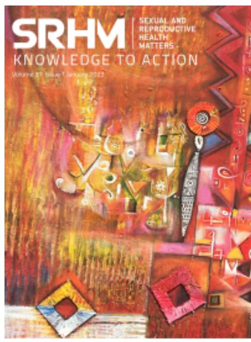


Sexual and Reproductive Health Matters

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/zrhm21

Definitions, perspectives, and reasons for conscientious objection among healthcare workers, facility managers, and staff in South Africa: a qualitative study

Makgoale Magwentshu, Rumbidzayi Chingwende, Abongile Jim, Justine van Rooyen, Helen Hajiyiannis, Nalini Naidoo, Neil Orr, Jamie Menzel & Erin Pearson

To cite this article: Makgoale Magwentshu, Rumbidzayi Chingwende, Abongile Jim, Justine van Rooyen, Helen Hajiyiannis, Nalini Naidoo, Neil Orr, Jamie Menzel & Erin Pearson (2023) Definitions, perspectives, and reasons for conscientious objection among healthcare workers, facility managers, and staff in South Africa: a qualitative study, Sexual and Reproductive Health Matters, 31:1, 2184291, DOI: 10.1080/26410397.2023.2184291

To link to this article: https://doi.org/10.1080/26410397.2023.2184291

© 2023 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group

Published online: 29 Mar 2023.

Submit your article to this journal

Article views: 1547

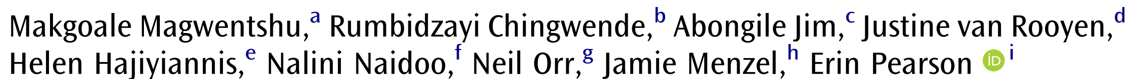
View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at https://www.tandfonline.com/action/journalInformation?journalCode=zrhm21

SRHM SEXUAL AND REPRODUCTIVE HEALTH MATTERS KNOWLEDGE TO ACTION

Definitions, perspectives, and reasons for conscientious objection among healthcare workers, facility managers, and staff in South Africa: a qualitative study



Makgoale Magwentshu,[a] Rumbidzayi Chingwende,[b] Abongile Jim,[c] Justine van Rooyen,[d] Helen Hajiyiannis,[e] Nalini Naidoo,[f] Neil Orr,[g] Jamie Menzel,[h] Erin Pearson [i]

a Senior Health Systems Advisor, Ipas South Africa, Johannesburg, South Africa

b Program Manager, Ipas South Africa, Johannesburg, South Africa

c Research, Monitoring and Evaluation Advisor, Ipas South Africa, Johannesburg, South Africa

d Research, Monitoring and Evaluation Advisor, Ipas South Africa, Johannesburg, South Africa

e Principle Researcher, Centre for AIDS Development, Research and Evaluation, Johannesburg, South Africa

f Senior Researcher, Centre for AIDS Development, Research and Evaluation, Johannesburg, South Africa

g Senior Researcher, Centre for AIDS Development, Research and Evaluation, Johannesburg, South Africa

h Research, Monitoring and Evaluation Advisor, Ipas, Chapel Hill, NC, USA

i Associate Director of Learning and Innovation, Ipas, Chapel Hill, NC, USA. *Correspondence:* pearsone@ipas.org

Abstract: *Conscientious objection (CO) on the part of healthcare providers is a growing threat to safe abortion access. In South Africa, evidence suggests that this legal clause may be manipulated as a justification for public-sector healthcare providers to exempt themselves from their duties to provide essential reproductive health services as required by national laws and protocols. This qualitative study improves our understanding of the definitions, perspectives, and use of CO among providers, staff, and facility managers in South Africa, and CO's effect on public-sector abortion availability. Using 18 focus group discussions and 23 in-depth interviews, we examined CO attitudes and behaviours of staff from health facilities that provide abortion care in Gauteng, Limpopo, KwaZulu-Natal, and Eastern Cape Provinces. We find that CO is invoked for a variety of reasons, some unrelated to the legal basis for objection. There have been progressive shifts in attitudes towards abortion over time, but stigma against women and girls who seek abortion remains substantial among staff at facilities providing abortion. Providers who offer abortion services also report high levels of discrimination and isolation from colleagues. Such factors, combined with operational barriers to offering quality abortion care (such as lack of training support or financial incentives) and lack of clarity on CO definitions and procedures, may incentivise some providers to invoke CO inappropriately. Dissemination of national guidelines on CO should be prioritised to reduce ambiguity, and interventions addressing abortion stigma should be considered for all facility staff to safeguard abortion availability in South Africa.* DOI: 10.1080/26410397.2023.2184291

