mortality and morbidity in South Africa (Mokgethi, Ehlers and Merwe 2006:33). The development and implementation of CTOP was associated with a shift from illegal abortion to legal TOP in South Africa and signified a great achievement for the country in terms of developing its new democracy and culture of human rights for all. According to Mamabolo (2006:22) therefore:

Prior to the introduction of the Abortion and Sterilization Act, there was no properly defined law on abortion...The Abortion and Sterilization Act stipulates that abortion was to be performed in a state-controlled institutions by two medical officers in specific circumstances only: [when] pregnancy threatens the women's health, pregnancy posing a serious threat to the women's mental health, physical or mental defects of the unborn child and pregnancy due to rape or incest.

Research conducted on the liberalisation of TOP services raises concerns in politics, civil society, religious faith communities, and among health personnel such as nurses as to whether provision by the State of TOP services was considered to be legalised murder. Yet, as National Department of Health (2000:3) could state:

The 1996 Choice on Termination of Pregnancy Act (Act 92 of 1996) is one of the most important sections of legislation aimed at improving women's lives...By allowing all women the right to choose whether to terminate their pregnancies within certain specified parameters, South Africa has embarked on a journey to bring access to safe TOP to all women, in order to prevent morbidity and mortality associated with unsafe and illegal 'back street' abortions.

As Osman and Thompson (2012) have noted, between 2008 and 2010 South Africa experienced about 4,867 maternal deaths⁶. During this period, 186 women died as a

⁵ www.mariestopes.org.za

⁶ www.mariestopes.org.za

direct result of septic miscarriage in public healthcare facilities, 23% of these deaths being the result of unsafe abortions⁷.

The complications following unsafe and illegal abortions include, severe bleeding, uterine perforation, tearing of the cervix, severe damage to the genitalia and abdomen, internal infection of the abdomen and blood poisoning (Osman and Thompson 2012). It is essential that nurses help women seeking TOP services in public hospitals, so as to improve their health and well-being. The implementation of TOP in designated public hospitals is therefore considered to be the most significant step in giving respect to women's sexual reproductive choices and bodily integrity (Mhlanga 2003:115). The legalisation of abortion was thus a way of minimising the maternal morbidity and mortality rate. According to Osman and Thompson (2012), the legalisation of abortion or TOP in 1996 also reduced the number of unsafe abortion-related deaths by 90%. Nevertheless, there are still serious challenges nationwide regarding the implementation of CTOP legislation⁸. One serious challenge is the shortage of willing and trained nursing personnel to provide TOP services in public healthcare institutions, as some registered nurses refrain from offering this service to patients. Despite existing research, many questions therefore remain regarding how TOP is to be implemented in public hospitals across the country.

3. Nursing Practice and the Termination of Pregnancy

It is evidenced that nurses working in hospitals or clinics authorised to provide TOP services in South Africa are experiencing a general lack of support and counselling services from public hospitals (Mokgethi, Ehlers and Merwe 2006:33). In addition, many of the recipients of stigma associated with the provision of TOP services created through tension among other nursing staff (Harrison, *et al.*, 2000:428). This may have played a role in shaping nurses' negative attitude towards TOP in an environment where TOP has become legalised in South Africa. As a result, it is challenging for nurses today to deal with the provision of TOP services in their own working environment. Some nurses prefer to remain silent regarding the health benefits of

⁷ www.marriestopes.org.za

⁸ www.mariestopes.org.za

TOP, thereby adding to their resistance to render TOP services. Nurses have knowledge about these benefits and should share these with women trying to make their own decision regarding TOP and their reproductive health. Yet, some nurses prefer to hide behind culture and religion so as to avoid rendering and discussing TOP services with other women. Scholars such as Walker (1996:46) and Macleod and Feltham-King (2012) agree that women who render TOP services are seen to be acting against cultural traditions and values, hence influencing other nurses to choose not to be trained as TOP providers.

Registered nursing staff working in public hospital facilities have mixed views with regard to the provision of TOP services. In South Africa, it is not uncommon for healthcare professionals such as registered nurses in public hospitals to oppose the legalisation of abortion on the basis that it is against their religious and cultural beliefs (Walker 1996; Sibuyi 2004; Macleod and Feltham-King 2012:4). That being said, other nurses find that their religious and cultural beliefs oblige them to provide TOP services in public hospitals (Potgieter and Andrew 2004:27). Scholars such as Walker (1996) and Sibuyi (2004) argue that primary healthcare nurses oppose the legalisation of TOP because they believe that abortion goes against their identity as African nurses, women, mothers and wives, and is influenced by their ontological understanding of womanhood and motherhood. Walker (1996:46) goes on to state that “in their discourse, abortion symbolizes a denial of women’s true calling...To them when a woman has an abortion she is ending not only her pregnancy but also her opportunity to be a mother and even her womanhood.” This is influenced by a patriarchal ideology in which women’s identities are primarily associated with child-bearing. Such patriarchal ideas among nurses have shaped the way they view TOP, interpreting it as undermining a woman’s ability to become a mother.

Nurses who feel that women have the freedom to choose their own reproduction health are influenced by a number of issues related to the public health discourse, as well as human rights and sociocultural discourses (Potgieter and Andrew 2004:20). Examining TOP from each of these perspectives will offer nurses a broader understanding of the services offered. Introducing nurses to a variety of understandings can motivate them to provide these services to women seeking TOP at

public health institutions. In so-doing, it will assist women to exert control over their own reproductive health.

By undergoing training as TOP providers, nurses learn that they can improve women's health through providing safe medical procedures for the termination of pregnancy and thereby reduce the number of unsafe backstreet abortions (Potgieter and Andrew 2004:24). Some nurses regard the liberalisation of TOP laws in South Africa as an opportunity to help women gain control of their reproductive health and to prevent the escalation of the mortality rate and infertility among women (Trueman and Magwentshu 2013:399). Although some of these nurses do not call themselves feminists, their activist understandings and approach to the experiences of women's suffering motivates them to care for patients seeking TOP services in public hospitals. Moreover, nurses who opt to provide these services also sometimes understood see themselves as being 'lifesavers.'

Tyer-Viola *et al.*, (2011) have proposed a set of principles of social responsibility that not only help prevent death and suffering, but also motivate nurses to understand their role in the care of patients in public hospitals. Those nurses that choose to become providers of TOP services argue that South African women have new public rights and that providing this service will help women to have access to exercise these rights even more (Potgieter and Andrew 2004:26). According to Potgieter and Andrew (2004:25), some nurses acknowledge that "no women can be blamed for unwanted pregnancy and that contraception fails." Accordingly, not only do nurses who opt to receive such training so as to improve women's health, but also realise that it is their right to provide this service to women.

In many public hospitals, women nurses make up the majority of healthcare workers, and they are the first to encounter patients seeking TOP. As such, they perform a significant role in restructuring healthcare services in South Africa, especially with regard to the implementation and rendering of TOP services (Partners in Health 2013; Walker 1996). In a study conducted by Walker (1996:53), one participant stated that "my work as a woman is to help the woman who wants to have the child, not the woman who wants to have an abortion." This statement might suggest that the role of the nurse is service to the life of the child. Accordingly, this idea could also justify the

idea that the unborn child has a right to life and the right of women to control their reproductive health rights especially in dealing with the burden of an unwanted pregnancy. This might also be one of the things that influences those nurses that do not support women seeking TOP services in public hospitals.

Statistical data provided by Osman and Thompson (2012) and Trueman and Magwentshu (2013) suggest that the South African Department of Health is facing a shortage of personnel to provide TOP services. Generally, across South Africa there is a shortage of qualified nursing staff willing to provide TOP services to women in public hospitals. The Province of KwaZulu-Natal, where this research was conducted, faces the same problem that affects the rest of the country (Gresh and Maharaj 2014:682). Such staff shortages have a negative impact on women seeking TOP services and may also contribute to their behaviour in accessing these services in public hospitals.

Although the South African Department of Health has managed to make TOP services available in all eleven provinces, women seeking TOP services are still not receiving care in public hospitals, but prefer to terminate their pregnancy in unauthorised places (Harries, *et al.*, 2014). One of the reasons for this might be the long waiting period to receive healthcare services in public hospital due to lack of nurses willing to provide TOP services (Dickson-Tetteh and Billings 2002). Some nurses are unwilling to provide TOP services because they view it as an unimportant health issue compared to other health challenges such as HIV and AIDS. Other nurses simply opt out of providing TOP services due to factors such as stigmatisation. South Africa has been able to train a few nurses in each province to provide TOP services, but there are still challenges in rendering TOP healthcare services. For example, nursing professionals who provide TOP services are often stigmatised, discriminated against and experience isolation in the workplace (Lipp 2011:116). In order to deal with this problem, the Department of Health needs to implement training workshops to raise awareness among nurses about TOP and its benefits for women's health and reproductive rights. Nevertheless, those nurses in public hospitals who are willing to provide the service face a number of challenges, including lack of support from management and colleagues alike (Lipp 2011:116).

4. Religion and Culture of Nurses and the Termination of Pregnancy

Research conducted by Walker (1996) indicates that the majority of primary healthcare nurses reject abortion and that they express anger and hostility towards those women who seek TOP services at public hospitals. As Walker (1996:56) has noted, “attitudes towards abortion were cast in harsh, antagonistic and judgmental terms.” Such judgmental attitudes also cause nursing professionals to abstain from helping women access TOP services in public hospitals.

Based on the above discussion, is it possible to take religion out of nurses or is it possible to take nurses out of religion in the workplace? Scholars such as Walker (1996), Macleod and Feltham-King (2012) and Potgieter and Andrew (2004) agree that nurses are health professionals who can help women take control of their reproductive health, but that they have different views on how to address the problem of implementing TOP services. Walker (1996:56) and Macleod and Feltham-King (2012:4) claim that religion and culture are serious deficits that shape nurses’ negative assessment of TOP services as a provision of public health. This in turn leads to their refusal to provide TOP services or to undergo Department of Health training. Potgieter (2004), however argues that some nursing professionals opt to be trained to provide TOP services because they are influenced by their culture and religion. Accordingly, the point can be made that religious and cultural beliefs can play both positive and negative roles in shaping nurses’ understanding of TOP services in the context of public health. What remains unknown however is what individual nurse’s think about TOP and how religion can influence a positive attitude towards women seeking TOP services in public hospitals.

The main arguments for nurses who opt to provide TOP services are located within the framework of the human rights discourse, within which women have the reproductive right to decide the termination of unwanted pregnancies. Nurses who provide TOP services understand that they are supporting women’s human and reproductive rights (Potgieter and Andrew 2004:24). In line with this, feminist biomedical ethics prioritises those topics related to women’s health and argues that women have the right to have full control over their bodies (Nyrovaara 2011:12). As a

consequence, nurses who take the human rights position understand fully that women cannot be blamed for unwanted pregnancies, unlike some of their nursing colleagues who may blame women for not using contraceptives (Potgieter and Andrew 2004:25).

Some nurses who support the provision of TOP services at public health institutions also understand that they are supporting the policies of a post-apartheid and democratic South African Government. As such, the provision of TOP service falls within their duties as citizens and as nursing professionals (Potgieter and Andrew 2004:26). This is driven by the understanding that nurses are implementing a policy that they fought hard for, an argument which is driven by political objectives. Scholars of feminist biomedical ethics aim “to develop a more inclusive theory of bioethics, taking seriously the standpoints and experiences of women and other marginalized social groups” (Nyrovaara 2011:12). It is crucial therefore to note that a woman’s choice to have control of their own body is fundamental to a woman’s right to have access to quality healthcare services.

Sociocultural discourse is one of the most important issues raised by nurses who opt to be trained to provide TOP services in South Africa. Some nurses specified that TOP was not against their culture and religion, but was part and parcel of it (Potgieter and Andrew 2004:26). The same argument has been raised by Bradford (1991:21) when she asserted that abortion has been practiced in South Africa for centuries. Potgieter and Andrew also make this point when they confirm that, “many participants pointed out that for years, women in African societies have used herbs and other traditional medicine to terminate unwanted pregnancies” (2004:26).

Another important aspect that nursing professionals need to be aware of is the fact that cultural and religious practices are not static, but are subject to constant change in relation to time and space. Respondents cited in the study of Potgieter and Andrew (2004:27) attest that “culture changes....Before, we used the traditional medicine to help women, now we use the modern way” to help women access safe abortion procedures. In the context that I come from, namely Zimbabwe, women have for many years relied on other women that know how to use traditional medicine to terminate pregnancies. Although these practices are unsafe and unauthorised, Zimbabwean women have to continue to rely upon such unsafe and life-threatening

practices because the law in that country forbids access to the legal termination of pregnancy as the reproductive right of women.

All this indicates that there are cultural and religious traditions available which are rich resources that can assist nurses develop a positive view of TOP services. Potgieter and Andrew (2005:26) have pointed out that “women in African societies have used herbs and other traditional medicine to terminate unwanted pregnancies.” Even though nurses are aware of TOP being provided by traditional means in numerous contexts and communities, they are nevertheless motivated to provide TOP services in public health facilities where it is safer for women’s health. Accordingly, nursing professionals who opt to be trained as TOP providers interpret and combine religion and culture together in order to better support women’s access to health services (Potgieter and Andrew 2005).

5. Chapter Summary

In this chapter, I have sought to illustrate through the relevant literature that TOP is a critical and contentious issue in politics, religion, and in medicine. Moreover, it is important to understand the health benefit of TOP in the South African context. Offering TOP services in public hospitals and clinics is a societal good that gives South African women the opportunity to take control of their reproductive health. In providing such services nursing professionals are helping women attain their reproductive health rights while also directly minimising morbidity and mortality rates among women in South Africa.

CHAPTER FOUR

THEORETICAL FRAMEWORK OF THE STUDY

1. Introduction

The theoretical base that guides this study is that of the, “Framework of Social Responsibility for Nursing” as described by Tyer-Viola, *et al.*, (2009). Together with this framework, I draw from the personal experiences of nursing professionals who from healthcare for women seeking TOP in public hospitals. In total, there are four fundamental principles of social responsibility, namely, to promote health, to restore health, to prevent illness, and to alleviate suffering. The concept of social responsibility is therefore a requirement for nurses to remain responsible, loyal and accountable to patients receiving healthcare at public hospitals.

The Framework of Social Responsibility for Nursing is relevant to my study because it combines the Code of Ethics as outlined by Neumann, *et al.*, (2010) and HPCSA (2008). Together with the four fundamental principles noted above, “nursing encompasses the prevention of illness, the alleviation of suffering, the protection of health and the promotion and restoration of health in the care of individuals, families, groups, and communities” (Neumann, *et al.*, 2010:10). These four principles are crucial for socially responsible nursing practice when providing healthcare services to communities.

Figure 1 below provides a summary of the Framework of Social Responsibility for Nursing, with the addition of religious belief. I purposefully include religious belief as an asset in nursing practice. I argue that because the religious belief of nurses indirectly or direct influences their relationships with patients in the working environment, these must be taken into account. When offering TOP in public hospitals, nurses experience various forms of stress associated with both medical and surgical procedures. Identifying religious convictions and beliefs as an additional principle of social responsibility might assist nurses to manage the stress they often experience with the provision of TOP services. According to Lipp and Fothergill

(2009:115), “having a sense of humour and some sort of religions and spiritual conviction have also been found to be a means of dispelling stress in abortion care.” Religion therefore might be an asset in facilitating and improving healthcare services to patients. It is also important to mention that although social responsibility was not mentioned as part of nursing practices as in other professions, it remains key in service delivery to patients in public hospitals (Tyer-Viola, *et al.*, 2009; Kelly, *et al.*, 2008).

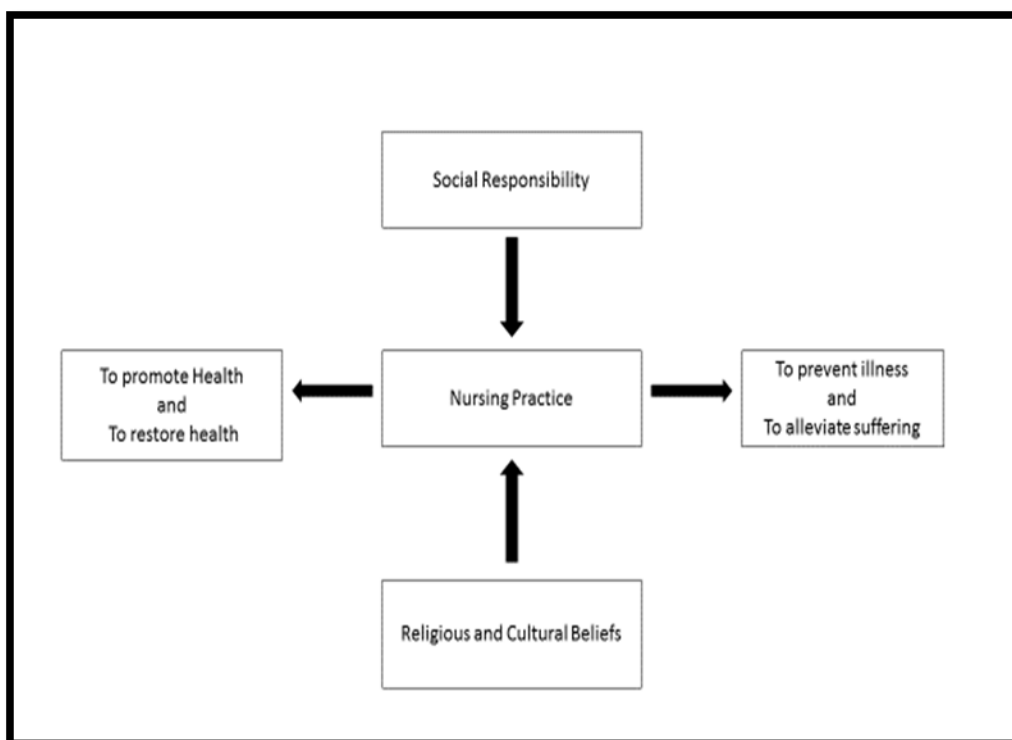


Figure 1

The Framework of Social Responsibility of Nursing Practice

This diagrammatic representation of the Framework of Social Responsibility for Nursing given in Figure 1 above, intends to assist nurses improve their ability to provide healthcare services. The principles therein highlighted address some of the important factors that are helpful in situating the nursing profession as a human caring science that should also promote human dignity and the respect of patients seeking healthcare at public hospitals. Moreover, these principles can be viewed as a representation of the important role that nurses play in providing healthcare service to all patients. The social responsibility principles are fundamental in promoting and

improving the level of service delivery, especially in public healthcare services. Nursing professional services is an essential human need (American Nursing Association 2010:4).

Figure 1 further illustrates the web of fundamental principles that guide nursing practice, how these principles are connected to one another, and how may assist nurses to provide better healthcare services. Figure 1 also reveals that nursing professional practice is at the centre and is informed by the concept of social responsibility and a Code of Ethics. Religious and cultural beliefs directly or indirectly influence and inform nursing professionals in providing healthcare services to patients. Having been informed by the framework of social responsibility and religious beliefs, this will guide nurses in their level of care. The results yielded from the Code of Ethics and the Framework of Social Responsibility for Nursing are, to promote health, to restore health, to prevent illness and alleviating suffering. In order for nurses to improve service delivery to patients, they have to adhere to these fundamental principles.

In the following section I will discuss the meaning of social responsibility, as well as describe in detail how these fundamental principles have direct relation to the provision of healthcare and TOP services by nursing professionals.

The diagrammatic representation of the Framework of Social Responsibility for Nursing provided in Figure 1 above, reveals that nursing professionals play a significant role in providing healthcare services. They are the first to encounter patients seeking healthcare services in hospitals. The principles are interrelated and concern the provision of services to both healthy and ill patients seeking healthcare services and support. All patients need to be treated with dignity and respect as stipulated by the South African Code of Conduct for Health Professionals (HPSA 2008).

2. The Role of Social Responsibility in Nursing Practice

The principles outlined in the Framework of Social Responsibility for Nursing enables nurses to advocate for social change and improving the overall well-being of society. Tyer-Viola, *et al.*, (2009) have noted that nurses have a social responsibility to advocate for the needs of patients and that they should focus on how to deal with the social problems affecting people's health. This includes, concerns relating to poverty, access to healthcare, and environmental conditions affecting human health in general. Without undermining the fact that in religious, political and medical domains, TOP is a contested issue that affect women's health. It is a difficult issue to address even though the practice has been legalised within South Africa since 1996.

Nursing professionals play a major role in caring for women seeking TOP services, and as such they are also responsible for avoiding moral or religious judgment of patients. In other words, nurses are not allowed to judge patients seeking TOP services, but are required to allow women to have control over their reproductive health. In order for nurses to cope with the emotional stress associated with providing TOP, nurses need to develop "high levels of self-esteem, good social support networks, hardiness and good coping skills, mastery and personal control, emotional stability and good psychological release mechanisms" (Lipp and Fothergill 2009:111).

Scholars such as Kane (2009) and Harries, *et al.*, (2014) illustrate their concern that nurses in South Africa misinterpret the practice of conscientious objection by not offering TOP services to women in public hospitals. Therefore, the Framework of Social Responsibility for Nursing might assist nurses to develop a sense of commitment to fulfilling their duty to serve the community. This remains central in advancing the health of the community as well the health of the individual. Tyer-Viola, *et al.*, (2009:110) have argued that "nursing can do this not just because it is right and just, but because many nurses' education prepared nurses to assume this responsibility." Conversely, social responsibility might also be a useful tool to assist nursing professionals to develop continuity in their delivery of services to patients, such as women seeking TOP services. According to Lipp and Fothergill (2009:111) nurses have a responsibility to care as they, "are often the first point of contact for women who need to undergo an abortion...this is literally a life changing decision for

the women and the nurse must ensure that the decision is right one for the women at that time and in her own particular circumstances.” This means that nurses must not discourage or judge women seeking TOP services in public hospitals. Instead, “nurses must facilitate but not unduly influence the decision in the face of her own views, those society or possibly the view of the others (Lipp and Fothergill 2009:111).

The implementation and development of relevant policies is also another factor that affects the nursing profession. Tyer-Viola, *et al.*, (2009:110) point out that the responsibilities of nurses are also expressed within the issues that affect the profession. The approval of the CTOP Act of 1992 gave women the right to choose to terminate pregnancy, and was one of the policies affecting nursing practice and their need to render services to women seeking TOP services in South African public hospitals (Meel and Kaswa 2009). A larger question however, is concerned with what it means to practice socially responsible nursing? In order to understand the Framework of Social Responsibility for Nursing, it is crucial to clarify what is meant by social responsibility.

3. The Scope of Social Responsibility as Related to Nursing Practice

Scholars such as Tyer-Viola, *et al.*, (2009) and Kelly, *et al.*, (2008), have noted that social responsibility is not well-defined in relation to the nursing profession. Accordingly, Tyer-Viola, *et al.*, (2009:111) maintain that, “the concept of social responsibility is closely connected with many professions, providing an important construct for guiding the overall development of these professions and their members.” The framework of social responsibility is clearly embraced in disciplines such as human rights, social justice and community engagement. While in the nursing profession social responsibility is embraced, it is not clearly explicated as in other healthcare professions such as that of physicians (2009:111).

The reasons why there are differences in the understanding of social responsibility in relation to the nursing profession is that within the discipline of medicine the main priority is to provide healthcare. Nevertheless, social responsibility is wholeheartedly embraced by some medical professionals such as Physicians for Human Rights and

Médecins Sans Frontières/Doctors without Borders (MSF). These associations all express social responsibility in ways that can also be applied in nursing practice (Tyer-Viola, *et al.*, 2009:111). Although nursing could be part of this category, Tyer-Viola, *et al.*, (2009) and Kelly, *et al.*, (2008) argue that even if nursing has no dedicated organisation that solely focuses on social responsibility and health equity, nursing professionals are accountable for alleviating sickness and suffering as well as in promoting health.

In the domain of nursing, there are few definitions that link social responsibility to nursing practice. Kelly, *et al.*, propose two such definitions: First, they define social responsibility as “the social force that binds you to your obligations and the concern of action demanded by that force” (2008:2). Second, they define it as “an ethical or ideological theory that an entity whether it is a State, government, corporation, organisation or individual has a responsibility to society” (2008:2). In regard to Tyer-Viola, *et al.*, (2009:111), social responsibility is defined as:

A core value that includes awareness, knowledge and behaviour based upon commitment to the value of equity access and justice: a dedication to civic involvement and environmental sustainability and respect for diversity and freedom of expression.

From the above scholarly definitions of social responsibility as it relates to nursing practice, one could say that the duties of nursing practice embrace social responsibility so as to provide service delivery in public hospitals. According to Tyer-Viola, *et al.*, (2009:111), some early nursing leaders and activists in the late nineteenth and early twentieth centuries such as Florence Nightingale, Lillian Wald and Lavinia Dock, embraced the link between social responsibility and nursing practice. Kelly, *et al.*, (2008:1), on the other hand, suggest that while there is a deep and complex relationship between nursing and social responsibility, it is also important to acknowledge that there are important differences between the two. Nevertheless, what is important here to note is the correlation that exists between social responsibility and nursing practice.

In the case of women seeking TOP services at public hospitals, the duty of nursing professionals is to provide information and offer alternate ways of dealing with the

challenge rather than to neglect women seeking TOP services. In providing TOP services, nurses develop self-esteem, where their personal accomplishments and job satisfaction increases their ability to develop coping skills and strategies in order to manage work-related stress (Lipp and Fothergill 2009). Since TOP service delivery is an emotionally demanding job, nursing professionals need to develop self-esteem to help them render quality services to women. This will contribute to changing the language use and high levels of stigmatisation and prevent nurses from neglecting and judging patients seeking TOP services. This forms part of the social responsibility of nursing practice.

4. The Social Context of Social Responsibility

In nursing practice, social responsibilities serve to transform the concept of caring to include the welfare of society more generally. The Framework of Social Responsibility for Nursing can be a useful model for nursing practice that can shift the focus from individual and family-health needs towards the health needs of communities and societies in general (Tyer-Viola, *et al.*, 2009:111). However, the danger is that an overt emphasis on community health needs, might also lead nurses to overlook or neglect individual health needs, such as those of women seeking TOP services in public hospitals.

While the concern for the wellbeing of the community and the greater society remains significant in service delivery, individual health also need to be considered, particularly in relation to women seeking TOP services at public health facilities. Although Kelly, *et al.*, (2009) states that there is uncertainty regarding the social responsibility of nurses, I argue that linking social responsibility and nursing responsibility can yield significant benefits in delivering healthcare services to individuals, communities and societies in general. In order to effectively provide these services, especially in an environment where TOP is not welcomed, it is the responsibility of the nurse to develop protective mechanisms that can minimise the chance of victimisation and stigmatisation inside and outside of their working environment (Lipp and Fothergill 2009:114).

As Kelly, *et al.*, (2008:3) have noted, social responsibility is “strongly linked to the values of all professions in general and nursing in particular.” Kelly, *et al.*, (2008) further note that “the underlying construct of social responsibility are woven into the fabric of nursing’s history and codes of ethics and practices.” To substantiate this position, Tyer-Viola, *et al.*, (2009:111) also argue that nursing has an overwhelming social responsibility of meeting the health needs of members of the public and in delivering healthcare services in general. Kelly, *et al.*, (2008:3) thus argues that social responsibility among nurses is measured in terms of their concern for the welfare of others, their feelings of duty to help others, and their willing ability in providing healthcare.

While social responsibility is clearly defined in the world of business, within nursing and medicine it is not. In the world of business, social responsibility is a voluntary requirement, whereas in the nursing profession it obligatory (Tyer-Viola, *et al.*, 2009:111). Social responsibility is therefore compulsory for nurses if they are to remain accountable to those they provide services to. In this sense, social responsibility also embraces their social contract towards society. In nursing practice, social contract towards society is based on the health needs of the community in line with their professional rights and responsibilities to care for patients (Neumann, *et al.*, 2010). Nurses that provide TOP services need to have a sense of personal accomplishment and the ability to value the achievements of their work. In rendering TOP services therefore, nurses need to understand the scope of their work as being a way of assisting women in the exercise of their reproductive health rights.

5. The Social Contract and Nursing Practice

The notion that nurses are accountable to the public is critical in the provision of healthcare services. The eight principles of Batho Pele in kick-starting the transformation of service delivery is a good example of making public service providers, including nurses, loyal to service delivery.⁹ In line with this, Neumann, *et al.*, (2010) indicate that:

⁹ <www.dss/limpopo.gov.za/docs/bathopele/>

The public has recognised nursing as one of the most trusted professions...This trusted position imposes a responsibility to provide the very best healthcare, which requires well-educated, clinically astute nurses and a professional associated composed of these nurses which establishes a code of ethics, standards of care and practice, educational and practice requirements, and policies that govern the profession.

6. The Social Implications of Social Responsibility

6.1. Women's Dignity as Human Dignity

The principles of social responsibility seek to promote human dignity. In my opinion this includes the innate right of moral treatment. For example, as the Health Professions Council of South Africa (2008:2) have stated, "healthcare practitioners should respect patients as persons, and acknowledge their intrinsic worth, dignity, and sense of value." Hence, it is the responsibility of nurses to respect women's decision to terminate pregnancy in order to exercise their reproductive choices.

6.2. The Availability and Willingness of Nurses to Provide TOP services

Refusing to care for women seeking TOP services, or an unwillingness to refer them to a registered medical practitioner that will undertake the procedure, indirectly supports the oppression of women within the nursing profession. In KwaZulu-Natal, there are healthcare professionals in public hospitals and clinics who not only refuse to provide TOP services, but also refuse to be trained to provide TOP services (Harrison, *et al.*, 2000:425). As a result of the lack of TOP service providers, the number of women hospitalised has increased in South Africa. In 1997, about 200,000 women were hospitalised for medical treatment due to receiving incomplete TOP procedures at the hands of unregistered, backstreet abortionists. This could have been avoided if nurses had created space for women to have access to TOP services (2000:425). Some feminist theologians, for instance, have been concerned with the liberation of women from patriarchal cultures, and several have tried to address access

to TOP as a health issue for women. Accordingly, McCarrick and Darragh (2001:3) argue that:

Women's healthcare, women's role both as patient and healthcare professional, there are many new reproductive technologies, the exclusion of women as research subjects, as well as the broader topic of feminist contributions to ethical theory itself, have all become topics of interest for feminist bioethical writers.

Nursing as a profession is a women-dominated career, should encourage a professional code of ethics which promotes the development of women in specific situations to be central in decision making in order to avoid conflicts.

The concept of social responsibility and an ethics of care are central to the nursing profession, as nurses are at the forefront of providing public access to quality healthcare. In other words, the nursing profession needs to guard against negative judgments and attitudes towards women seeking TOP, and provide healthcare to women seeking TOP as with any other health challenge. Providing this service will have a number of health benefits such as reducing stress, psychological disturbances, and social problems among women. Finally, TOP services prevent human suffering, such as increased morbidity and mortality rates due to incomplete abortions performed in unauthorised clinics.

6.3. The Choice of TOP and Reproductive Health

The ability to respect a woman's choice to control their reproductive health is an issue of justice. In this study, I argue that nurses are primary caring agents and that their failure to provide care to women seeking TOP is an injustice. I do not intend to undermine the fact that healthcare providers have their own rights, but that their rights do not bar them from referring women patients to colleagues willing to provide TOP services.

In the nursing profession, the idea of caring is central. Caring means not simply providing medical attention, but includes the ability to listen to the concerns of

women seeking TOP services. Groenhout (2004:2) points out that “theory alone cannot make people better but if people want to be moral, caring agents, theory can provide guidelines for decision making.” For nurses, it would be beneficial if they were influenced by a social ethic of care and accept the social responsibility to prevent human suffering. The theory of social responsibility highlights the notion that the nursing profession is responsible to society and that nursing’s professional interest must be rooted in serving the interests of society and that their responsibility will remain guided by an ethics of care (Kelly, *et al.*, 2008; Neumann, *et al.*, 2010).

According to Boff (2007), caring is the opposite of neglect and carelessness. Accordingly, caring “represents an attitude of activity, of concern of responsibility and of an effective involvement with the other” (2007:14). The concept of social responsibility can be a useful tool to empower nurses to take their social responsibility seriously when carrying out their duties at public hospitals and clinics. Groenhout (2004:3) can thus state that:

The notion of a feminist ethic is based on the ideal of care is likewise contentious, since feminist have often been concerned to release women from the requirement that they care for others in a way that destroy their own lives.

An ethics of care in the nursing profession can thus play a fundamental role in providing coping mechanisms for providers of healthcare services to women seeking TOP.

6.4. A Women-centred Model of Caring in Nursing

The concept of social responsibility requires nurses to remain responsible, loyal and accountable to patients receiving healthcare in public hospitals. These ethical guidelines must be contextualised in the South African health sector, and be in-line with the South African Code of Ethics where service delivery is patient-centred and the needs of the patient has first priority for nursing practitioners (HPCSA 2008). However, as Tyer-Viola, *et al.*, (2009:110) argue, “as a human caring science, nursing has the expertise to advance society...As a profession; nursing also has the capacity to focus on the well-being of the society in advocating for social change.” In relation to

the concept of social responsibility, the nursing profession is crucial in improving women's health. In Boff's view, caring is "fundamental mode-of-being" (2007:14). Although one cannot undermine the fact that providers of TOP in the United Kingdom and in South Africa can be stigmatised, providing TOP in public hospitals will contribute to changing discriminatory attitudes in society and among healthcare professionals (Lipp 2011; Walker 1996).

6.5. Caring and Good Work in the Nursing Profession

Central to an ethic of care in the nursing profession is the concept of social responsibility. This raises four fundamental principles that can be used as guidelines for nurses in South Africa in helping women seeking TOP services in public hospital. Neumann, *et al.*, (2010:3) defines the nursing profession as:

The protection, promotion, and optimisation of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.

Any action that undermines these principles, whether religious or cultural practices, undermines medical autonomy and compromises women's health. Although the nursing profession has been given the authority to care, its practices should be grounded within the framework of social responsibility. This framework is derived from a complex social base and includes a social contract towards the communities (Neumann, *et al.*, 2010). In this, nurses are called to care for all patients regardless of their medical condition or needs. In addition, as Neuman, *et al.*, (2010) have remarked:

There is a social contract between society and the profession...Under its terms, society grants the professions authority over functions vital to itself and permits them considerable autonomy in the conduct of their own affairs. In return, the nursing professions are expected to act responsibly; always mindful of the public trust...Self-regulation to assure quality and performance is at the heart of this relationship.

In other words, the public, among them women, must be able to place their trust in nurses.

6.6. An Ethics of Caring in Nursing Practices

In KwaZulu-Natal, the nursing profession is dominated by women. Culturally, women are predominantly seen as caring agents, a mind-set that helps nurses to care for patients (Solidarity Research Institute 2009:3-4). It is therefore important to incorporate the voice of women when analysing the ethics of care within the nursing profession.

Nurses that provide healthcare for women seeking TOP services in public hospitals in South Africa play a fundamental role in enabling women to exercise their reproductive rights. To implement the idea of social responsibility and put a code of conduct into practice within the nursing profession, an ethics of care is important, consisting of the ability to listen, to be there for patients and also to avoid judgmental attitudes towards women seeking TOP services. Such will improve the health-seeking behaviour of women nursing professionals.

Expressions of caring within the nursing profession are also central in the provision of care to patients seeking TOP services in public hospitals. Respecting women's choices, especially when assisting them to gain access to TOP services, will enhance women's dignity, a fundamental values raised by the concept of social responsibility.