Keywords: conscientious objection, South Africa, abortion, stigma, health provider attitudes

Introduction

Each year approximately 7 million women in low- and middle-income countries are treated for complications from clandestine abortion,[1] and many of these complications can be avoided through access to safe legal abortion services. Although many countries have restrictions on abortion legality, 94% of women live in countries where there are some legal indications for the procedure.[2,3] However, barriers to access remain rampant in many of these settings, even in cases where abortion is legally permissible. Widespread invocation of conscientious objection (CO) on the part of providers without appropriate referral for safe abortion services is an emerging political, legal, and social issue, as demonstrated by the abundance

© 2023 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group
This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial License (http://creativecommons.org/licenses/by-nc/4.0/), which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited. The terms on which this article has been published allow the posting of the Accepted Manuscript in a repository by the author(s) or with their consent.

of literature, commentary, and legal discourse surrounding CO in recent years.[4–7] In response, the World Health Organization recognised the practice of CO without referral as a threat to safe abortion access.[8,9] Many countries where CO poses a problem have restrictive abortion laws, but CO also creates significant barriers to abortion access in countries such as South Africa that have more liberal abortion laws.[10]

Conscientious objection is the right of an individual to refuse to participate in an activity that he or she considers incompatible with his or her moral, religious, philosophical, or ethical beliefs.[11] In the case of abortion care, this most often manifests in the form of health providers refusing to administer abortion services due to moral or religious opposition, though CO laws are often written to ensure that women can still obtain safe and timely abortion care through referral to other providers, as required by international guidelines on CO.[8,12,13] Despite international guidelines about CO and protections put in place to ensure the correct use of CO, evidence suggests that this legal clause may be misused as a justification for public sector healthcare providers to exempt themselves from their duties to provide essential reproductive health services for women, as required by national laws and protocols. Examples of other reasons a provider may choose to invoke CO include misunderstanding the legal framework, fear of police harassment or legal punishment, social stigma of providing abortion, personal attitudes or perceptions of who is deserving of abortion, or personal economic gain (by sending cases to private clinics where they can charge for the service).[14–17] Research also points to the consequences of CO on women and girls accessing abortion when appropriate referrals are not provided, including unsafe abortion and increased stigma and maltreatment of patients seeking abortion care.[18–21]

The South African Choice on Termination of Pregnancy (CTOP) Act No. 92 of 1996 and its amendment is considered one of the most liberal and progressive pieces of legislation on abortion worldwide, allowing abortion on request up to 12 weeks of pregnancy and up to 20 weeks in cases where the pregnant person's mental or physical health is in danger or on socioeconomic grounds.[22,23] It is also expansive in who can provide abortion, with registered and trained nurses and midwives able to provide medical and surgical abortion up to 12 weeks of pregnancy and doctors able to provide up to 20 weeks. While studies showed an initial reduction in maternal morbidity and mortality after passage of the CTOP Act,[24] unsafe abortion remains common and pregnancy-related maternal mortality remains high across the country.[25] Although barriers to abortion access such as stigma and shame in formal settings and lack of availability to safe abortion services may be contributing to unsafe abortion in South Africa, there is evidence to suggest that CO also plays a role in limiting women's access to safe abortion and may exacerbate issues of service availability.[8,10,25] A report issued in 2011 showed that over half of public facilities in South Africa that are meant to provide abortion services fail to do so, citing CO invoked by their providers as among the main reasons.[26,27] Conscientious objection in South Africa is governed by the Constitution of the Republic of South Africa 1996; however, it is not included in the CTOP Act. Section 15 of the Constitution allows for freedom of conscience, religion, thought, or belief, which covers both the client and the service provider in terms of choice and belief on abortion.[28] However, healthcare personnel are limited in the right to CO; they cannot refuse to provide pre- or post-abortion care and are required to provide information, facility access, and referral to a confirmed, functioning health facility for abortion services.[29] Only healthcare providers can claim CO; staff who do not provide direct patient care (such as facility managers) cannot claim conscientious objection. Furthermore, it is an offence if any person prevents a lawful termination of pregnancy (TOP) service or obstructs access to a facility for this purpose,[25] but to date no one in South Africa has been charged with misuse of CO.