Religious faith traditions are central in the provision of care and support to its members. If nurses working in public hospitals are part of a religious faith tradition, it is important to incorporate these so as to understand the phenomenon of care among nursing professionals. The African Religious Health Asset Programme (ARHAP) has an approach to health that might fit well in addressing the dilemma between religion and nursing. However, there are challenges in creating space and balance between nurses' religious and cultural practices and their social responsibility to care for patients.

6.7. The Relationship between Religion and Culture in Nursing Practice

The religious and cultural beliefs of nurses may have a vital role to play in promoting the provision of care to patients seeking healthcare services in public hospitals. It may also empower nurses to provide care to patients seeking TOP in public hospitals. Scholars such as Ben Natan and Melitz (2011) suggest that nurses' religious and cultural beliefs may be of benefit to improving nurses' commitment to work and to provide TOP services to women seeking support and care in public hospitals.

Religion offers an interpretive framework for nurses providing TOP services. Religion and cultural beliefs therefore inform nurses in decision making even where a Code of Ethics is central in guiding and informing their decisions in the nursing profession. De Gruchy (2007:21) argues that "people understand health and sickness within a wider 'worldview', and one of the roles of religion in that worldview is to offer an interpretive framework for health and sickness." It is contention that if religious nurses develop an awareness of the ways in which unwanted pregnancies threaten the health of women, it can assist them to develop religious tolerance and understanding when offering care and support. Hence, nursing practice is informed by both religious and cultural beliefs in providing healthcare to women seeking TOP services at public hospitals.

Scholars such as Schmid (2007) are of the view that the care offered by religious nurses has the potential to be more holistic than care offered by non-religious nurses. In Schmid's view, "the care offered by religious entities is more holistic in its approach and more comprehensive in the range of services offered than that offered by secular or public providers" (2007:31). Although nurses provide physical and medical treatment to the body, it has been discovered that physicians and healthcare providers such as nurses, who take religious and spiritual histories of their patients help them to understand the patients' religious backgrounds, and to determine how they may use their religion as a coping mechanism with illness (Lee and Newberg 2005).

Central to a nurse's understanding of social responsibility is an awareness of the uniqueness of religious nurses in "keeping the quest for the good, right and health life alive as such, thereby pushing it beyond mere individual physical satisfaction" (Grundmann 2007:35). Consequently, a nurse's religious and cultural beliefs might influence them in offering quality and holistic services to patients seeking TOP services in public hospitals.

8. Chapter Summary

The social responsibility of nurses remain central in the provision of healthcare services to patients. Regardless of the medical condition of patients, nurses have a duty to deal with inequality in delivering healthcare services. Adhering to a Framework of Social Responsibility for Nursing will be a useful tool in the working environment. This will particularly be the case in developing an understanding of a nurse's duty to work towards the prevention of illness, the alleviation of suffering, the protection of health, and the promotion and restoration of health in the care of individuals, families, groups, and communities. Hence, religion might be used as an asset in promoting health-seeking behaviour among women accessing TOP services.

CHAPTER FIVE

METHODOLOGY OF THE RESEARCH

1. Introduction

In this chapter, I will outline the methodology that guided this research study. The study is positioned within the interpretive research paradigm and thus pays attention to people's subjective experiences and qualitative interpretations (Gray 2004; Terre Blanche and Durrheim 1999). The interpretation of phenomena in the world is based on the experiences of people involved, in this case, nurses who identified themselves as being religious, and their experiences of caring for women seeking TOP services at public hospitals. The research seeks to understand how nurses' religious and cultural beliefs influenced their experiences of and attitudes towards providing healthcare to women seeking TOP at a public hospital.

An interpretive approach presumes that people's personal experiences are best understood by interacting with research participants and paying attention to what they say to us as researchers (Gray 2004; Terre Blanche and Durrheim 1999). Gray (2004:21) states that, "meaning are handled in, and are modified by, an interactive process used by people in dealing with the phenomena that are encountered." In this regard, there was a need for face-to-face interaction with the participants so as to create an environment whereby participants could better express their emotions, feelings and meanings attached to their current working context.

In the same way, this research study sought to obtain in-depth insights into the individual subjective experiences of nurses' commitment to work, and how their commitment to religious and cultural beliefs influenced them in their provision of healthcare services to women seeking TOP in a public hospital. In order to do so, the study makes use of a phenomenological methodology as a means of conducting interpretive research. In this, it was vital to explore each individual participant's lived experience with regard to their religious and cultural involvements and how these influenced their attitudes towards women seeking TOP services at a public hospital.

I therefore made use of the qualitative research technique as this approach allowed for qualitative interaction between participants and myself as the researcher, which is a relevant approach in interpretive research.

Since the method of data gathering was in-depth one-on-one interactions with the participants, qualitative research methods are appropriate as it creates personal interaction between the researcher and participants, which is suitable in interpretive approaches. Personal interaction between participants and me as the researcher helped me to obtain more information from each of the participants in respect to the research questions posed. In this study, the qualitative research method is an appropriate method to gather data because it allows the researcher to, “explore attitudes, behaviour and experiences through such methods as interviews or focus groups...It attempts to get an in-depth opinion from participants” (Dawson 2002:15, 2007:15). Qualitative research enables the exploration of the lived experiences of the participants and provides access to knowledge concerning each of the participant’s attitudes, behaviours and life experiences in the provision of healthcare to women seeking TOP services at a public hospital.

From the interviews that I conducted, I also observed that participants were more open and decoding information useful to the overall purpose of the study. Personal engagement between me as the interviewer/researcher and the participants in a private and safe place also helped me gain a personal understanding of each of the participant’s personal opinions regarding the provision of healthcare services to TOP patients. Another important factor about personal interaction that shaped the way I came to understand each of the participant’s views was through finding clarity in each and every research question. Each of the participants was open enough to share their experiences of care for TOP patients. This made it easier for me to identify themes used in the analysis of this study.

In this study, I explore how religious and cultural beliefs can function as both assets and deficits in nurses’ provision of healthcare for women seeking TOP services in public hospitals. In order to gather data relevant to the research questions, it was necessary to obtain the stories and experiences of the nurses and their care for women seeking TOP services at a public hospital. Moreover, the personal opinions of the

participants in the study played a vital role in the study. In-depth individual interviews were also used to collect data.

In this chapter I will outline the research methods employed for data collection as well as in the recruitment and selection of the study participants.

2. Research Design: A Phenomenological Study

In this study, I aimed to investigate nurses' religious and cultural attitudes and how these found expression in the way they cared for women seeking TOP services at a public hospital. As was evidenced in the literature, some nurses in KwaZulu-Natal opted not to provide healthcare services to women seeking termination of pregnancy, while others were happy to do so (Harrison, *et al.*, 2000; Potgieter and Andrew 2009).

This research study draws upon phenomenological and qualitative approaches. In phenomenological research, "the researcher attempts to understand how one or more individuals experience a phenomenon" (Johnson and Christensen 2012:48). Phenomenological research explores events in relation individuals' experience of a phenomenon (Johnson and Christensen 2012:48; Gray 2004:21). A phenomenological research methodology was applied in this research study because it enabled me as a researcher to describe and interpret the 'life-worlds' of human experience, wherein meaning is derived from people who are involved in social reality (Gray 2004:22). In this regard, semi-structured interviews were used to explore the experiences of the participant nurses who identified themselves as religious and their experiences to care for women seeking TOP services at a public hospital.

Johnson and Christensen (2012:48) argue that, "the key element of a phenomenological research study is that the researcher "attempts to understand how people experience a phenomenon from the person's own perspectives." The meaning of a phenomenon is derived from the participants involved in the study (Gray 2004; Johnson and Christensen 2012). In the present study, I found out that my personal engagement with participants also helped me to draw meaning from each personal participant useful for the final analysis of the research. The meaning of the views of

each of the participants was also drawn out through personal clarification and verification on what each of the participants were saying during the interview process. As Gray (2004:21) points out:

The key is gaining the subjective experience of the subject, sometimes by trying to put oneself in the place of the subject...Hence, phenomenology becomes an exploration, via personal experience, of prevailing cultural understandings...Value is ascribed not only to the interpretations of researchers, but also of the subjects of the research themselves.

Those which came out within the research findings in the analysis chapter were not based on my personal interpretation of the data, but was influenced by the participants involved in the research and this was important because it minimises misinterpretation of data gathered during the interview process. Meaning is not derived from the interpretation of the researcher's external theoretical models of a phenomenon, but is based on the individuals who participated in the research (Gray 2004:21). I agree with Lesebe (2009:60) who argues that:

As researchers we are able to gain access to the multifaceted nature and complexity of social settings as well as factors that foster relationships in such settings through phenomenological studies.

The meaning derived from the data is not solely based on theoretical approaches, but rather it creates links between the theoretical objectives of the research and the personal understanding participant's experiences in providing healthcare services to women seeking TOP at a public hospital.

In the case of provision of TOP services in a South African public hospital, nurses have different views and understandings of TOP. According to the *Stanford Encyclopedia of Philosophy*:

Phenomenological studies the structure of various types of experience ranging from perception, thought, memory, imagination, emotion, desire, and volition to bodily awareness, embodied action, and social activity, including linguistic activity....The structure of these forms of experience typically involves what Husserl called 'intentionality,' that is, the directedness of experience toward things in the world, the

property of consciousness that, it is a consciousness of or about something (2003).

With regard to the different experiences explored in phenomenological studies, my research only focuses on the perceptions, thoughts and the linguistics of participants. It was therefore crucial during the interviews to listen the participant's thoughts and perceptions regarding TOP.

Johnson and Christensen (2012:384) argue that the objective of “phenomenological research is to obtain a view into your research participants’ life-worlds and to understand their personal meaning (i.e., what something means to them) constructed from their lived experiences.” Phenomenology is therefore a tool used to achieve an understanding of participants, to explore phenomenon from their point of view, and to understand how they ascribe meaning to a thing. This assisted me as a researcher to find the logic and reasoning behind a participant’s provision of healthcare for TOP patients at a public hospital. Both Johnson and Christensen (2012) and Gray (2004) acknowledge that the reliability and value of the data collected should not rely on the interpretation and description of the researcher, but must be based on the concepts, thought patterns, ideas and images raised by the participants themselves. Hence, an understanding of the logic and reasoning of each of the participants made it easy for me as a researcher to come up with certain themes relevant for analysis within this study.

Phenomenological research generally assumes that each individual is not completely different. Indeed, phenomenologists generally assume that there is some commonality in human experiences and hence they seek to understand this commonality (Johnson and Christensen 2012:385). The idea of a commonality of experience also affects how researchers interpret and describe the phenomenon under study. According to Lesebe:

The emphasis of [phenomenological researchers] is the identification and description of the common elements (essences) of the participants’ shared experiences...In addition to describing each participant’s unique experiences, common experiences across the participants are also discussed (2009:61).

Nurses who are working in public health have different views on TOP, as well as different attitudes and opinions about the provision of TOP services to women. While

some understand it as an issue concerning women's health, others view it as an ethical and moral issue.

3. Research Methods

Research methods “are the tools that are used to gather data” (Dawson 2007:38). This study falls within the qualitative research paradigm. I used the primary method which according to Dawson (2002:40), “involves the study of a subject through first-hand observation and investigation.” In this study, interviews were used as a source of understanding personal opinion of nurses regarding their attitudes and behaviours towards women seeking TOP service in a public hospital. This helped me to better understand the different views and opinions of each of the nurse participants in the provision of care to women seeking TOP services at a public hospital.

3.1. Research Procedures

In August 2013, I approached Edendale Hospital for permission to conduct interviews among nurses. Permission to conduct my research at this hospital, for various reasons, proved not to be impossible. In September 2013, I therefore approached Grey's Hospital, Pietermaritzburg instead. The main objective was to obtain permission from the hospital manager. Once I received permission, I proceeded to apply to the Provincial Department of Health for approval. Upon receiving their approval, I was able to submit my research proposal to the University of KwaZulu-Natal's Biomedical Research Ethics Committee for ethical approval to conduct the research. The research was approved by the Ethics Committee on 10 April 2014.

Following on from this, I arranged to meet with the hospital nursing manager to discuss the logistics of my research project, and to find nurses who identified themselves as being religious, who had knowledge and experience in providing healthcare services to women seeking TOP in public hospitals, and who were willing to participate in my study. The unit manager [ward manager] was also informed about the general overview of the research, the communication process being done through E-mails. From there, I make appointments telephonically with the unit manager to

explain my objective and identify suitable participants who could partake in the study. After a week, I managed to find nurses who agreed to participate in the interviews. Once I understood the daily routine and activities of nurses working in the gynaecology and obstetrics departments, most of my appointment with participants were conducted in the afternoon when nurses were not so busy.

My reason for choosing to conduct this study at Grey's Hospital, Pietermaritzburg, was due to the religious history of its establishment. Although being a public hospital, it incorporates medical professionals from different religious groups. Religious (Christian) facilities such as a Chapel and Bibles are available in every ward at Grey's Hospital. These resources are used by many nurses for the purpose of divine worship.

In all, six participants were interviewed. The interviewees worked in the labour ward, the gynaecology ward, the maternity ward, while about four were working in the gynaecology ward where TOP patients are admitted in Grey's Hospital as well as other hospitals across the province.

Out of the six participants, five were registered nurses and one was a staff nurse. A Registered Nurse (RN) is a professional person registered as a nurse or as a midwife under the nursing Act (Act 50 Of 1978 cited in Mamabolo 2006:17). In this study, registered nurses are professional nurses who are working with patients seeking or undergoing termination of pregnancy (gynaecology and obstetrics) procedures at public hospitals.

3.2. Sampling Process

Sampling is “the process of drawing a sample from a population” (Johnson and Christensen 2012:216). As I have mentioned in the previous section, the hospital manager sent my request to her staff and I managed to find six nurses. All appointments were made telephonically and interviews were conducted based on the availability of participants. Initially, I had planned to interview eight nurses, but due to various personal reasons I only managed to interview six participants. In this study, I used a purposive sampling method to choose six nurses who agreed to participate in

the research. The aim of using purposive sampling was to identify a small number of nurse participants who met the criteria of having experience with TOP services at a public hospital and who were self-identified as being religious.

Moreover, I made use of the snowball sampling technique to recruit participants. Because of time constraints, it was not possible to contact all registered or staff nurses working at the hospital to participate in the research. I therefore asked the nurses to refer me to their colleagues who might agree to take part in the research project. The main purpose of using a snowball sampling technique was to recruit self-identified religious nurses who had experience working in public hospitals, and who had access to women in pre-abortion and post-abortion phases at their hospital. The sample was not restricted to any particular religious group working in the maternity ward, but was open to all religious traditions. Most of the participants were from the Christian faith, or influenced both by Christian and African religious traditions. A sample of six nurses was ultimately recruited.

3.3. In-depth Interviews

Individual in-depth interviews were used to gather individual narratives of care for women seeking TOP services in Grey's Hospital, Pietermaritzburg. Semi-structured questions were used in order to “achieve a holistic understanding of the interviewees’ point of view” (Dawson 2002:27). According to Dawson, semi-structured interviews “remain flexible so that other important information can still arise” during the interview (2002:29). The idea of choosing semi-structured interviews was on the premise that they are more flexible and that each of the participants provide individual information useful in the study.

Appointments were arranged telephonically on different dates depending on the availability of participants who agreed to participate in the interview process. Since all interviews were conducted during working hours, the sister-in-charge and nurses who participated suggested to set up a room where all the interviews could be conducted.

The six nurses were all interviewed at once. Most of the interviews were conducted in the afternoon where participants were not too busy. All interviews were conducted in the hospital in a private room available at that time. The interviews were voice recorded and transcribed for later analysis.

Each of the interviews were conducted individually, as face-to-face meetings between the researcher and the participants. This was done in a private room allocated for that purpose in order to create a safe space for in-depth discussions with each nurse regarding their religious and cultural views and positions regarding TOP procedures and services.

All interviewees signed informed consent forms before the interviews were conducted.¹⁰ All participants involved in this study were given the opportunity to withdraw from the study at any time.

The interviews were conducted over the course of nineteen days between 23 May and 12 June 2014. From the information given in the personal statement,¹¹ I stated that the interviews were to be conducted in English as the researcher was not a Zulu language speaker. All nurses who agreed to participate in this research were comfortable using English as their chosen language of communication.

The title of the study was constantly changed due to comments from my supervisor. Nevertheless, the focus of the study is not substantially different from the one approved by Biomedical Ethics, University of KwaZulu-Natal Ethical Clearance Committee, from Grey's Hospital manager, or with respect to the permission gained from the KwaZulu-Natal Department of Health.¹² All changes were clearly communicated to the Post-Graduate Administration Office at the School of Religion, Philosophy and Classics, College of Humanities, University of KwaZulu-Natal.

¹⁰ See, Appendix 1.

¹¹ See, Appendix 2.

¹² See, Appendix 3, 4.

4. The Process and Method of Data Analysis

For the purpose of analysing data, I utilised thematic analysis where the nurse's statements were coded and classified into themes in relation to the overall focus of the study, even though I was aware that there were a number of different methods applied to analysing qualitative research data, such as content analysis, discourse analysis, comparative analysis and thematic analysis (Dawson 2007:119). In this research study, I made use of thematic analysis because it is a flexible method of data analysis data, and it can be easily applied to the phenomenon under investigation (Braun and Clarke 2006:27). Thematic analysis is a method aimed at identifying, grouping, and recording material within the interview transcripts into major themes that are common among all participants. The data is then organised and described in rich detail, before moving on to interpretation of the various aspects of the topic under study (Braun and Clarke 2006:6).