Guidelines developed in 2019 clarified the obligations of health professionals claiming CO and stated that health professionals who wished to claim CO must document this in writing and address it with the facility manager during the hiring process.[30,31] Dissemination of the guidelines began in 2020 and is ongoing, but previous research documented a general lack of understanding of CO among public sector healthcare workers, leading to fragmentation of services and broad misuse of CO.[10,20,32] In addition, research shows that poor understanding of CO and varied reasons for its use hamper availability of abortion services throughout South Africa and particularly in rural areas, where the number of total providers is often small, and CO can render

entire healthcare facilities nonfunctional to abortion services.[32,33]

Studies from South Africa and the African region have explored perspectives of providers, government officials, and NGO staff on CO.[10,21,33,34] However, absent from these studies is a more in-depth exploration of the perspectives of facility management and support staff who are not directly responsible for abortion provision. Research from Argentina, Mexico, and Bolivia demonstrates that in those settings CO is being claimed by department heads and facility managers, as well as staff with no involvement in the abortion service, with devastating impacts on abortion availability.[5,20] Our study adds to the evidence base by exploring the perspectives and practice of CO among public sector providers, support staff, and facility managers in South Africa, and CO's relationship to public-sector abortion availability. This study is also timely; the recent deterioration of socioeconomic circumstances in South Africa has broadened the divide between women who must rely on public-sector abortion services and those who can afford care in private settings,[35] necessitating a better understanding of the context in which TOP providers currently serve and the safeguarding of public-sector abortion availability in the face of CO. This qualitative formative research study improves our understanding of the definitions, perspectives, and use of CO among providers, staff, and facility managers in South Africa, and CO's effect on public-sector abortion availability.

Methods

Study design and setting

Data were collected as part of a larger three-country study on CO led by Ipas in South Africa, Mexico, and Bolivia. Ipas is an international non-governmental organisation with offices in 18 countries focused on advancing access to sexual and reproductive health services, including safe abortion and contraception. The study consisted of a formative research phase, which included qualitative research and a user-centred design process to develop interventions to mitigate the impact of CO on women's access to safe abortion care, and an intervention implementation and testing phase. The formative, qualitative findings are presented here, and the quantitative results will be reported in an upcoming publication. Focus group discussions (FGDs) were conducted with healthcare providers and support staff to explore the breadth of reasons for CO and to understand how women's and girls' access to safe abortion can be maintained in the context of CO. In-depth interviews (IDIs) were conducted on similar topics with facility managers and providers and support staff who did not feel comfortable sharing their views in a group setting. Through the FGDs and IDIs, the study team gained insight into the complexities of CO in the facility setting and the roles that different actors play, including support staff who are typically excluded from CO research. This analysis focuses on South Africa formative research; findings from Bolivia and Mexico are published elsewhere.[20] Data were collected from March to June 2019 by research partners at the Centre for AIDS Development, Research and Evaluation (CADRE), a South African non-profit based in Johannesburg, focused primarily on HIV/AIDS research. Data were collected from one district in each of four purposively selected provinces in South Africa: Gauteng (GP), Limpopo (LP), KwaZulu-Natal (KZN), and Eastern Cape (EC). These four provinces and districts were selected because Ipas had a past, current, or planned project to improve abortion service quality and would more easily be able to implement the developed interventions in those districts in the second stage of the study (described above). The presence of Ipas projects is indicative of the need for access to safe abortion care; maternal mortality in all four provinces is higher than the national maternal mortality rate.[36] KwaZulu-Natal has the highest population of women of reproductive age with only a few facilities designated to provide TOP services.[37] In the Eastern Cape Province, research suggests that despite the CTOP Act No 92 of 1996 and its amendment, illegal abortion is still prevalent.[38] In the selected district within each province, all TOP-designated facilities were approached for participation. Data are reported at the provincial level rather than the district level to protect participants' anonymity.

Study subjects and selection

The formative research consisted of 18 focus groups and 23 in-depth interviews in four provinces among a convenience sample of healthcare workers, health facility managers, and support staff, including staff working as administrators, receptionists, pharmacists, counsellors, cleaners, and security guards. Support staff were included