The data was analysed based on themes evolving from the interviews. As the researcher, I looked for patterns that emerged from the different transcripts (Dawson 2007:120). According to Braun and Clarke (2006:10) "a theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set." In relation to the received data and analysis, I made some changes so as to ensure that the meaning of each of the statements was accessible, being careful in correcting the verbatim reports, especially the English grammar and syntax, in order to ensure the sense of each was retained. However, I did not interfere with the meaning of what participants were saying and in most cases the changes in grammar and syntax consisted of only minor changes.

Thematic analysis in qualitative research is described as an "inductive thematic analysis" (Fareday and Muir-Cochrane 2006:2). The themes constructed during the analysis process of this research project were inductive because they were generated from individual nurses and their understanding of the provision of care for women seeking TOP services at Grey's Hospital, Pietermaritzburg.

The analytical procedure followed was the one proposed by Braun and Clarke (2006). In Table 1 below, I outline the different stages of data that I used for data analysis in the present study.

Phase	Braun and Clarke (2006)
1	Familiarising yourself with data
2	Generating initial codes
3	Searching for themes
4	Reviewing themes
5	Defining themes
6	Producing the report

Table 1
Stages of Data Capturing

It was helpful to follow the six procedures outlined above. It made it easier to internalise information produced through the research process, as well as serving to create different themes that addressed my research objectives. During the first stage of data analysis, I identified significant statements, either through a few words, an entire phrase, a sentence, or several sentences relevant to the phenomenon under investigation (Johnson and Christensen 2012:387). This meant that the analysis of data began during the interview process, where I as the researcher began to identify themes important to the study. As the researcher, I was responsible for interviewing the participants and transcribing the information received from a digital audio recorder. As a researcher, I began to gain a general understanding during the interviews as well as when transcribing the voice recordings. The transcription process also aided my understanding of the phenomenon of care among religious nurses in Grey's Hospital. Moreover, through a process of repeatedly reading the transcripts my internalisation of the data was enhanced. This process help me to capture statements, phrases, words and sentences meaningful to the research under investigation. The presentation and analysis of data in the current research will be demonstrated in the chapters which follow.

5. Ethical Considerations

According to Churchill (1991:103), research ethics are very important because they aid the development of moral standards by which research situations can be handled. These standards apply to all circumstances in which there may be actual or potential harm of any kind to individuals involved in the study. Since TOP is a controversial subject in the public health sector, the information and personal details concerning all participants remain strictly confidential. The information gathered will be destroyed upon completion of the research project. All participants will be made aware that their participation is voluntary and that this research will be solely used for the academic purpose of obtaining a Masters Degree at the University of KwaZulu-Natal (UKZN).

All information gathered is kept in a safe place. Names of the participants, as well as any other personal information was considered confidential and anonymous and as such is not mentioned in the research report. In the presentation of data pseudonyms will be used in the study to protect the privacy of the research participants. I also made sure that all participants were well informed about the voluntary nature of their participation and that they had the right to withdraw from the study at any time. All participants were also informed about the potential impact of the investigation and that the study was a Masters Degree research study conducted for academic purposes. This was evidenced in the cover letter and consent form attached to the front of the measuring instrument.

6. Delineation and Limitation of the Study

The study deliberately avoids generalised views on religious and cultural views on TOP among nurses in KwaZulu-Natal as the research focus was on how the views and behaviours of an individual nurse participant influences them to provide medical services to women seeking TOP services in public hospital. Generalisation was not the goal of this research project, rather it sought to “explain or describe what is happening within a small group of people” (Dawson 2007:49-50). As a consequence, information gathered in this research might not provide insights into the behaviour of

the wider population regarding TOP. In addition, I accept that if similar research is carried out it might produce different research findings.

Some of the difficulties that I faced when conducting this research concerned the following:

- i. The use of the English language in conducting the interviews. In this research, I was using English and some participants were unable to express their views well in English as they would have if the interviews were conducted in the Zulu language. If I had been given the opportunity to find a female research assistant or co-investigator to conduct some of the interviews, the interviews would have been conducted in the Zulu language since most of my participants were Zulu-speaking people. As part of my degree programme however, it is required that I produce a research study as part of my Masters in Theology course in the Religion, Gender and Health Programme, in the School of Religion, Philosophy and Classics at the University of KwaZulu-Natal. As part of the course requirements, it is expected that I conduct this research on my own and not as part of a team.
- ii. I made the assumption that since nursing profession is a female-dominated career, being a male conducting such a research with female nurses would be a barrier to gathering their views on providing TOP services at public hospitals. However, I observed that this was not the case as all the female nurse participants expressed being comfortable decoding information openly to me, even though I was a male researcher.
- iii. The research questions were focused specifically on the religious/cultural phenomena in regard to the research participant's support or objection to TOP services offered at public hospitals, and not on the medical, surgical, or bodily intricacies of TOP.

7. Chapter Summary

In this chapter, I presented a detailed outline of the research methodology and research design that was used in this research study. In conducting a research of this nature, I found out that there is a lot of preparation as well as a number of challenges in conducting a research in the medical domain as well as on religious and cultural beliefs.

CHAPTER SIX

NURSES' REFLECTIONS ON AND VIEWS OF TERMINATION OF PREGNANCY

1. Introduction

In this chapter I will present some background information of participants, material from the interviews, and how this shaped the way I came to understand the major themes that emerged during the interviews. It is also important at this stage to clarify that nurses in public hospitals are not performing the medical procedures to help women terminate their pregnancy, but instead offer general care to patients who are undergoing TOP in their respective working environment.

2. General Background of the Research Participants

All participants had four to thirty-three years working experience in the field of nursing. All participants were female and each were registered midwives, registered nurses or staff nurses, see appendix 5 on page 133. Six nurses in total participate in the study and four participants identified themselves as being of the Christian faith, coming from different Christian denominations, see appendix 5 on page 133. Two participants identified themselves as being influenced both by Christianity and African Indigenous Religion, see appendix 5 on page 133. All the participants indicated that during their working history they had encountered women seeking TOP at least once, and that they had general knowledge regarding TOP.

The focus of the questions asked during the interviews was to explore the extent to which religion assists nurses working in public hospitals and their experiences in providing healthcare services to women seeking TOP. Their views and attitudes were influenced by their experiences, religious affiliation and their cultural beliefs as well as their age. The age range of the participants was between 26 to 55 years and all participants worked for more than one year in public hospitals in South Africa. Their

age and experience also influenced the way they shared information regarding their individual views on their experiences of offering TOP services to women in public hospitals.

In this Chapter, I will outline the main themes from the interviews, particularly in relation to each of the nurse's religious and cultural beliefs and work experiences in providing healthcare services to women seeking TOP services at public hospitals. The themes which emerged from the interviews included personal convictions and preferences, attitudes of self and those of their peers regarding TOP, religious convictions and each of the participant's responses to TOP in their working environment.

3. Main Themes

There were three main themes that emerged from the information shared by the participants in the study. These themes emerged in connection with the interview questions which aimed to address the main questions of the study. These themes were: personal conviction; social attitude of self and one's peers about TOP, and finally, religious convictions.

3.1. Personal Convictions and Preferences

3.1.1. An Ethics of Care

An ethic of care in the nursing profession is the ability for nurses to recognise the needs of patients in order to respond to them and their action or reaction in response to the healthcare needs of patients. This demonstrates the competence of nurses at work to fulfil the needs of patients. According to an ethics of care in nursing practice, nurses are required to have compassion, show respect for and promote human dignity, respect each individual's worth and uniqueness, unrestricted by virtue of social or

economic status, personal attributes, or the nature of health problems (See, Nursing World Code of Ethics 2010:1).

Most of the nurses that participated in this research regarded nursing as a 'calling.' As such, some of the research participants indicated a deep personal desire and commitment to serve patients according to the value of the task or profession.¹³ Still others considered nursing a career choice they wanted to pursue with passion. Two of the participants stated that they developed an interest in working as a nurse while they were still in high school. As Sharon¹⁴ was to state:

I think it was a vocational thing for me. I always wanted to become a nurse and it's not something that I just use as an option for employment. I remember when I was in class 2 and I remember my dad asking me, "Girl what do you want to do when you grow up?" and I said I want to be a nurse, it have never changed and I became a nurse (Interview dated 23 May 2014).

Likewise, Silindile remarked:

I was passionate about it [nursing] while I was at high school (Interview dated 06 June 2014).

The research participant Lungile also stated that nursing was her passion and that she wanted to care for people who needed help:

Nursing ... was and...continues to be my passion" (Interview dated 23 May 2014).

Besides being passionate about taking up nursing, most of the participants indicated that the nursing of patients is one of the fundamental duties of a nursing professional. Almost all participants were trained in midwifery and some preferred to work in the gynaecology ward, where patients admitted included those who were seeking TOP. Working in the gynaecology ward for many was less distressing compared to the

¹³ <www.ncbi.nlm.nih.gov/pub/>.

medical ward, because patients receiving treatment there were not expected to stay long in the ward as compared to a medical ward. Participants such as Silindile could remark:

I don't want to nurse somebody I know is going to die anyway. Regardless of whatever I am going to do they are going to die, it is depressing. I want to treat somebody and go home, yes. It's like in the case of women who seek termination of pregnancy, you treat them, they go, they might stay for few days and go, and it's not depressing (Interview dated 06 June 2014).

Similarly, Philile could state:

I might say that, they do not spend much time in here as compared to the medical ward especially when the condition of the patients is serious. They stay too long in the ward. If the patients deliver at night, we can take that patients that same night and by 10am in the morning they will be ready to go (Interview dated 12 June 2014).

As Naresh also commented:

Well, they are so many things, the fact that you come here you are nursing somebody, nursing them back to normal health you will be able to provide care to them, you see, that keeps me going every day. Although I acknowledge that it's not easy sometimes, you don't enjoy it as such, but you will be motivated to continue to work, especially if many patients are getting well and go home it's really great (Interview dated 12 June 2014).

While some nurses preferred to provide healthcare for women seeking TOP, most participants accepted that women seeking TOP had different experiences and different health needs. In respect to those women seeking TOP services for social and economic reason, the nurses interviewed expressed their difficulty in assisting such patients. In the case of women who had been raped and women who were thus

unwilling to continue with their pregnancy, the nurses interviewed indicated that they willingly offered them advice in relation to their circumstances. This is a strong assertion, one that seems to be common among healthcare workers opposed to TOP. They felt that many women used TOP as a form of contraception.

Participants such as Silindile said that:

We treat them [TOP patients] the same but keeping in mind that their circumstances are not the same, like the one who was raped...you counsel her according to the situation, but the one who is doing it just for social reasons you also treat them and provide care like any other patient as well and advise them not to use it (TOP) as a contraceptive method. It's not a good thing to any of them but depending on the circumstance, I mean you can't deny them to control their reproductive choices, you see (Interview dated 06 June 2014).

Some participants felt difficulty in providing TOP services for social reasons because they did not consider it as a serious health issue. For example, some women wanted TOP because they felt they could not raise a child due to economic restraints. Others, wanted TOP services because they considered that the resultant child would be unwanted or would inconvenience their future activities.

As Philile was to state:

Already I have judged a patient without knowing the reason why she is looking for abortion, but with time I begin to learn and to accept that different people have different beliefs and...they do what they want to do to their bodies, they have a choice to do it at that time depending on their health need. I learn to accept the whole process and I care for them now without judging them. Even if the Bible can say I am [committing] a sin by helping them, I think I am doing the right thing to help women to exercise their right as women, you see....Whatever I do, I do to save the life of a patient. To stop them from going outside the hospital to do it because they will die and at the same time, and

they come to us when they are sick. I will assist in the whole process and I have to take her to the mortuary and all that (Interview dated 12 June 2014).

In cases where pregnancy threatened a woman's life, especially in the case of physical or genetic abnormalities such as when the foetus was found to have a structural heart defect, or where there were abnormalities affecting the foetal cells, all research participants indicated that they had less prejudice and felt obliged to provide care and support to save women's life.

Sharon therefore commented:

If it is a foetus abnormality, then the doctor will advise the mother, the doctor will allow this abnormal foetus to come out, in that case, that is okay, because in my own experience. I know that if the child is retarded, very retarded they are social problem involved in all that. But when the child is a normal and healthy and the child is getting murdered so yes, that traumatises us as a nurse (Interview dated 23 May 2014).

Likewise, Naresh also said:

It's something that is not right to do, it depends on different cases like in the case of foetal abnormalities, that kind of the problem that has to be done, from personal and religious view it has to be done. In that case you have to offer the care or whatever (Interview dated 12 June 2014).

During the interviews, I observed that some participants saw nursing and caring for patients, including women seeking TOP, as an essential part of their job description. They felt they had to do it. Even if the public may judge them, they felt they should remain loyal to their work.

Of the participants, Silindile noted that:

It is part of my work, I am doing it [caring for TOP patients] for what I have been employed to do. If they do stigmatise me it's their own problem and it's not my problem. I am doing it for women's health you see. I don't care, maybe they stigmatize or judge me today, but in future it's their child too will be here and they will want me to assist them or their family member whoever and they want me to take care of them. So if you stigmatise us that we are doing this here....What do you want to do with that relative of yours? (Interview dated 06 June 2014).

And, again as Sharon could state:

The public can't judge us, this is our job, this is service delivery and so how can they judge us, they can't judge us, they know that we are nurses that's it, that is our where they stop, it's our job. We can't leave this job and...do something else we are not qualified to do anything else this is our job, we are qualified, we are professionals, we have got masters degrees and what...this is what we choose to do you see (Interview dated 23 May 2014).

And finally, as Naresh could remark:

As a Christian, some of the difficulties I am thinking we might have is being labelled as baby killers, but I do not think that they can say it out because as nurses it's our job and our duties to care for everyone who need help. Whether they stigmatises us we don't care, it's our duty to assist patients rather than to allow them to go and have access to abortion outside the hospital and sometimes they die. If you are working here they is no not need to fear to be labelled by other nurses or even the society, my duty as a Christian it to help those who are in need of my service (Interview dated 12 June 2014).

Most of the research participants felt that their responsibility and duty was to provide healthcare services to patients seeking TOP services regardless of their risk of being

stigmatised. They also felt that the provision of TOP service is the fulfilment of their social responsibility to reduce death and illness associated with illegal and unsanitary abortions conducted in unauthorised places. In short, the nurses indicated that the provision of TOP in public hospitals is a risk-taking duty where the community and even other workers can stigmatise them. Nevertheless, what was key to them was the concern of the patients as a given priority of the nursing profession.

3.1.2. Rights Discourse

As a general observation, I noted a definite ‘rights discourse’ in the dialogue of many of the research participants. A rights discourse was found where participants felt that they were assisting women to access TOP, which they viewed as a fundamental human right (Potgieter and Andrew 2009:25). TOP is a reproductive right for all women, as well as access to public healthcare services, including seeking TOP services.

This is supported by Silindile, who noted:

I must tell you, it's not something very nice for me to perform termination of pregnancy to a women, but also I can't deny them to exercise their rights as women, you see. But you find out that sometimes, some women come for termination of pregnancy because maybe the baby or the foetus is abnormal and they will be advised by the doctors to terminate and some are raped, that is a different story, which you have to give your heart to them (Interview dated 06 June 2014).

As did Sharon in her interview:

It is their right, the government has put it in the constitution, so you cannot take away person's right, if the government is saying you can have an abortion, then why not it's your rights, it's your choice, that is my view, it's your choice....I am getting paid for this work, and I am

not doing it for free, it's what you want and it's legal, it's safe and the government is saying you can do it and it's my job to give you service delivery....You can report me for not doing it, you see. At least here we have an understanding because they are two of us who are [Roman] Catholics, at least they understand us but otherwise we could actually get into trouble, because we don't want to initiate [providing to doing abortion procedures] abortion, but we clean up the mess, we clean up the mess, we do everything else. But to initiate we won't do it you see (Interview dated 23 May 2014).

Some of the comments from the other nurse participants also suggested that nurses enjoyed limited rights compared to those of their patients, even though they continue to care for TOP patients in public hospitals.

Accordingly, some of the research participants such as Philile could state:

Well, firstly, it is being expected to do stuff you do not believe in because they said you sign up for this kind of work, since you are working here, this is what you have to do and you don't have a choice, being a nurse means you don't have a choice lately and since we are in a gynaecology ward, you do not have a choice but you have to provide care to women seeking TOP whether you believe it or not, you have to treat them whether you believe in it or not, you see....I must tell you, it's not something very nice for me to perform termination of pregnancy to a woman, but also I can't deny them to exercise their rights as women, you see....Although they [other nurses] still render the services, but most of them are not happy at all. They still have an understanding of the old constitution which deprive women the freedom and the right to abort you see (Interview dated 12 June 2014).

As did Naresh in his dialogue:

I don't see the reason why they avoid or object it's not your choice, you are working here and at the end of the day this is your job and you

are working here and you are not going to do the abortion procedure to the patients, it's done by doctors, you know, you just offer the nursing care to them, I do not see any reason to object to [offering] the nursing care needed by the patients. You are not physically doing it, it's a different case where you are working in abortion clinics it's a different issue [there] you have to do it. To those who find it hard to help patients they have to leave the ward and work in another department instead of judging patients who are seeking medical healthcare other than the backdoor ones (Interview dated 12 June 2014).

3.2. Personal and Peer Views about TOP services

3.2.1. Affirmation and Acceptance

An affirmation to assist women to undergo a TOP procedure is where participants give statements in their interviews that support the right of women to have the sexual and reproductive choice to terminate their pregnancy and to have access to TOP services in public hospitals.

For example, Sharon could affirm that:

I feel that if a women want[s] to have an abortion, she can go right ahead and have [an] abortion and because if she want to have an abortion (Interview dated 23 May 14).

This research participant confirmed that patients have the reproductive freedom to choose to terminate their pregnancy. Even without mentioning the law, participants confirmed their requirement to provide healthcare to women seeking TOP in public hospitals.