as they often interact with TOP clients and can have an impact on their access to services (e.g. women and girls may be turned away from the facility when asking a security guard or cleaner for directions to the TOP unit). Focus groups included 6–8 participants each when possible (some were smaller due to scheduling difficulties) and ranged between 2 and 3 hours. Ipas sent formal letters to each Provincial Department of Health (PDOH) to inform them of the study and request that they inform the TOP-designated facilities in the identified provinces about the research study should they grant permission for the study. Once permission had been granted by each PDOH and ethics clearance had been obtained from the Human Sciences Research Council (HSRC) (Protocol #REC 9/21/11/18 approved on 20 February 2019) and the PDOHs, all facilities designated to provide TOP services within the selected district were contacted, the research was explained, and they were asked if they were interested in participating. A total of 19 facilities agreed to participate out of 26 approached. Reasons for declining were not documented for all non-participating facilities, but most did not participate due to inability to obtain facility-level ethical approvals during the data collection period. All participating health facilities provided written permission for the study to take place. Large posters describing the study were put up in common areas and in staffrooms at facilities. Ipas provided a cell phone number for volunteers to register their interest and utilised the provincial Ipas Reproductive Health Coordinators and the TOP Providers to liaise with volunteers and to ensure volunteers met the minimum criteria for participation which were:

- All participants were staff in designated TOP public health facilities;
- Participants expressed a willingness to talk openly and to share their opinions about abortion and CO;
- Participants provided informed consent for the audio-recording of discussions.

Active follow-up at each of the facilities needed to take place for recruitment. This took the form of phone calls and face-to-face visits to management, TOP providers, midwives, and staff in the labour wards. All participants volunteered to participate in the research. Participants included: healthcare providers (predominantly nurses and midwives), facility management, and support staff. To reduce social desirability bias in the group setting, all participants were asked to self-identify as TOP objectors, non-objectors, or as undecided[1] and attend the corresponding FGD. However, five FGDs included a mix of participants due to small numbers of people in specific categories and scheduling challenges. Participants only joined a mixed group discussion if they said that they were comfortable openly talking about their views in a mixed group. Participants who were unsure of how they identified were advised to attend an "undecided" FGD. Facility managers were invited to participate in IDIs rather than FGDs to avoid uncomfortable power dynamics in the group discussion with facility staff. Providers and support staff were also given the option to complete an IDI if they did not feel comfortable speaking in an FGD format. Seven facility managers completed IDIs, and 14 others elected to complete an IDI rather than participate in an FGD.

Data collection tools and development

Semi-structured interview guides for both IDIs and FGDs were developed based on an initial literature review and situational analysis of CO in South Africa. Separate guides were created for objectors, non-objectors and undecided providers, and facility managers and support staff participating in FGDs and IDIs. Data were collected by CADRE researchers to ensure separation between study participation and any support provided through Ipas projects. IDIs and FGDs were digitally recorded, and interviewers took written notes to document their observations during the interviews. Data were collected in the participant's preferred language. The majority of participants were fluent in English, but in the few cases where English was not the main language of the participant (primarily IDIs of support staff), real-time translation took place with the aid of a local translator. In-depth interviews and FGDs were conducted in a private location. Audio recordings and electronic data are securely locked and password protected at CADRE until 2026 as per the relevant legislation in South Africa regarding data protection. All

[1]Participants were asked to self-identify as either an "objector" (i.e. someone who objects to the legal provision of abortion), a "non-objector" (i.e. someone who does not object to the legal provision of abortion) or as "undecided" (i.e. someone who is undecided about where they stand on the issue of legal provision of abortion).

identifying data were removed from transcripts and for the purposes of reports and feedback to key stakeholders.

Data collector training and informed consent

Researchers from CADRE participated in a Values Clarification and Attitude Transformation (VCAT) workshop led by Ipas to sensitise them to any potential personal prejudices or reservations regarding TOP prior to data collection.[39] The researchers from CADRE were qualitative research specialists and were trained on the IDI and FGD guides in addition to training on interviewing in the context of abortion, including training not to apply pressure, to give the participants space to express their concerns and address them, and to recognise if a participant was experiencing distress as a result of participating in the IDI or FGD. Informed consent was obtained in-person in a private area by the researchers before an IDI or FGD. An information sheet was provided which included the contact information for the relevant ethics committees should any concerns or questions arise subsequent to involvement in the study.

Data analysis

Data were transcribed verbatim following a project protocol. Transcribed data were reviewed for accuracy by the person who collected the data. Transcripts were coded inductively by CADRE researchers using thematic categorisation based on the main themes in the data collection tools. Initial codes reflected topics included in the data collection instruments; following the first round of data review, codes were further refined and applied to subsequent rounds of data collection. A sample of transcripts was double-coded, and discrepancies were discussed and the codebook refined until an inter-coder agreement of 85% was achieved. Data coding and analysis were done using qualitative data management software, HyperResearch 3.7.2.

Results

Participant characteristics

A total of 95 staff from 19 public sector health facilities participated. Among the 95 study participants, 23 were TOP providers (doctors, nurses, nurse-midwifes, or midwifes), 48 were clinicians who were not TOP providers (doctors, nurses, nurse-midwifes, midwifes, or assistant nurses), and 24 were support staff (managers and other administrators, receptionists, pharmacists, counsellors, cleaners, and security guards). The breakdown of participants by objector status and participant type can be found in Table 1. The average age of all participants was 44 years. Most participants ($n = 87$) were female. The four most widely spoken languages were isiXhosa ($n = 24$), isiZulu ($n = 20$), Sepedi ($n = 15$), and English ($n = 15$). All other languages were spoken by fewer than 5% of participants. Periods of employment at facilities ranged from 2 months to 37 years, averaging 9.1 years.

Definitions and procedures for registering CO

Respondents were asked about their familiarity with CO as a concept and procedures in place for objecting to TOP. Participants reported confusion in applying CO due to lack of a clear legal definition or guidelines for its application.

Definitions of CO

Participants had mixed levels of familiarity with the concept of "conscientious objection" as pertains to TOP provision. Most had heard of CO

Table 1. Participants by type and objector status

Cadre	TOP provider $n = 23$		Other clinicians $n = 48$		Support staff $n = 24$		All $n = 95$	
	n	%	n	%	n	%	n	%
Non-objector	23	100%	18	37%	10	42%	51	54%
Undecided	0	0%	8	17%	6	25%	14	15%
Objector	0	0%	22	46%	8	33%	30	31%

but could not establish clear parameters for its meaning and could only describe it in vague terms. This ambiguity was present among both healthcare providers and facility managers.

"*I am familiar with the term, but I don't know exactly what it means.*" (Facility Manager, Undecided, Gauteng Province)

"*I think it's the right that we as the healthcare providers have to refuse to do certain procedures.*" (Facility Manager, Non-Objector, Gauteng Province)

In some cases, providers had too narrow a definition for CO, believing that denial of abortion care was antithetical to the oath that providers take and was not permissible in any case (even on religious grounds). In other cases, participants had an overly broad view of CO, asserting that it is applicable in any case where the provider does not wish to perform TOP.

"*I think when you talk about conscientious objection for a nurse, our pledge does not make room for conscientious objections. Because our pledge says we will not consider religion, creed whatever to come between you and our patients. So conscientious objection does not exist when it comes to a nurse's duty.*" (TOP Provider, Non-Objector, Eastern Cape Province)

"*It's when you say I won't do it – I won't allow it to be done – I think it's up to an individual … people are free to object or to say their views.*" (Facility Manager, Non-Objector, Limpopo Province)

Procedures for registering CO

Along with a confusion and misunderstanding of the CO definition, there was no uniformity among participants on formal procedures for registering an objection to TOP service provision. When asked whether there were any defined facility policies or procedures for registering CO, most participants said no. Instead, they shared that objection to TOP is usually handled verbally and informally, resulting in the objecting provider being transferred to another department. Even facility managers spoke of informal procedures, with no structured ethics committee or oversight of CO. Only a small minority of providers described submitting written objections to TOP.

"*As far as I know, it just says, according to the law, it just says if somebody objects to it, they need to refer a patient to another provider that will do it, but they don't tell you that it has to be documented or it has to be written somewhere, or what the whole protocol is.*" (TOP Provider, Non-Objector, KwaZulu-Natal Province)

"*No, there is no formal procedure … but there is [this] outing that they take – debriefing that they undergo to revive them, but formally as the institution there is nothing that is done … we just reallocate you out.*" (Facility Manager, Non-Objector, KwaZulu-Natal Province)

In a few cases, providers who had just returned from a recent TOP training workshop reported learning of policies that require written objection to TOP participation. However, these policies did not always correspond to the procedures undertaken at the facility from which the provider originated. In this focus group exchange, two participants make the distinction between recommendation and policy:

Participant 1: *So we have the right to conscientious objection, with the meaning that we have the right to refuse to carry out duties or tasks that we feel we are not competent enough to perform, or we feel that they are not in line with our values or our beliefs. But then we have to make it in writing, where we notify our supervisors or a manager in writing, also stating the reasons why you don't want to perform a specific duty that is assigned to you, or that is part of your scope of practice.*

Facilitator: *All right, has anybody else here heard about conscientious objection?*

Participant 2: *No…[Participant 1] has recently enrolled in her XXXX degree study, so we, in the hospital, we don't have a standing policy that has stated what she has just said. Only, because she is from school, in her books and stuff, but here in the hospital, we don't have that. We don't have a standard policy that specifically states the reasons that she said to us now.* (Healthcare Providers, Mixed Attitudes towards TOP, Gauteng Province)

General provider attitudes towards providing abortion

Study participants were asked to gauge general attitudes of providers towards TOP, meaning their perception of how other providers feel about abortion provision. Individuals expressed mixed attitudes towards the provision of TOP and estimated that there is a diverse range of outlooks on TOP provision, evenly split among

objectors, non-objectors, and those who are undecided about abortion. Emergent themes on attitudes about TOP are described below.