Some research participants said that some of their women patients had sought TOP services due to financial constraints, as well as the social challenges they face as women. Most women who sought TOP services in public hospitals lacked any form of financial stability. Some research participants mentioned the fact that some patients sought TOP because they could not afford to take care of their children. Others, were still young and wanted to pursue their further education.

For example, Silindile said in her interview that:

It's actually different for every patient, some will come and say that they want to terminate because they cannot afford to take care and to raise the child or maybe they are still at school, or maybe they want to terminate because their family does not know that they are pregnant and in most families, getting pregnant at a [young] age is unacceptable (Interview dated 06 May 2014).

Some nurses suggested that helping women to access TOP services in Grey's Hospital, Pietermaritzburg may minimise the morbidity and mortality rates among South African women. They pointed out that making TOP freely available to women may improve their patient's health status, and thereby increase the control of their reproductive health.

Some of the participants articulated this fact clearly, as did Silindile in her interview:

Some of them [women] find it not easy to come to a hospital to request termination of pregnancy they are some dodgy practices available out there, which provide them with medication to abort, but some of them they come here ill-ill-ill, you see, because outside the hospital, they don't do it properly as it is supposed to be done and some of them end up dying from that, but I think maybe they are scared, I don't know (Interview dated 06 June 2014).

Again, as Sharon was to remark:

What is our choice we don't really have a choice because if we refuse to do that abortion, it means, we are sending people to a backstreet abortion and by sending a patient to backstreet abortion we are sending the patient to death, because we have many-many cases that come here to Grey's, the patient get backstreet abortion, got septic abortion and they come here half dead and some of them even die, so that is why we have to be strong enough in our jobs (Interview dated 23 May 2014)

Sharon went on to further acknowledge that:

But I feel that if a women want to have an abortion it is her body, it is her right and it is her sin (Interview dated 23 May 2014).

It was important for most of the research participants to provide TOP services because it helps to avoid illness, death and other complications among women if they undergo TOP at unauthorised locations. If nurses do not offer TOP they are putting women's health at risk.

As Lungile, one the participants, captured this point clearly when she stated that:

They can do it, it's their own position and they might have been influenced by their culture, church tradition to help those who are in need. As you know we leave in community with others, such understanding will help them to provide women with health service to encourage women's health (Interview dated 23 May 2014).

Central to what Lungile said was her conviction that religious and cultural beliefs, whether they be from a Christian tradition or any other religion, also motivate healthcare professionals to consider the health of their patients as being of paramount importance.

3.2.2. Stigmatisation and Rejection

Stigmatisation in the context of my research is where nurses make use of statements that reveal some measure of disapproval in providing healthcare to women seeking TOP services. According to Paterson (2005:3), stigma is connected with deep-seated attitudes and communal norms. Discrimination is a dynamic process that can (but need not) occur as a result of stigma. As Patterson (2005:3-4) has shown:

Symbolic stigma that carries the weight of the religious, moral, cultural and social baggage associated with particular disease, imbuing them with negative meanings that go far beyond the instrumental concerns over risk and resources constraint.

Some of the research participants offered statements that stigmatise women who are seeking TOP services. Accordingly, this may influence the way they provide healthcare to TOP patients.

Many of the participant's comments and the type of language they used to describe women seeking TOP services, inevitably stigmatises these women and might influence women's behaviour in seeking access to TOP services at a public hospital. In particular, I noted that some participants used pejorative expressions such as, "baby killers," "abortion is a sin" and describing TOP as "a seasonal thing." The use of these kinds of comments stigmatises women who are seeking TOP services in public hospitals.

The research participant Silindile, was of the opinion that:

It's a season thing to terminate of pregnancy, you know, especially after winter, you find out that by August, September and October you find more of the girls seeking termination of pregnancy and after first of season January, February and March that is the most time we get most of women seeking termination of pregnancy (Interview dated 06 June 2014).

The research participant Sharon, also offered the following opinion:

Stigma has always been there that is why these women go to these private clinics to do it secretly rather than coming here. It's a thing that women would be judged, I mean, who wants to be a baby killer you know. I am saying this because abortion is murder at the end of the day no matter how you see it, murder is murder (Interview dated 23 May 2014).

Some of the participants felt that some of the women patients seeking TOP services were not only baby killers, but were also sexually promiscuous. Using this kind of language stigmatises women who are seeking access to TOP services in public hospitals.

Accordingly, the research participant Silindile, was to state:

To come to the hospital to request termination of pregnancy, they rather go to those people or areas. Some of them are scared of being labelled as baby killers and some nurses, especially those who are at their fifty years and above are still not feeling comfortable to provide care to women who seek termination of pregnancy, you see (Interview dated 06 June 2014).

Likewise, Nomusa was to remark:

It also happens that some women who are cheating while their husband are at work and they get pregnant and [that] pregnancy might complicate their marriages if they can keep the baby, again abortion is the only option that they have to protect their marriages (Interview dated 30 June 2014).

From my general observations, I also noticed that many participants commented that nurses scolded and judged patients seeking TOP services. This does not only has the result of barring many women from accessing public healthcare services, including

TOP services, but it often forces pregnant women to consult unauthorised clinics and practitioners, thereby putting their health at serious risk.

For example, the research participant Sharon stated that:

Because according to them, they don't want to come to the hospital or clinics, because nurses judged them, so you see, that is mainly the reason why they rather avoid the clinics or hospital and go to these unsafe places because of the fear of being scolded, judged, and the fear of being found out (Interview dated 23 May 2014).

Some participants advise women to reconsider TOP and rather opt to carry their child to term and give the baby over for adoption once born. Other nursing professionals, point to the child support grants offered by the South African Government as a way of discouraging women to undergo TOP procedures.

Part of the professional duty of registered nurses is to provide patients with advice about the option of adoption. This helps patients to make an informed decision before considering TOP services in public hospitals. From my research, it appeared that all the participant nurses in the research seemed to advise women patients to avoid undergoing TOP procedures and instead, agree to put the child up for adoption once the child has been born.

Sharon captured this thought very clearly when she said that:

So she can go ahead and do it, because she is given other options. Like, we don't just do abortion, we first refer them to our social worker who will counsel her, who will give her other options of adoption and tell her about the "imali yeqolo or SASSA grant" and all those things, you see she is given options she don't just come here and have an abortion, because we are a tertiary hospital, we are not the first line, the district and neither we are a clinic you see so if she still feel after the counselling and after all the advice that she gets and she don't want to give up the baby for adoption and she want[s] to have it

[TOP], I say she can have it, it's her body, it's her sin and it [is] between her and God (Interview dated 23 May 2014).

In addition to this, it would appear that some of the women seeking TOP services are blamed for being sexually promiscuous by many of the research participants. This deliberately stigmatises women seeking TOP services in public hospitals. Some of the research participants argued that based on their own personal experiences of TOP, women tend to discourage other women who seek this services and thereby object to provide the service because of the experiences of trauma if the foetus is fully formed.

Some participants such as Sharon could thus state:

You see some nurses object because they just feel that these children, because you find out these children are coming to seek abortion so you know they just object because they just feel that these children are promiscuous there is free family planning, so why is [it] that they [women] are not using condoms, you know, things like that....When we find unpleasant, nurses are getting traumatised, that is what happens, but...most of the time the baby come[s] out alive and it traumatised me and traumatizes the poor doctor too. So it was so traumatic that I feel like I need counselling, I am also a mother of children and a grandchildren and you know (Interview dated 23 May 2014).

The research participant Silindile could also state:

For example, maybe she [has] done it before and she don't want to see someone going through that same procedure or do it again to someone else, it could be many reasons I [do] not even know (Interview dated 06 June 2014).

3.3. Religious Convictions and Termination of Pregnancy

3.3.1. Religion as a Health Asset

South African public healthcare as a service faces challenges in implementing certain healthcare policies and services, TOP services is a case in point. Based on this, religion may help nurses to work and the department of health to implement TOP service. Religious affiliation can assist nurses in interacting constructively with patients and with colleagues in their working environment. Religious beliefs influences nurses to interact also with patients who are seeking TOP services.

In this regard, the research participant Naresh could therefore indicate that:

Religion can be used as a centre to address areas of conflicting understanding between a nurse and the patients regardless of their condition. So nurses have to understand women's experience and their reproductive rights. It can also be used to educate people...to deal with issues which we don't normally speak about, like abortion, HIV and AIDS you know. But also to encourage them not to use abortion but to choose other option and to understand that children are a blessing [from God] you know. So TOP is not the only way out you see but they can use the other alternatives (Interview dated 12 June 2014).

Likewise, Lungile could make the remark that:

Yes, it does have influence and it helps me to notice what is wrong and what is right, it helps me to have good conscience to care for patients seeking healthcare. In actual fact it help[s] me to develop good ethical practice in my work to deal with both patients as well as my colleagues (Interview dated 23 May 2014).

Religion is also useful in creating a good working environment and good relations with patients. Most of the research participants indicated that religious affiliation,

especially Christianity and African Indigenous Religion, helped them respond better to the needs of their patients.

This is clearly evidenced Philile, when she remarked that:

So I think if you are not a religious nurse you end up responding badly to that person or patients you are nursing, but if you are a religious person, religious beliefs such as Christianity, help you to be well disciplined the way you relate to every patient, because some of these patients will find ways of dealing with their stress on you and frustrating you, if you are not a religious you end up walking away (Interview dated 12 June 2014).

What also emerged from the research data is that the Christianity, as well as African Indigenous Religion, influences the attitudes of those nursing professionals who care for women seeking TOP services at Grey's Hospital, Pietermaritzburg. Indeed, nurses reported that they found it easier to relate to women's experiences such that of racial and societal marginalisation when seeking TOP services.

Research participants such as Lungile stated that:

So as a Methodist [member] I value women's concerns and their emotional and spiritual health, for me it's important and my religion is a back-up to preserve women's lives, health and dignity to the best of my ability, you see....As I have said before, it's not only in the Christian tradition, but it is also from our culture as a Zulu, we believe life in totality, I live in community with other women and their health concern is my concern too. As a nurse "ngimuntu wabantu." But it does not mean that we can take away the fact that it is unpleasant and difficult to do it (Interview dated 23 May 2014)

As Philile was also to confirm:

My religion as a Christian help[s] me to be able to relate to [women's stories] and to be able to regain hope, without influences those following my religious tradition as a [Roman] Catholic you see. Even to have trust in us that we are giving them the right medicine to help them to recover quickly. I have forgotten to mention that it also help[s] me to counsel them and I think if you are not a caring nursing you will just leave them just like that. At this hospital we do not have chaplains, we only have social workers and they are just a few of them so, to deal with all the patients only in one ward will take several days, that is if we do have one here (Interview dated 12 June 2014).

Many nurses who participated in this research study indicated that prayer was a useful tool and used as a coping mechanism to de-stress in situations where they found providing healthcare to women seeking TOP services either objectionable and/or unpleasant. For example, in the case of the death of a patient, or other medical emergency, participant nurses indicated that they used prayer as a coping mechanism.

Some participants such as Sharon could thus state:

I actually pray over the foetus and I baptize the foetus and it make[s] me less distressed, if I baptised the foetus in the name of the father, the son and the Holy Spirit, at least I know that I am sending this child back to be an angel (Interview dated 23 May 2014).

Religious and cultural beliefs assisted nurses to de-stress if they felt emotionally overwhelmed in the working environment, either through patients or their colleagues. In addition, a religious affiliation also influences the behavioural patterns of nursing professionals in providing treatment to patients with dignity and respect.

This was borne out by Philile, who stated:

At church there is a book they gave us and it's written in Zulu though, "uthandaze kuqala ngesimo obhekene naso" which means pray for every condition or every kind of situation you might be facing. Since I know that, being at work is quite demanding emotionally and you also need to be strong spiritually, I read that book almost every day, in the prayer book there is a list of prayers, if you got into trouble you go there and if you have a problem you go there. So whatever situation I am facing each day I just take that prayer book and check which prayer is suitable for that condition and I will just say it, I will keep on saying it every day until I am satisfied (Interview dated 12 June 2014).

Likewise, Naresh could also state:

I do pray or just do away with it by being silent for a moment, sometime its emotional to see someone want to abort it's really disturbing emotionally and psychologically and praying will help to deal with emotional stress, you see (Interview dated 12 June 2014).

And later in the interview, Naresh would again confirm:

I think religion [has] a bigger role to play in helping us as nurses to see and to treat patients with dignity and respect you see or to treat them holistically. It also gives me power and wisdom to care, you see what I mean. But sometimes it must be moderated so that I do not end up try to convert people to [my] religion thinking that it is a better religion than that of the patient (Interview dated 12 June 2014).

Similarly, Philile could state:

So now if a person is stressed anyhow this can demotivate you and some nurses will take their stress to patients for instance women seeking TOP. So now, if my level of stress is lowered by my

participation in prayer and all that I will offer good care to patients. For me it's not money I earn at the end of the month that motivate[s] me to do my work, it's also my religious beliefs as well, Jesus was healing the sick including women and I am also doing the same. Nursing is my job but I am doing for my ancestors and Jesus as well, they want to see people happy, you see (Interview dated 12 June 2014).

3.3.2. Religion as a Health Deficit

In some cases, the research participants reported that they found the provision of TOP at public hospitals both ethically and morally wrong. Regardless of the fact that it helped women enjoy the right to control their sexual and reproductive health and prevent illness and death associated with abortion. Many of the research participants reported that although they were aware of how TOP services benefit women's health, they still found it hard to render healthcare services to women seeking TOP services at Grey's Hospital, Pietermaritzburg. The reason they gave for this was that not only did TOP cause them both spiritual and emotional distress, but other nursing colleagues tried to dissuade them from providing TOP services. Moreover, they reported that TOP was in direct conflict with their religious affiliation and therefore created tension in their professional lives.

For example, the research participant Philile could state that:

I am a [Roman] Catholic myself, but I have to provide service to women seeking TOP for their own benefit. Sometimes there is a clash between my work and my beliefs as a [Roman] Catholic (Interview dated 12 June 2014).

In addition, Lungile could remark:

I am being disturbed spiritually because my religion as a Christian does not allow me to do so, but for me it's not good, but I can't do anything because I am being employed by the government, I am

working in the ward that I am supposed to provide support and to assist in providing abortion to patients seeking TOP service (Interview dated 23 May 2014).

And later in the same interview, Lungile would again remark:

Yes, I am a Christian, there is that verse in [the] Bible that says do not kill, and I don't like this thing of abortion. And this verse makes me feel uncomfortable to provide healthcare and support to women seeking abortion. Situated in this ward, there is nothing I can do (Interview dated 23 May 2014).

In the Zulu understanding of death, a particular individual cleansing ritual has to be performed if a person was directly or indirectly involved with the death of another human being. Nurses who participate in this research indicated that this kind of cultural understanding also influences them to object to TOP and therefore found it hard to render TOP services and provide healthcare support to women seeking TOP.

Some of the research participants such as Lungile could therefore note that:

Basically, it's their religion or their culture that can influence them to object. In the church you are advised not to do bad things and culturally, abortion is strongly opposed and many people don't like it and it's against their family values (Interview dated 23 May 2014).

As did Philile, who stated:

Well, the society see women having abortions as walking graves, that is what people say and you know in our culture when someone close to you have died you need a cleansing rituals, so now if you come here and you have [an] abortion without no one knowing at home, how are you going to do the cleansing rituals, when you go back home after abortion you are contaminated or they will say you are dirty or you have that darkness....They say bad luck is following you, if...an

accident happened like you have been knocked down by a car, if someone knows about it they will think it's because of that baby that you abort [ed] and you have never gone through the process of ritual cleansing...it is seen as a huge sin to have an abortion and normally they do not think why the patients requested for abortion and the other thing they forget that women have a choice to choose to have a baby or not. So now the health of the patient for us Zulu for example we do not take into consideration the health of the mother (Interview dated 12 June 2014).

In another interview, Lungile would add:

I understand that any kind of killing is against the will of God. Even if I still have that kind of biases of labelling abortion as killing, I also have the conscience to address women's challenges of unwanted pregnancy (Interview dated 23 May 2014)

4. Chapter Summary

By and large, collected data from my interviews illustrated the fact that many of the research participants were aware of the health benefits associated with women's access to TOP services. Most research participant's confirmed that patients have the right to have sexual reproductive freedom to terminate unwanted pregnancy, even in instances where they believe that TOP is wrong.

Most research participants considered nursing as a calling or as their passion, this implies that nurses felt that nursing patients is the fundamental duties of nursing practice to care for patients seeking TOP. Thus help them to develop a positive attitude about TOP patients at public health. On the other hand, some participants also preferred to provide healthcare services to women whose pregnancy endangers the health of the mother or in the case of foetal abnormalities and find it difficult to offer TOP services to women seeking TOP for social and economic reason where women felt that they can manage to support the child.

Most nurses who participate in the research also felt that providing TOP will assist women to exercise the right to good health and by so doing assisted them to have control of their sexual and reproductive health. As a result of that reduces illness, death and other complications related to abortion offered in unauthorised locations.

Although some research participants demonstrated that religious and cultural beliefs of nurses as a hinder in the provision of TOP, which might directly or indirectly have a negative impact to reduce morbidity and mortality rate among women. However most participants in the research find out that their religious and cultural beliefs also help them to respond positively to the needs of TOP patients under their care. More so, religious and cultural beliefs assist them to distress if they felt emotional overwhelming in the working environment, either patients [including patients seeking TOP] or colleagues at Greys' Hospital.

CHAPTER SEVEN

ANALYSIS OF THE RESEARCH FINDINGS, RECOMMENDATIONS AND CONCLUSIONS OF THE STUDY

1. Introduction

In the previous chapter, I presented three broad areas of investigation which have been explored in this research study. They were: personal convictions, social attitudes about termination of pregnancy, and religious convictions. This final chapter aims to provide an analysis of the research in relation to the literature consulted for the study and information gathered during the interviews. The outcome of the current study highlights a number of themes identified from interviews with each participant and an analysis of the transcripts.

The formulation of themes in this chapter is guided by interview questions that were classified into three broad categories suitable for analysis of the current research findings. First, the interview questions were designed to cover the themes of behaviour and practice in relation to the nurses' experiences of caring for TOP patients in a public hospital. Second, I will discuss the affirmations, ambivalences and stigmatisation of nurses in providing TOP services. Finally, I will discuss the role of religion as a health asset or deficit in nurses' healthcare services for patients seeking TOP services at public hospitals. Through these areas of investigation, my aim will be to focus on the overall objectives of the study, which is to explore nurses' religious and cultural beliefs and the influences they bring in providing healthcare to women seeking TOP services at Grey's Hospital, Pietermaritzburg.

2. Behaviour and Nursing Practice

2.1. An Ethic of Care and Rights-of-the-Patient Discourse

From my reading in terms of behaviour in nursing practice, within the discourse there seems to be a tension between the ethics of care expected from a nurse over and against that of the rights of a patient. The social responsibility of nurses and the rights of patients reveals that nurses are obliged in terms of their work and responsibility to provide healthcare and support to all patients under their care (Kelly, *et al.*, 2008:2). According to Tyer-Viola, *et al.*, (2004:110) nurses are universally expected to act with social responsibility, and according to and American Nursing Association (2010:5), they must operate according the limits of the law of the country in which they work. In South Africa, TOP is legal and available to women upon request and in the context where patients request to undergo TOP services, the decision of the patient is always adhered to. Accordingly, the Health Professions Council of South Africa (HPCSA 2008:5) expects nurses to adhere to a Code of Conduct which states that they are bound to act in the best interests of their patients. Within the South African Code of Conduct, health practitioners privilege the right of the patient in conjunction with that of social responsibility (2008:5-6).

The research findings from research participants and also from the literature consulted in this present study demonstrated an understanding of an ethics caring as well as social responsibility towards patients seeking medical assistance at Grey's Hospital, Pietermaritzburg. In the Health Professions Council of South Africa, Code of Conduct (HPCSA 2008:5), it states that, professional healthcare providers (i.e., nurses) must prioritise the health interests of their patients. The HPCSA Code of Conduct also emphasises that “patients who choose to have a legal abortion have a right to a timely procedure, as well as competent, supportive care, both physical and psychological.” In addition, the rights and responsibility of nurses is “to provide the patient with objective information and to offer access to resources before, during and after voluntary termination of pregnancy.”¹⁵

¹⁵ <www.nysna.org/practice/position/>

One of the key responsibility of nursing practice is to provide care to patients based on the core values and standard of nursing practice (HPCSA 2008:3). The research participants in terms of this present study indicated a clear understanding of the Code of Conduct mandated by the HPCSA.

As the research participant Philile was to confirm:

The health of a patient come first regardless of their conditions and in accordance with their needs (Interview dated 12 June 14).

This kind of understanding is an indication that the nursing profession is more than just a job or the money which motivates them to provide care. In particular, within the interviews there was some indication of commitment and responsibility shown among the nurses (See also, Nicholson, Slade and Fletcher 2010:2250). The provision of care to patients is not only about the salary that nurses receive, but it is also based on a strong commitment to improve the overall health of patients (Gallagher, Porock and Edgley 2009:856). Indeed, as some research has suggested, even though some nurses (particularly in the public sector) receive low salaries, most nurses remain committed to their work.

According to Sharon therefore, she stated that:

I love to nurse the sick you know. I just feel that it's a calling you know, because you cannot just take anybody from the street to do this kind of job. But we have trim times and the money in nursing has never been great, nurses are not rich people you know what I am saying (Interview dated 23 May 2014).

While all South African nurses are mandated by a Code of Conduct to provide care to all their patients who need healthcare services, it is also in line with the “Framework of Social Responsibility for Nursing” as described by Tyer-Viola, *et al.*, (2009), where the duty of the nursing profession is based on a social contract to care for patients to ensure that women have equal access to good healthcare (Ibisomi and Odimegwu 2008:207). Accordingly:

The social contract includes rights and responsibilities, public accountability, partnership between nurse and patient, respect for the values and beliefs of the patient and the nurse, and the understanding that public policy, and the system in which it occurs, influence the health and well-being of society and professional nursing (Kelly, *et.al.*,2008:6).

While nurses having an understanding of the Code of Conduct and the “Framework of Social Responsibility for Nursing” in order have a social contract towards the society and individuals that they serve (Tyler-Viola, *et al.*, 2004:110), some of the research participants regarded nursing as a calling or passion. This too is in line with the overall description of the Code of Conduct mandated in HPCSA (2008),

Hence, the research participant Lungile was to admit:

Nursing for me continues to be my passion (Interview dated 23 May 2014).

Having a vocation or calling implies that caring for TOP patients is driven by self-attachment to their work and therefore accords with some elements of social responsibility. Despite some ambivalence being expressed towards TOP services, the participant nurses in the research felt that the South African law obliges them to provide TOP services to women and they have no choice. As a result, they rather provided the service to patients (Mokgethi 2006:33). South African Constitutional law allows all its citizens to exercise their right to choose on all important matters, thereby enriching the freedom of religion, thought, belief and opinion. It leaves no exceptions, and therefore allows women to exercise control of their reproductive health. Any patient therefore who seeks TOP services must be provided with healthcare services at public hospitals (Sibuyi 2004:75).

The research participant Sharon also shared a similar sentiment, when she stated:

It's my Job and I am getting paid for this work, and I am not doing it for free, it's what you want and it's legal, it's safe and the government is saying you can do it and it's my job to give you service delivery. You

can report me because you can report me for not doing it, you see”
(Interview dated 23 May 2014).

Providing healthcare services to women seeking TOP services is an emotional and demanding job (Lipp and Fothergill 2009:116). Some of the research participants maintained that there was less work in providing services to TOP patients because they recover quickly and can soon be discharged from hospital.

As the research participant Philile was to confirm:

After doing the procedure it would be like a day and usually its two to three days after the procedure and they will be discharged (Interview dated 12 June 2014).

The research participant Philile made a similar remark:

As compared to this ward where TOP patients and other gynaecological patients are admitted, you find the patient is walking up and down the corridors (Interview dated 12 June 2014).

This might suggest that providing TOP in public hospitals is a less demanding job as compared to other medical and surgical wards in the hospital working environment. However, nurses have developed a sense of social responsibility to cope with the changing roles in providing TOP services to women. Indeed, some of the research participants interviewed expressed strong feelings that the South African law required them to provide TOP services to patients in designated public hospitals around the country (Mokgethi 2006:33).

This was confirmed by the research participant Philile when she stated:

Whatever I do, I do it (TOP) to save the life of a patient (women) and not to go outside (unauthorised places) the hospital to do it and its safe, free and legal, at the same time it's part of job to do it because in unauthorised places they will die and at the same time some will come

to us when they are very sick. They is nothing I can do it's their choice, you see (Interview dated 12 June 2014).

Caring for TOP patients and the interpretation of the law thus raised mixed emotions among the participants due to the tensions that exist between the personal, the moral, and the professional demands in healthcare systems (Mamabolo 2006:3).

In gender studies, which includes feminist theologians and feminist bio-ethicists, the same sentiments are often raised that a woman's sexual and reproductive choice is a critical human right issue where a woman has the right to choose to terminate their pregnancy. Access therefore to quality healthcare services is a human right issue (Nyrovaara 2011:12; Annandale and Clark 1996). Women are central in the decision making process especially concerning their choices regarding their reproductive health and this promotes the dignity of women especially in accessing health services in public hospitals (Cain 2000:170). In the nursing profession, field studies by Potgieter and Andrew (2004:25) have highlighted the fact that those nurses who are trained and willing to provide TOP services have been influenced by the human rights discourse (2004:25). The CTOP Act of 1996 has thus been interpreted in a positive way, both in the literature consulted and also in the data obtained in the research interviews.

According to Philile she noted that:

We are also aware of women's rights and we also want to fulfil them....They were providing service to help women to have control over their reproductive health and rendering TOP for them was a human rights issue (Interview dated 23 May 2014).

The notion of a human (i.e., patient's) right discourse was promulgated on the understanding that, "A woman's control over her body becomes a fundamental human right" (Fried, *et al.*, 2012:26). This strong argument of, "the duties of citizens could be explored in ongoing training to encourage midwives to be trained as TOP providers" (Potgieter and Andrew 2004:25).

The participant Nomusa also indicated that:

We are aware of the right of women which have been mandated by the government and we are here to fulfil that (Interview dated 30 June 2014).

This opinion might better explain the importance of recognising women's access to TOP services as a patients' rights issue and not as a moral issue. This might lessen the mortality and morbidity rate. In the literature consulted, as well as in my personal engagement with participants it was evidenced that TOP is part of a patient's right to have access to health services.

While most of the research participants seemed to support this position that, most saw it as a way of fulfilling and helping women enjoy full control of their reproductive health (Cain 2000:170). Some of the research participants differed greatly in their view that TOP had been imposed on them by the South African Government imposed it on them, they understood their role of indirectly fulfilling government policy (Varkey 2001:269).

While some of the participants admitted providing TOP service as an additional work, others denied that they offered TOP services, insisting that it was the doctor who performed the actual procedure (Sibuyi 2004:76). While some ambivalence was expressed by the participants as to the controversial nature of TOP and its contribution to improving women's health, they nevertheless agreed that it enables women to have control of their reproductive health.

Another participant Nomusa was also to remark:

It's not us, but doctors, for as we assist in the process. And if they agree to provide the service, they will render the service to them. Even the tablets that they use, it's not inserted by us is the doctors (Interview dated 30 June 2014).

While other participants indicated that TOP is performed by doctors, some participants indicated that TOP is not part of the scope of their practice. This might indicate that while some nurses do not want to provide the service, they also do not want to associate their job with TOP procedures.

Accordingly, Sharon was to state:

It's our job when you sign up you don't say I am not going to do abortion, I am not going to do this, I am not going to that it's not my scope of practice. Abortions have never been in our scope of practice. You see whether it is there or not there, nursing is nursing and termination of pregnancy now is something new that is coming in and they have never been given a choice, to either agree or to refuse (Interview dated 23 May 2014).

This might suggest that nurses seem to have a feeling that the law is binding upon them, restricting and indirectly forcing them to provide TOP services to women who request the procedure at public hospitals. Nevertheless, the research participants did not view this as taking away their responsibility to care for women seeking TOP as nurses. Indeed, they continued to express loyalty to their work and to their patients. In this, there does seem to be a tension between the obligation to an Ethics of Care over and against the social responsibility of nurses in caring for patients seeking TOP services. Regardless however of what each nurse feels about TOP, the right of the patient always comes first and if nurses prefer to use the Code of Conduct, they might not be able to do everything in the interest of the patient's demand. Actually, the conscientious objection indicates that they do not work along with each other.

2.2. Affirmation, Ambivalence and Stigmatisation

As with the apparent tension between the legal requirement of nurses and a professional health work ethic, this tension often manifests itself in the work of many nurses. While some might find it affirming toward TOP, from my research it was evidenced that while some are ambivalent, while others are either the recipients or

receivers of stigmatic behaviour. According to Gallagher, Porock and Edgley (2010:851) nurses experience a variety of reactions both from their patients and colleagues, reactions which are both negative and positive about TOP. In order to deal with this, nurses who work with TOP patients often do not disclose where and what they are doing in the hospital wards.

As Gallagher, Porock and Edgley (2010:852) further point out, nurses in public hospitals have developed an understanding that their patients have the right to choose to TOP services. Other scholars have argued that nurses who are providing TOP service and patients who are seeking TOP services in public hospitals experience some stigmatisation because under normal circumstances TOP in South Africa is against given cultural practices where women are expected to give birth as a symbol of their womanhood (Lipp 2011:118). While on the one hand, Tong (2000:136) has argued that a woman sexual and reproductive rights especially in the context of abortion of unwanted pregnancy, since unwanted pregnancy oppressively burdens women by restricting them to have the right to choose; on the other, it has been evidenced that nurses have developed a patient-centred approach to an ethics of care, being influenced by social responsibility and the South African law providing TOP services. Nurses who oppose the CTOP Act of 1996 have developed some form of ambivalence to avoid giving healthcare to women seeking TOP, interpreting in terms of conscientious objection on the basis of religious, moral beliefs, or stigma (Harries, *et al.*, 2014; Kane 2004).

In the current research, most of the research participants indicated that they were aware of the effects and impact of TOP services in terms of fostering women's agency and promoting sexual and reproductive health, dignity and bodily integrity (De Gruchy and Baldwin-Ragaven 2000:312).

According to Lungile she noted that:

It is better to serve women's lives than to stigmatise them; it's their rights (Interview dated 23 May 2014).

On the same note, lack of TOP services in public hospitals perpetuates high rates of mortality and morbidity, directly related to illegal abortions, especially those provided by unauthorised personnel (Osman and Thompson 2012).

Most research participants demonstrated some form of affirmation, ambivalence or stigmatisation towards providing TOP services to women. The nurses felt that the right of women to have access to TOP services is not only a good thing for women, but also young girls because it will decrease the maternal mortality and morbidity rates, as well as enable women to make their own decisions concerning sexual and reproductive rights (Sibuyi 2004).

In this regard, participant Nomusa stated that:

I don't feel comfortable to assist in termination of pregnancy, but I can do it for the sack of the women's health. The reason being that, a nurse is somebody to preserve life, now if you assist the person who want to terminate pregnancy, I am helping them to have control of their reproductive health, you see (Interview dated 30 June 2014).

Nurses have a clear understanding of the benefits of offering TOP services at public hospitals insofar as it curbs the morbidity and mortality rate associated with illegal abortions provided outside of authorised hospitals. The provision of TOP in public hospitals will better improve women's health and also assist them to enjoy autonomy in the control of their reproductive health (Cahill 2005:172). A similar concern is also made by Meel and Raswa (2009:1), that "in complete abortions and in particular unsafe abortions are main causes of mortality and morbidity in South Africa."

In line with this assertion, research participants such as Lungile noted that:

Some of them (women) ended up going to seek assistance outside the hospital in unauthorised providers and die. (Interview dated 23 May 2014).

According to Neumann *et al.*, nurses who provide TOP services in public hospitals is a means of fulfilling the “Framework of Social Responsibility for Nurses” as it aims to encourage nurses in the “prevention of illness, the alleviation of suffering, and the protection of health, promotion and restoration of health in the caring of individuals, families, groups, and communities” (2010:10).

Even if some participants are qualified to provide or assist with TOP services in public hospitals, they are guided by South African law and their professional Code of Conduct. Hence, if they find themselves at unease in rendering TOP services and medical assistance, they may ask to be recused, invoking the conscientious objection clause which states that they only have “the right to refuse to provide abortion services applies only to the actual abortion procedure.” Consequently, these nurses may find it obligatory for them to care for patients seeking TOP services (Harries, *et al.*, 2014:2).

There was common understanding among the research participants regarding the provision of rendering TOP services. Some nurses found it difficult to provide healthcare services for women who they believed wanted to use TOP as a method of contraception, as well as for women who wanted to terminate their pregnancy based on social or economic reasons, and TOP services to young girls. However, in exceptional cases such as foetal abnormality, or in the case where pregnancy threatens a woman’s health or life and also in regard to pregnancy arising from rape or incest, they can suspend their objection to provide TOP services (Abdel-Aziz, Arch and Al-Taher 2004:559).

According to participant Naresh she stated that:

I can understand those women who come here to seek abortion as a result of foetal abnormality, the woman’s life is in danger, so it’s easy to provide care to those ones and those who have been raped and not for those who just used termination of pregnancy as a contraceptive, you see (Interview dated 12 June 2014).

Most participants indicated that in the provision of TOP, it is emotionally challenging for them to care for women who elect to terminate their pregnancy for reasons that they are too young and they need to continue with their education, or for social and economic reasons (Gallagher, Porock and Edgley 2009:853).

According to participant Nomusa she noted that:

In my culture (Zulu) young girls and boys are not allowed to have sexual intercourse and they are not allowed to get married while they are still very young and it's a taboo in Zulu culture (Interview dated 30 June 2014).

The research participant Silindile also stated that:

In most society it's (abortion) a taboo and people don't normally talk about it and if you do it in the Zulu tradition for example you need to go for cleansing you see (Interview dated 06 June 2014).

This may suggest that in Zulu culture, sexual intercourse and abortion is taboo. This may influence a nurse's attitude and their possible responses that stigmatise women seeking Top services at public hospitals. These ambivalences resonate with the research conducted by Lipp and Fothergill (2009:116), who have pointed out that:

Nurses divided the women they are attending for abortion into three categories of 'easy,' 'hostile' and 'very hard'....This allowed them to emotionally invest in or detach from women in in order to preserve their emotional integrity.

The same sentiments were also commonly expressed by the research participants in that they demonstrated an almost similar understanding to that of Lipp and Fothergill (2009), that in cases where a foetus was fully formed, it requires a nurse to be emotionally strong in the likely event of experiencing trauma or stress.

Participants such as Sharon remarked that:

The stigma has always been there that is why these women go to these private clinics to do it secretly rather than coming here. It's a thing that we, women would be judged, I mean, who wants to be a baby killer you know. What I am saying this is because abortion is murder at the end of the day no matter how you see it, so murder is murder (Interview dated 23 May 2014).

Negative feelings about TOP were also evidenced by another participant, Silindile when she commented that:

I must tell you, it's not something very nice for me to perform termination of pregnancy to a women, but also I can't deny them to exercise their rights as women, you see. But you find out that sometimes, some women come for termination of pregnancy because maybe the baby or the foetus is abnormal and they will be advised by the doctors to terminate and some are raped, that is a different story, which you have to give your heart to them (Interview dated 06 June 2014).

Even if nurses are willing to provide care to women who are seeking TOP, it is clear that some nurses place women seeking TOP into specific groups. They are willing to care for women seeking TOP as a result of foetal abnormality, yet they feel uncomfortable in providing care to patients who seek TOP for social and economic reasons.