Greater acceptance of TOP over time

One common message on provider attitudes towards TOP was that of improvement or "*softening*" of negative attitudes over recent years. A number of participants noted that more providers have come around to accepting or supporting TOP as a service for women, even if they have personal objections to the procedure. The basis for this softening is connected to a deeper understanding of TOP as a necessary service for women and girls in need. In Gauteng Province, a TOP provider stated:

"*The attitude [of staff] is very improved at this level – I don't get the bad attitude that I used to get when I started in early 2000 up to 2010. … their attitude is improving every day in this institution. [Staff] are doing exactly what they are supposed to do to treat patients with dignity, give patients information, because we do have the service in the hospital, direct them, and because I never got [negative] reports from any of my clients.*" (TOP Provider, Non-Objector, Gauteng Province)

In KwaZulu-Natal Province, there were also indications in one group of objectors that staff attitudes have "*softened up*" towards TOP, with some objecting nurses "*nearly reaching the stage of acceptance*".

Furthermore, participants mentioned a notable drop in obstructive behaviour on the part of providers who object to TOP. They described cases, both personal and observed, where providers who personally refuse to perform TOP still refer patients to TOP providers.

"*I am working in the antenatal ward, if the patient says she doesn't want the child, I would refer her to [the TOP provider] without a problem. But personally, I don't think I would do it, still.*" (Healthcare Provider, Objector, KwaZulu-Natal Province)

These types of statements – that despite objections to TOP by some staff, there were no reports of denial of service, or obstruction of TOP service – were made during FGDs and IDIs across all study facilities, suggesting that objectors are aware of their duty to refer.

Exceptions for rape or life of the pregnant person

The majority of participants, including those who do not support TOP, shared that women and girls who were raped or whose lives are in danger due to pregnancy should be allowed to access TOP without exception. Providers expressed compassion for women in these specific situations, which would override typical objections to TOP.

"*Shoo, that one, that's when I feel like, I don't know I'm in-between when it comes to [rape]. I feel like if I'm raped, I won't like that child, knowing very well it was out of my control, the way this child was conceived. So I think for them I can say maybe yes, TOP can be provided to them.*" (Healthcare Provider, Objector, Gauteng Province)

"*Legal abortion, it's okay to people with, let me say, people that may be raped, they can have an abortion, cripple women, they can have an abortion, and that's all.*" (Support Staff, Undecided, Gauteng Province)

One facility manager also recognised that denying abortion to women who were raped may lead them to seek risky illegal abortions, an event that providers should guard against.

"*[In case of rape] I feel it's correct. It's the right thing for people to do, rather than doing the illegal abortions, where they can get a lot of complications, so, I feel they have to do it; they need it.*" (Facility Manager, Undecided, Gauteng Province)

Reasons for objecting to abortion provision

Participants were asked to share their views on potential reasons why providers or facility management may object to abortion provision. Several themes for objection emerged: religious opposition to abortion, provider stigma against women who "choose" abortion over contraception, fear of stigma against providers who support abortion, and lack of financial incentives for providing abortion.

Religious beliefs

Religious opposition to abortion was one of the most commonly cited reasons for non-support of TOP, which is a legal ground for CO. For objectors who cite religion as the reason, abortion is viewed as the equivalent of killing another person, and the fetus is considered a child that is meant to exist regardless of the woman's choice. Some TOP objectors refuse to attend any TOP training or awareness-raising on the basis of religious views.