From the literature I have consulted and the interviews conducted, it was clear that while some participants are willing to provide TOP services, other respondent's revealed ambivalent feelings regarding the provision of TOP services in public hospitals. This dichotomy might suggest that while some nurses made statements which were more affirming, they had ambivalent feelings which were more lenient than those nurses who made stigmatising statements to women seeking TOP services in public hospital. Those who were more lenient were more likely to promote women

to have access to TOP services and therefore exercise control over their reproductive health. This would also curb the maternal mortality and morbidity rates in South Africa.

3. Religion, Culture and Nursing Care

For a significant number of religious traditions, TOP is prohibited except under certain circumstances. Hence, in Islam and the Christian Protestant tradition, abortion is allowed if pregnancy threatens the mother's life, there is proven foetal abnormality, or in the case of rape or incest. While within other religious traditions, abortion is not allowed, for example among the Jehovah's Witnesses and Hinduism (Perry, *et al.*, n.d.:11, 25). Generally, Walker (1991) and Perry, *et al.*, (n.d.) conducted research which highlighted the controversial debate regarding TOP and religions such as Hinduism, Christianity (Protest and Roman Catholic), Islam, Hinduism, Jehovah's Witness, Protestant, and African Indigenous Religions, all of which have their own doctrines, teachings and positions regarding TOP. Whatever they believe or teach in connection with TOP may have direct or indirect influence upon nurses, to either object or assent to provide TOP services in public hospitals. This could be as a result of the influence of religious teaching, opinions and positions regarding termination of pregnancy. The research conducted by Parry, *et al.*, (n.d.) among religious groupings generally found that each religious tradition had a different position on abortion. Some religions allowed TOP in those cases where pregnancy threatens the life or overall health of a women.

Religious positions and teachings regarding TOP services in public hospitals have a role to play in influencing nursing behaviour. While TOP in Roman Catholic Churches, Hinduism and Jehovah's Witness doctrinal teaching is not allowed under any circumstances, devotees advocate for the right of the child over the right of the mother. The provision of TOP in public hospitals from a Roman Catholic perspective is understood as "a violent act which harms those who choose it even more than those on whom it is inflicted" (Stephens, *et al.*, 2010:515). Lack of TOP services in public hospitals might influence women to seek the service from unauthorised clinics and individuals.

Although the above stance is crucial in promoting the life of the foetus, in a context where the reproductive choice for women becomes important, this ideology is worsened through women suffering and promoting a patriarchal culture which only views women as mothers and child bearers (Walker 1991; Conteh 2008). Unwanted pregnancy is not classified as an issue of women's health, but rather is viewed as a symbol of motherhood.

In the Zulu tradition, women who terminate their pregnancy are seen as denying themselves the opportunity of motherhood and undermining the gift of pregnancy which might affect their physical, psychological or emotional health and wellbeing (Walker 1991; Lipp 2011). In a number of Christian traditions and in some African Indigenous Traditions, TOP is discouraged and is to be avoided at all cost in order to promote life (Mbiti 1969). Zulu nurses who hold this kind of understanding are most likely to oppose the provision of TOP in their working environment, based on the premise that TOP amounts to the murder of the unborn child (Macleod and Feltham-King 2012:737; Gallagher, Porock and Edgley 2009:851).

According to Silindile, she noted that:

In most society it's (abortion) a taboo and people don't normally talk about it and if you do it (abortion) in the Zulu tradition for example you need to go for cleansing you see (Interview dated 06 June 2014).

A number of religious beliefs are against TOP. In a number of religious movements, including those within the Christian tradition and in some African Indigenous Religions, TOP is discouraged because it challenges received cultural norms and understandings about the role of women as child bearers (Cohen and Kennedy 2000:105; Narayan 2000:177). As a result of the influence of Christianity and African Indigenous Religion, some nurses objected to providing TOP services in terms of their conscientious objection.

In South Africa, it has been evidenced that nurses' religious affiliations are often understood as barriers to women to access TOP services. According to Harries, *et al.*, (2014:1-2) "providers who were opposing to render or participating in abortion

services often on the grounds of religious or moral beliefs, stigma associated with abortion.” This verifies that nurses are still willing to help women gain control of their reproductive health, especially the burden of an unwanted pregnancy.

Despite accrediting health benefits and reducing maternal mortality and morbidity rates by 91.1% since the CTOP Act No. 92 of 1996 was passed into South African law (Harries, *et al.*, 2014:1), there is a lack of healthcare providers (i.e., registered nurses and midwives) willing to be trained and provide TOP services at public hospitals. This has been identified as a major contributing factor influencing women to access TOP services at unauthorised clinics. As result of this challenge, the number of abortion-related deaths and diseases among women in many communities may increase (Moore and Ellis 2013).

According to Philile, she stated that:

Some people or nurses I work with, are high-high against TOP, they even refuse to render any kind of treatment to them if it is not oral medication they don't get closer to it (Interview dated 12 June 2014).

Accordingly, Harries, *et al.*, (2014:1) have pointed out that:

Conscientious objection as it relates to the law in South Africa raises issues of competing rights in relation to women's right to exercise reproductive autonomy and healthcare worker's right to freedom of conscience, belief, thought and religion.

In South Africa, nurses use conscientious objection as a relief and as a way to avoid executing their duties and responsibilities to participate and provide TOP services at public hospitals. This is directly against the “Framework of Social Responsibility for Nurses” as a core value in providing TOP services (Kelly, *et al.*, 2008:3 and Tyer-Viola, *et al.*, 2009:111). Misinterpretation of the conscientious objection clause has produced negative outcomes on women and their access to reproductive health. Nurses have interpreted it as their way of exercising their freedom of conscience not to render, participate, or provide TOP healthcare to women.

Stigmatisation and rejection of women to choose to terminate their pregnancy was also a common challenge felt among most participants. According to the “Position Statement on the Role and Responsibility of Registered Professional Nurses in Abortion” it indicated that it was a nurse’s “responsibility to provide the patients with objective information and to offer access to resources before, during and after a voluntary termination of pregnancy”. In the current study, I also noted that some advice given to women seeking TOP service have led to the development of stigmatisation and rejection of TOP patients in public hospital. Some of the research participants also divulged their disapproval of TOP in the form of judgmental statements which stigmatises women seeking TOP in public hospital.

As participant Sharon was to state:

After all the advice that she gets and she don't want to give up the baby for adoption and she want to have it (abortion), I say she can have it, it's her body, it's her sin and it between her and God (Interview dated 23 May 2014).

In a number of cases, religious participants, whether Christian (Roman Catholic, Methodist and Anglican) or following African Indigenous Religion, indicated a clear disapproval of providing TOP, where unwanted pregnancy was branded as a ‘sin’, ‘killing,’ and ‘murder.’

Participants such as Philile stated that:

It is mainly because of their beliefs that have an understanding that it's (TOP) a killing without taking into account the health of the mother. With the common understanding it's a sin and also of being judgmental behaviour among other nurses. Like, why do you get pregnant if you do not want it in the first place or why do you sleep around with men. Contraceptives are available and why are you not using it instead of giving us a problem with this abortion thing (Interview dated 12 June 2014).

Research participant Silindile was also of a similar opinion:

In most society it's (TOP) a taboo and people don't normally talk about it and if you do it in Zulu tradition for example you need to go for cleansing, you see. Some members of the society don't understand the reasons why these women do it and it is not considered a health matter, you see (Interview dated 06 June 2014).

As I indicated above, it appears that some healthcare providers themselves are still not ready to offer TOP service. Nurses continue to stigmatise TOP service as a 'sin' and women seeking TOP as 'baby killers.' These are some of the barriers that women need to overcome if they are to have control of their reproductive health. Such stigmatisation and rejection among healthcare providers might influence women to seek help from traditional healers and unauthorised clinics which are not safe for women's health (Moore and Ellis 2013). Even if nursing professionals stigmatise women seeking TOP services, from the Interview dated 21 June 2014 some felt that their involvement in providing these services to women made some contribution in minimising maternal morbidity and maternal mortality rates among women.

A research conducted by Constant (2014:302) indicated that approximately 51.5% of women in South Africa reported that they have access to TOP services in public hospitals or clinics. Some 20.5% have access to TOP from traditional healers, while 10.2% went to other places. For a further 5.4% the location was unknown. It was also shown that the highest number of women seeking TOP from traditional healers are found in KwaZulu-Natal (Constant 2014:302). Within the same province, opposition to TOP is "strong and most providers have refused to provide the service" (Harrison, *et al.*, 2000:424). Based on the statistics provided by Constant (2014:302) provide us with the intensity of the challenges of TOP in the province. A large number of women seeking TOP in traditional healer in KwaZulu-Natal might suggest that opposition to TOP is in proposition of women seeking the services outside authorised hospitals.

The stigmatisation of women, especially from nurses, may also influence women's behaviour to continue to suffer from lack of proper healthcare services. Yet, if nurses use both the law and the conscientious objection clause in line with the "Framework

of Social Responsibility for Nurses” this will help women gain control of their reproductive health.

4. Religion as Deficit or Asset in the Context of TOP

4.1. Religious and Cultural Beliefs as Health Deficits within Nursing Practice

Religious and cultural affiliation influences the attitudes of nurses towards TOP patients seeking this service. Religion is branded as one of the barriers for women to have access to TOP services in public hospital. According to Abdel-Azziz, Arch and Al-Taher (2004:559) and Macleod and Feltham-King (2012:4), most pro-life religious traditions understand abortion as the killing or murder of an innocent child. In some instances, TOP is culturally unacceptable and is a source of shame. As a consequence, nurses who are affiliated to such a religious tradition are more likely to express negative attitudes regarding the provision and implementation of TOP services in public hospital across South Africa.

Reproductive health for women is still a challenge in public hospitals. In KwaZulu-Natal, opposition to TOP is a common phenomenon (Harrison, *et al.*, 2000:425). Many nurses are unwilling to provide TOP services mainly because of religious affiliation and the age of patients seeking TOP, such as young girls and also patients who have had repeated terminations. Among such women and young girls it makes it uneasy for nurses to provide care (Harries, Stinson and Orner 2009:11).

For example, the research participant Nomusa was to remark that:

It might also base on the cultural beliefs, in my culture young girls and boys are not allowed to have sexual intercourse and they are not allowed to get married while they are still very young and it's a taboo in Zulu culture (Interview dated 30 June 2014).

While this may discourage some women to have access to TOP service, it may also suggest that young women are still having a challenge to control their reproductive choices particularly with respect to accessing TOP services in public hospitals (Nyrovaara 2012; Cain 2000).

Prevailing religious and cultural beliefs around women's reproductive health influences nurses to develop negative feelings towards the provision of TOP services. Culturally, sexual intercourse between young girls and is not approved in many religious traditions. Consequently, nurses who are religious felt that many women seeking TOP are promiscuous by nature (Macleod and Feltham-King 2012:5). Macleod and Feltham-King (2012:5) went further in noting that virginity testing among the Zulu and Xhosa peoples threatens their cultural practices in that by having TOP, this will allow women to threaten given cultural norms. Hence, because of the Zulu prohibition on premarital sex, TOP risks stigmatisation and accusation for both the patient and the nurse and thus both are discouraged from pursuing TOP.

Some nurses develop deep feelings of ambivalence regarding their involvement in TOP services. For example, some nurses interpret conscientious objection as the right not to participate in the provision of healthcare services to women seeking TOP in public hospitals. This acts as a barrier by influencing nurses not to provide care to women seeking TOP in public hospitals (Kane 2009:910). In the South African context, there is still much resistance by nurses in providing TOP services, despite evidence that the country will continue to experience an increased maternal mortality and morbidity rate as a result of backstreet abortions which are unsafe for women's health (Mamabolo 2006).

The research participant Sharon thus affirmed:

I am a Roman Catholic I do not do abortion at all, even though if I am working in this here, I will never terminate someone's pregnancy because I feel I got my own sin and I cannot take upon other people's sin. But I feel that if a women want to have an abortion it is her body, it is her right and it is her sin (Interview dated 23 May 2014).

Because many women in KwaZulu-Natal access TOP services from traditional healers, this exposes many to serious injury, disease and even death (Constant 2014). One participant was explicit about the traditional Zulu views about abortion and ritual purity. She insisted that abortion causes a disruption to the Zulu religious moral order. This requires some rituals to be performed in relation to the ancestors, secret TOP does not make this possible.

The research participant Philile was to remark that:

Well, [in] the society see women having abortion[s] as walking graves; that is what people say and you know in our culture when someone closer to you have died you need to perform a cleansing rituals, so now if you come here and you have abortion without no one knowing at home, how are you going to do the cleansing rituals, when you go back home after abortion you are contaminated or they will say you are dirty or you have that darkness, that they call (Interview dated 12 June 2014).

Scholars have shown that nurses who are religious develop a negative attitude to women seeking TOP more than nurses who are not religious (Harrison, *et al.*, 2000; Trueman and Magwentshu 2013). The academic literature from various countries confirms that religious and cultural beliefs influences the opposition of TOP among nurses in public hospitals. This opposition is basically as a result of the terminology used by nurses who in caring for women seeking TOP show some form of disapproval (Walker 1996:53).

One participant Nomusa, thus stated:

They are groups that are formed in the church (on Sunday) where health related matters are being discussed, so it is the duty of the faith community to care for the life rather than taking human life (Interview dated 30 June 2014).

In the current research, opposition to TOP is influenced through religious affiliation. In addition, the terminology often used by nurses makes it difficult for them to render the service. Research conducted by Mamabolo (2006:22) has indicated that registered nursing professionals providing TOP services at Soshanguve Community Health Centre understood abortion as murder and as such considered abortion morally wrong. In line with this, the nurses who participated in the current research held similar sentiments (Mamabolo 2006:222; Walker 1996:51).

Accordingly, the research participant Sharon stated that:

The fact that I love people and I want to help people, that I am very religious and very staunch in my religion, How can I help you if you want to kill your baby, exactly you tell me, so how can my faith going to help you if you want to kill your baby (Interview dated 23 May 2014).

Other factors contributing to the opposition to TOP is the language identified in scholarly works where the degrading descriptions by nurses of women seeking TOP services is of great concern in regard to the reproductive health for women (Gallagher 2009:853). However, what is emerging from the literature and from the research participants, is that the opposition to TOP especially from among nurses of different religious affiliations is still a challenge in public hospitals. Participants who were using terminology such as “termination of pregnancy” and “foetus” were more affirming and more accommodating in their response and in their understanding of TOP as women’s reproductive choice and women’s health. While others prefer to use terminology like ‘abortion,’ ‘baby killer,’ and ‘murder’ raised stigmatising statements as well as developing strong negative feelings regarding women seeking TOP in public hospitals.

If nurses use language such as ‘killing’ or ‘murder’ in regard to TOP rather than the language of choice, it creates a negative influence on the kind of engagement they have with their patients. The kind of language that a nurse chooses, conveys and exposes personal attitudes and feelings about providing TOP even if the nurse states that s/he cares about women seeking TOP. Religion and culture assumes a punitive or

judgmental orientation towards TOP patients displayed in both health professional practice and even among scholars.

Despite the indication that religion can be a positive resource, in most cases, the research participants and the literature paints religion in a negative light. There, religion is seen as judgmental and stigmatising. That said, in providing healthcare to TOP patients, this does not necessarily mean that such nurses are judgmental or creating an aura of stigma.

4.2. Religious and Cultural Beliefs as Health Assets within Nursing Practice

It is unjust of scholars to view nurses' religious affiliation as a stumbling block in rendering TOP services in public hospitals. In the current research, I am of the opinion that religion can positively influence nurses to render healthcare services to women seeking TOP services.

Having discussed above the negative contribution of religion in opposing TOP services, I think such principles misrepresent the role of religion and its otherwise positive influence in compelling healthcare professionals to provide TOP services in public hospitals. In the current research I am aware of the negative contribution and impact that religious beliefs can have in opposing TOP service as well as discouraging women to have control of their reproductive health.

Religious and cultural beliefs directly or indirectly help nurses in rendering TOP services to patients at Grey's Hospital, Pietermaritzburg. From my personal observations, religious and cultural beliefs might also be accredited in influencing nurses to render TOP services to women. For example, research conducted by Potgieter and Andrew (2004:25-26) has noted a similar strand that some nurses opt to provide healthcare services to women seeking TOP in public hospitals in KwaZulu-Natal that is driven by religious affiliation. Their study also contends that their religious affiliation encouraged the nurses to provide healthcare services to women seeking TOP in public hospitals (2004:25-26). Some of the research participants in the interview dated 12 June 2014, in the present study indirectly indicated that religious

opposing TOP needs to be reviewed and challenged based on the current laws which helps women to make their own reproductive health choices.

This also demonstrates a link between religious affiliation and the social responsibility of nursing professionals to care for patients seeking TOP. Religious and cultural involvement also assists nurses to develop a moral and ethical understanding of rendering healthcare services for patients. In the current study, the research participants indicated that religious and cultural beliefs encouraged them to assist women to exercise their right to reproductive health. On the other hand, some of the research participants indicated that the experiences of women's emotional and psychological health of women related to unwanted pregnancies. In one way or the other this might directly oppose the use of the conscientious objection clause in refusing render TOP services, in that it directly opposes nurses who applied the conscientious clause for them not to participate in TOP (Harries, *et al.*, 2014:2; Kane 2009:909). In other extreme cases, participants use the conscientious objection clause to render TOP services to women in Grey's Hospital. I think the nurses who participated in the current research were also aware of the conscientious objection clause in regard to TOP services to women. Religious affiliation help nurses to develop a conscience to render the service rather than to avoid rendering TOP services to women.

Some participants such as Lungile were saying:

Yes it (religion and culture) does have influence and it helps me to notice what is wrong and what is right, it helps me to have good conscience to care for patients seeking healthcare. In actual fact it help me to develop good ethical practice in my work, especially to deal with both patients and my colleagues as well (Interview dated 23 May 2014).