"*Some of them, they say their religion doesn't allow it. You know what they think? They think about this*

TOP, you are killing a baby or someone." (TOP Provider, Non-Objector, Gauteng Province)

"*It's only the religious – that I don't believe in it – my belief doesn't allow me to do termination of the pregnancy. We believe … that there is no child that is a mistake in the world, so we believe that the child must come on the earth.*" (Healthcare Provider, Objector, Gauteng Province)

"*Some of the staff members, they will even refuse to go for training. As long as the topic is about termination, some members will refuse to go. Some will say I can't go, based on my religion.*" (Facility Manager, Undecided, Gauteng Province)

However, as one facility manager put it, religious objection could be considered an abdication of the primary duty providers have to offer the highest level of care to clients:

"*It's a religious background, but here we are providing a service. It's got nothing to do with what religion you belong to or what sect of religion you belong to, or what you believe in. It's somebody that has come here and is asking for a service, and we provide that service here.*" (Facility Manager, Non-Objector, KwaZulu-Natal Province)

Stigma against people requesting TOP

Providers shared stigmatising beliefs regarding the provision of abortion services to women who are not in immediate physical danger or are not pregnant as a result of rape even though abortion is available on request in South Africa. For these participants, clients who "choose" abortion are seen as abusing the system and shirking their responsibility to practise safe sex through the use of modern contraceptives. This is especially true of women who undergo more than one TOP procedure. A number of providers objected to providing abortion to women who use it as a "*tool to prevent pregnancy*", and asserted that women should be more careful about using contraceptives to avoid pregnancy since "*prevention is available everywhere*". Paradoxically, participants noted the difficulties and limitations to accessing or using contraceptive methods but maintain that TOP use should be restricted:

"*What I feel it's not fine is in the case where TOP is used as a tool for prevention, to prevent pregnancy and that is what I am seeing happening in today's life. Many of the young people, instead of attending ah, family planning, they would rather go for TOP.*" (Healthcare Provider, Undecided, Gauteng Province)

"*Most of the clients, after termination of pregnancy … they don't do follow-ups at the local clinics. They do TOP like it's their family planning because you will find them, they will come back after two months, they want to do it again.*" (Healthcare Provider, Objector, Gauteng Province)

There is a particular bias against TOP among young women and girls, who are viewed as being "*reckless*" for seeking an abortion. Participants suggested that TOP access should be restricted as a means of incentivising responsible sexual behaviour of young women and girls.

"*It mustn't be just because it's free for all, anywhere anytime. Like especially for young girls, because the government is providing free condoms for men and for ladies. Why don't people use that, and not abortion? If we put some strict measures to it … that maybe if you are still young, a certain age, depending on the consequences, you cannot undergo abortion … then maybe it will help them to do things in a safe manner, and not being reckless, as they are doing now. Maybe it will help them sensitize the people, the young women to be more careful.*" (Healthcare Provider, Objector, Limpopo Province)

One receptionist discussed how her views on abortion had shifted over time from initially objecting to abortion to supporting it after seeing the effects of unsafe abortion on women and families. Despite her current support for women seeking TOP services, she discussed challenging men who call to inquire about TOP services because she felt that they should be taking responsibility for their actions and that they often force young women into unwanted abortions.

"*They [men] say hey, you are still doing abortion that side? … I say no, no, no. [The men say] Hey, it's my wife. I say no, I don't think it's your wife. So, wena, why don't you use condoms? I say hey, I just want to know. Then, after that, I say okay, sorry, I transfer to the TOP section … But if it's the lady or the young person just comes alone, no, I refer her straight to the TOP, because she understands why she does this. But hey, I don't like the person who forced, even these men that are phoning, you see.*" (Support Staff, Non-Objector, Limpopo Province)

Stigma against non-objectors of TOP

Another common reason cited for objection to abortion provision is a fear of judgment or stigma against the TOP providers themselves. Numerous participants shared experiences of being targeted for verbal abuse by other providers in facilities, disincentivising their desire to provide abortion and potentially increasing their tendency to object.

"*[Other staff] are looking at us like we are killers … they don't even want to talk to us … They hate us. You know, they just hate us … They don't like even to see us … and myself, I don't have friends.*" (Healthcare Provider, Undecided, KwaZulu-Natal Province)

In addition to verbal abuse, participants also reported social isolation by other providers or facility support staff as a method to indicate objection. Some reported that support staff such as cleaners or security guards may be less likely to verbalise their objections, and more likely to "*give you that look, you know, pull their body away, and you know, like they are afraid, keep away from her or keep away from that room – that room, they are killing babies*". Even in cases where colleagues may not have personal issues with a TOP provider, they may still limit interpersonal interactions in a way that isolates or shames the TOP provider.