According to data obtained through the research interviews, religious affiliation among nurses is a health asset in offering healthcare services to women. According to one participant, a nurse's religious and cultural beliefs help facilitate the level of care they provide patients. Indeed, to be a nurse means to have religious beliefs that can

guide them in their respective working environments, and their professional relationships with patients, nurses, doctors and other medical staff. This creates good relationships with other workers as well as create a conducive working environment for patients and staff alike.

As Silindile was to remark:

In a way yes, because being a nurse I think I am serving God's purpose to help people when they are sick you know. I think for you to be a nurse you need to have some form of religious belief to guide you in order to care for the patients. It makes it easier because my belief as a Christian helps me to be patient and even to my colleagues and also to be able to understand them. It becomes easier if you a Christian somebody to provide care because you can be tolerant and [show] respect as well (Interview dated 06 June 2014).

In one way, nurses are aware of the benefits of rendering TOP services to women, for example in being able to exercise their reproductive health choices and access healthcare services in public hospitals. Religion helps them to care for women's needs and the experiences of suffering and of unwanted pregnancies. Even if they do not define themselves as feminists, their responses to women's health needs nevertheless represents an empowering feminist position. The role of nurses who render TOP services supported by some of the concerns raised by feminists in addressing women's oppression by having access to quality healthcare services is of great importance. By accessing TOP services, it directly and indirectly assists women in gaining control over their bodies and their reproductive health choices.

Many of the research participants indicated that their religious affiliation gave them strength in their nursing practice, particularly in the care for patients as it was in line with their professional code of conduct. For example, intercessory prayer was reported as a common tool used as a coping mechanism in stress management. Some participants raised similar concerns especially in a case where the foetus was fully developed. Nurses found this one of the most distressing aspects of TOP.

A good example of this was when Silindile acknowledged the importance of prayer in her work as a nurse providing TOP services:

You basically pray for yourself to get the strength to carry on after that incident or after experiencing a trauma and at time you also pray for that patient so that God can help them to recover and to find the right way to do things and also for that poor child that have been aborted for whatever reasons (Interview dated 06 June 2014).

Another participant, Sharon admitted that praying for a foetus helped her cope with trauma:

I actual pray over the foetus and I baptise the foetus and it makes me less distressed. If I baptise the foetus in the Name of the Father, the Son and the Holy Spirit, at least I know that I am sending this child back to be an angel. I do not know about how other nurses deal with it. But as for me, I pray about it, I really pray about it, because it's really a very ugly sight (Interview dated 23 May 2014).

Work-related stress among nurses also affects their performance, especially in rendering healthcare services to women seeking TOP. According to Lipp and Fothergill (2009:110) stress affects the performance of nurses in the work place and it has been evidenced that nurses who experience stress at work separate themselves from the job, but feel bad about doing it. This may lead to absenteeism at work among nurses, especially those who work with women seeking TOP. Religious practices such as prayer are therefore important as they not only help nurses deal with work-related stress, but enable them to continue rendering caring services for patients seeking TOP in public hospitals. Such encounters are not only liberative, but they aide women in their agency towards reproductive health rather than face the stigma of judgmental attitudes and statements which might discourage women to visit public hospitals for TOP services.

In regard to this, research participant Sharon stated that:

The encounter with people seeking abortion, that is a difficulties which we encounter and as I have said we are prayerful and it is easy to get on with our job because if you can think about it, what is our choice? We don't really have a choice because if we refuse to do that abortion, it means, we are sending people to a backstreet abortionist and by sending a patient to a backstreet abortionist we are sending the patient to die, because we have many, many cases that come here to Grey's, where the patient gets a backstreet abortion, gets a septic abortion and they come here half dead and some of them even die, so that is why we have to be strong enough in our jobs. We are doing a job, it's a job we have to do it, it's a service delivery, it's in the Constitution, it's a patient's right. So we put our patients first, we also have our rights too, but we just have to be strong and do what we have to do, so we ask God to help us, that the reason why I say that, we pray before we start working, because we need God's help in our job (Interview dated 23 May 2014).

From the information I have gathered in the current research, it ably demonstrates that religious and cultural beliefs contribute positively in helping nurses care for women seeking TOP services. Similar research conducted by Oman and Thoresen (2003) has shown that religion is not only of benefit to patients, but is of great significance to motivate other healthcare providers such as clinicians, doctors, and psychologists because it empowers individual human beings through connecting them to their community, to the Supreme Being who gives psychological strength in the working environment. Religious belief also helps nurses to address the challenges of emotional stress in the case of caring for patients seeking TOP services.

For example, the research participant Philile was to remark:

I think it [Religion] does because at church they is a book they gave us and its written in Zulu though, "uthandaze kuqala ngesimo obhekene naso" which means pray for every condition or every kind of situation

you might be facing. Since I know that, being at work is quite demanding emotionally and you also need to be strong spiritually. I contacted or read that book almost every day, they have got a list of verses and topics, if you got into trouble you go there and if you have a problem you go there. So whatever situation I am facing each day I just take that prayer book and check which prayer is suitable for that condition and I will just say it. I will keep on saying it every day until I am satisfied (Interview dated 12 June 2014).

5. Conclusions and Recommendations

It is critical that nurses fulfil an ethics of caring related to professional healthcare practices guided by a code of ethics, social responsibility, and the South African Constitution and law that assures freedom and liberty for all. This research study into the religious and cultural factors that motivate nurses' attitudes towards women seeking TOP services at public hospitals. This research has indicated nurses' understanding of the challenges and the benefits of helping women attaining agency in their sexual and reproductive health rights.

The study however has shown that nurses demonstrated ambivalence feelings of whether religion helps them provide TOP services in Grey's Hospital, Pietermaritzburg. Even if most participants have a feeling that TOP is wrong or is a sin, most research participants indicated they continue to care for women seeking TOP services. Thus help to women to have control over sexual and reproductive health right. Thus morbidity and mortality rate among women in the KZN province. It does not necessarily minimizes mortality and mortality rate only, good nursing practices might also reduce the rate of HIV and AID infections, the number of unwanted pregnancy and well as unnecessary backstreet abortion among women in the province.

What also come out of this research is that most participants, a nurse's religious and cultural beliefs help facilitate the level of care they provide patients. Indeed, to be a nurse means to have religious beliefs that can guide them in their respective working

environments, and their professional relationships with patients, nurses, doctors and other medical staff. This creates good relationships with other workers as well as create a conducive working environment for patients and staff alike.

Most participants and also research conducted by Lipp and Fothergill (2009) also indicated religious affiliation does not benefit women who receive care, but it also assist nurses to cope with work-related stress among nurses as it also affects their level of performance, especially in rendering healthcare services to women seeking TOP. According to Lipp and Fothergill (2009:110) stress affects the performance of nurses in the work place and it has been evidenced that nurses who experience stress at work separate themselves from the job, but feel bad about doing it. This may lead to absenteeism at work among nurses, especially those who work with women seeking TOP. Religious practices such as prayer are therefore important as they not only help nurses deal with work-related stress, but enable them to continue providing health caring services for patients seeking TOP in public hospitals. Such encounters are not only liberative, but they aide women in their agency towards reproductive health rather than face the stigma or judgmental attitudes and statements which might discourage women to visit public hospitals for TOP services.

This research also makes some contribution in understanding the role religious affiliation makes as a health asset and health deficit as demonstrated by the interviews and documented by the other research consulted. I think one cannot universalise the notion that religious beliefs dominate in bringing opposition to TOP; instead, the research has also readily shown that religious beliefs can influencing nurses to provide quality healthcare services among nurses.

The findings of the research also demonstrated that nurses have a clear understanding of ethics of care as well as social responsibility. However most participants feel that patients who choose to have an abortion have a right a timely procedure as well as competent, supportive care both physical and psychological. I recommend that nurses and the community need to informed about the importance of sexual and reproductive health for women.

The research also found out that religious and cultural beliefs have positive contribution in addressing sensitive issues like termination of pregnancy and therefore

I recommend that both health care system and religious denomination need to work together in order to promote sexual and reproductive health for women, especially to develop a moral attitude which viewed TOP as a health issue. Than to understand TOP service as sinful act, this might help many women to access TOP services in public hospital.

In the current research I have also noticed that research participants demonstrated some form of affirmation, ambivalences and stigmatisation towards the provision of TOP services. But most of the uneasiness was influenced by religious and cultural beliefs for and against TOP remains central in the provision of the services. Thus the department of health need to launch campaign in community and also among nurses need to be done to make them aware of women's sexual and reproductive right.

Important information from the research findings also identify that much needs to be done to make the provision of TOP service a public discussions in the academic disciplines in order to break the silences around TOP as one of the health challenges we are facing in south Africa. Much need to be done in including religious and cultural components as part of nursing curriculum, in order to de-educate and to re-educate nurses on the health benefits of promoting the provision of TOP in public hospitals, their opposition of TOP or support of TOP need to revolve both on religion as well biomedical benefits to women's health.

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APPENDIX 1

INFORMATION SHEET

Date.....

Good morning and how are you? My name is Honest Mangena; my student identification number is 208510941. I am a Masters student at the University of KwaZulu-Natal at the School of Religion, Philosophy and Classics, Pietermaritzburg campus. I am conducting a study under the supervision of Dr F. G. Settler. You are being invited to consider participating in the study that aims to explore nurses' religious and cultural beliefs and its influence on their provision of health care for women seeking termination of pregnancy in Grey's Hospital, Pietermaritzburg.

The main aim of the research is to find out individual nurses' religion and cultural beliefs views help them to provide health care services to women seeking termination of pregnancy in public hospitals and also to describe the connection between nurses' religion and cultural beliefs and their understanding of the implications of termination of pregnancy to women's health.

About eight nurses are participating in this research and if you choose to participate in this research; the interview will take thirty to sixty minutes of your time and interview questions are semi-structured with audio recording with the consent of the research participants. After date has been recorded each respondent will receive a confidential hard copy for review.

I would also like you to know that participation in the study is voluntary. You may withdraw from the study any time you wish. I also want to highlight that some of the question might be distressing and you might not wish to answer due to personal reason, no one is going to be coerced to answer them. I have made arrangements with the manager of Child welfare Centre for to provide counselling should you choose to speak with someone.

The study will also guarantee you full confidentiality during the interview and will not use your real names at any point. The interview will be carried out in secluded and in a private venue where recording of information will remain confidential. Although there is no any financial benefit, your participation in this study will better help in the production of knowledge helpful to improve women's health in South Africa.

In the case where you want to raise your concern you can contact us on the following, my details, those of my supervisor, and the Biomedical Research Ethics Administration are provided below:

Mr. Honest Mangena / Dr. F. G. Settler
School of Religion, Philosophy and
Classics
University Of KwaZulu-Natal
Private Bag X01, Scottsville, 3201
Cell: 076-571-9006 or 084-611-6562
Email: hmangena@gmail.com
Email: settler@ukzn.ac.za

Biomedical Research
Ethics and Administration Research
Office
Govan Mbeki Building
Private Bag X 54001
Westville, Durban
Tel: 031-260-4769
Fax: 031-260-4609
Email: BREC@ukzn.ac.za

Contact Person for Counselling in the event of distress: Nontobeko Buthelezi, Child and Family Centre, UKZN. Tel. 033-2605166

APPENDIX 2

CONSENT FORM

I (Name)..... (Surname).....
hereby consent to participate in the following study conducted by Mr. Honest Mangena (Masters Student at UKZN) as an interviewee.

Proposed title of the study: “An Analysis of Nurses’ Religious and Cultural Beliefs and its Influence on their Provision of Healthcare for Women Seeking Termination of Pregnancy: A Case Study of Grey’s Hospital.”

I understand and confirm that I accept the following conditions for my participation as an interviewee:

- i. I am aware that participation in the research is voluntary. As a participant I am aware that I have the right to withdraw from the research if I feel discomfort or for whatever reason at any time without any negative or undesirable consequences to myself.
- ii. I have been assured of confidentiality—that my identity will not be revealed while the study is being conducted and when the study is published. Anonymous names will be used in place of actual names.
- iii. I am aware and accept that the researcher will use an audio recording device.
- iv. I accept the fact that the interview will be conducted in English and may last up to +/- 45 minutes.
- v. If I have questions about the study or about being a participant, I know I can contact the researcher by Email (hmangena@gmail.com) or telephonically (084-611-6562). I am aware that I can also seek further clarity from the project supervisor Dr. F. G. Settler at the University of KwaZulu-Natal in the School of Religion, Philosophy and Classics on the following contact details: Email: settler@ukzn.ac.za; Cell: 076-571-9006.

- vi. The research seeks to contribute to the to the body of existing literature to help to inform health care providers on the significance of religion to nurses providing health care services to women seeking termination of pregnancy in public hospital.

Signed on this (Date) day of (Month) 2013 in
..... (Place)

Signature of participant.....

Signature of researcher.....

APPENDIX 3

PERSONAL STATEMENT

My name is Honest Mangena, I am a Zimbabwean national. In my honours project, I was interested in researching on HIV and AIDS-related stigma especially challenging retributive theology where through my study I found that culturally women are blamed for being a source of HIV and AIDS in the family. On the other hand, I also came to appreciate that HIV and AIDS is a gendered issue and women's health is jeopardised.

In the context in Zimbabwe, abortion is illegal and is criminalised. Under the Zimbabwean constitution abortion is permitted only in the case of rape, incest and if it threatens women's health. In this context, access to safe abortion is not considered as a health challenge even if women are the most affected. There is little room for discussion of termination of pregnancy in the church and in public space where it is stigmatised as being murder.

I am a member of the Evangelical Lutheran Church in Zimbabwe located in the Midlands province in one of the rural districts in Mberengwa. Sadly in this district, conservative Christian values prevail and people frown upon pregnancy out of wedlock and oppose abortion as a way to deal with unwanted or unhealthy pregnancies. I am thus very much aware of the stigma and its effects on women and their families.

As part of my tertiary education in South Africa, it came to my attention that despite termination of pregnancy being legalised in South Africa, the implementation of termination of pregnancy remains a challenge in public hospitals in South Africa. Through my personal observation of the high number of suspect adverts for 'quick and clean' abortions around the city of Pietermaritzburg and also through the reading of relevant literature, it raised for me critical questions about termination of pregnancy.

Doing my Masters studies in the Religion, Gender and Health Programme in the School of Religion, Philosophy and Classics, University of KwaZulu-Natal, gave me an opportunity and also motivated me to conduct research on the relationship between nurses' religious and cultural beliefs and how it influenced them to provide termination of pregnancy services in their working environment.

Personally, I do not have any objections to the provision of termination of pregnancy or abortion and advocate for the right of women to freely decide what happens to their bodies. The study is focused specifically on the religious or cultural phenomenon for the support or objection to provide termination of pregnancy and is not concerned on the medical or bodily intricacies of such. The main aim of the research is to find out how and to what extent nurses' religion and cultural beliefs influence their provision of healthcare services to women seeking termination of pregnancy in public hospitals and also to describe the connection between nurses' religion and cultural beliefs and their understanding of the implications of termination of pregnancy to women's health.

Honest Mangena

Student Number: 208510941

APPENDIX 4

INTERVIEWS QUESTIONS FOR THE RESEARCH

Name:

Gender:

Time:

Age Range: 20-30.....30-40.....40-50.....50-above

1. How long have you been working as a nurse?
2. What area or level of healthcare do you work at? Clinic or regional Hospital
3. What motivated you to become and continue to work as a nurse?
4. What is your preferred area of nursing practice or specialisation as a nurse?
5. How frequently do you encounter patients seeking termination of pregnancy? (Daily, weekly, monthly?) Approximately, how many people per day/week/month?
6. In your experience, what are the reasons most women seek termination of pregnancy/abortion?
7. In your view, why do some women seek termination of pregnancy in unauthorised clinics?

Thank you, that was really helpful. Now I am going to ask you some questions around religion, beliefs and culture

8. Are you a religious person? Do you belong to any religious faith? If so, what faith? Does your faith have anything to do with you being a nurse
9. How do your beliefs influence your relationship to patients seeking public healthcare services?

10. In your opinion as a professional nurse, how does society view women seeking termination of pregnancy?

This is not to try to trick you or judge you, but I am now going to ask or seek your personal view on abortion.

11. What are YOUR views about women seeking termination of pregnancy in public hospitals?

12. Why do you think some nurses object *or not to object* to provide services to women seeking Termination of Pregnancy while others are happy to do so?

13. In your opinion, how do nurses cope with or deal with TOP when they find it objectionable/unpleasant? Objectionable they say they don't want to do it?

14. What role, if any, does faith/ religion play in nurses' feelings or opinions about termination of pregnancy?

15. (a) Do you allow your personal faith/religion to guide you in your encounters with patients seeking termination of pregnancy?

(b) If so, how does this happen?

16. Do you think that your faith/religion has a role to play in improving the level of health services to women seeking termination of pregnancy in the hospital? If so, elaborate.

17. As a healthcare provider, in what ways can religious beliefs be helpful in providing healthcare services to women seeking termination of pregnancy?

18. What are the challenges/problems/difficulties faced by religious nurses in their encounter and treatment of women seeking termination of pregnancy?

APPENDIX 5

CHARACTERISTICS RESEARCH PARTICIPANTS

Interviewee	Self-Identified Religious Tradition	Career Position	Race	Gender	Years Working as a nurse
1	Roman Catholic church	Midwife	Indian	Female	33 years
2	Roman catholic and Africa Indigenous religion	Midwife	Black African	Female	5 years
3	Pentecostal Church	Midwife	Black African		14 years
4	Anglican Church and African Indigenous religion	Midwife	Black Africa		7 years
5	Pentecostal church (Full Gospel church)	Staff Nurse	Indian		4 years
6	Methodist Church	Midwife	Black African		7 years