"*On a personal level, I don't have problems with [the provider]. I only have a problem with the procedures that they are doing in there, only … They shouldn't tell me about what they are doing there, how was their day, because I know it was horrible to me.*" (Healthcare Provider, Objector, Limpopo Province)

This type of social rejection can weigh heavy on TOP providers, leading them to feel guilty, lonely, and dehumanised by their co-workers.

"*The last time it was said, it was from one of the security guards. In fact, he said … 'Sister, after doing what you are doing, because it's like you are murdering kids, you are killing babies. Do you go for cleansing, and who is cleansing you?' … I am a TOP provider, but I am still a human being. Sometimes you do feel guilty, because they can make you feel guilty anyway.*" (Healthcare Provider, Non-Objector, Gauteng Province)

Lack of financial incentives for TOP provision

Healthcare workers may be further discouraged from becoming or remaining TOP providers by a lack of financial incentives for their work, thus encouraging invocation of CO in the public sector. In the South African public health system, abortion provision is not considered a specialty that would confer additional pay, which leads some TOP providers to switch to private facilities or abandon abortion training in search of a more lucrative post. Participants also recognised the need for additional material support for TOP providers who may feel tired or under considerable stress, often exacerbated by the shortage of TOP providers and workplace stigma as detailed above.

"*The thing is, what I want about this, because maybe that will motivate for people to come and train for TOP, they will need incentives … Such as maybe it's like a speciality. Yes, so they will get more money than what they get. If there is extra cash, I think that will motivate some of the nurses to do [the TOP] course.*" (Healthcare Provider, Non-Objector, Gauteng Province)

"*Some of them they went for training thinking it is a speciality and they would earn from it. Since there aren't any incentives given, they say no, they can't do it … We even have providers who deserted the services because they were tired, they were not taken care of, because there's no incentive …* " (Healthcare Provider, Non-Objector, Limpopo Province)

Even those who embark on TOP training programmes may eventually abandon the path due to a lack of monetary remuneration, which creates difficulties for facility managers trying to recruit or train staff in TOP. Several facility managers shared stories about losing TOP providers to private facilities or other specialties, once staff realised they would not be given incentives in the public sector. One facility manager stated that the need for money in this context is so great that adequate financial incentives may persuade providers who would not normally consider being TOP providers, or who claim CO as a guise for non-participation in TOP, to receive training and take up posts.

"*I realized money is the root of everything, people are broke … Nurses are having problems of their own … so they find themselves stranded, then going to the private sector. But if [TOP] was to be made a specialty, no people would [leave].*" (Facility Manager, Non-Objector, Limpopo Province)

The lack of financial remuneration may lead some providers to invoke CO as a protest against poor

pay for TOP provision. As one former TOP provider explained, in the absence of perceived "proper" monetary compensation for her work in the TOP ward, she used CO as the reason to stop providing TOP services and to be allocated to another function.

"*Once they decided to alienate us from the remuneration package, we said ok, now what I am going to do, I wrote to the management, I told them that on this and such a date I am experiencing all fears … I am leaving the program because I was saying the government had enacted this [conscientious objection act] … I cited the conscientious objection to them, and then I got to work in another ward.*" (Ex-TOP Provider, Non-Objector, Eastern Cape Province)

Facility-level barriers to TOP provision

In addition to personal reasons that may demotivate providers from offering TOP services and encourage invocation of CO for reasons outside of those protected by law, participants cited a number of facility-level barriers connected to use and misuse of CO. These reasons include lack of adequate staffing levels for TOP, management refusal to send staff for TOP training, and the unavailability of supportive measures such as debriefing sessions.

Shortage of TOP staffing was cited as one of the biggest impediments to maintaining abortion services. Clinics that are designated to provide abortion care often do not provide TOP services due to a lack of staff driven by a large number of objectors and providers who chose not to pursue TOP training because of lack of remuneration, workplace stress, and stigma. This lack of human resources for TOP is exacerbated by lack of budget for or refusal of management in providing TOP training for willing staff. Though staff shortages are not uncommon in this context, some participants felt that facility managers use budget shortfalls as a cover to avoid hiring or training staff in TOP, due to personal opposition to providing abortion services, despite the fact that facility managers are not permitted to claim CO.

"*Shortage of staff is the biggest excuse ever. It will forever be a challenge. There is shortage of staff everywhere, and it's something we cannot change. So, unfortunately, they use that as their main excuse [not to provide TOP].*" (TOP Provider, Non-Objector, Gauteng Province)

"*Personally I feel like most of the people that are in management are Christian people, who are like strong believers, who are against the service … they are denying people who want to [get trained in TOP]. They don't want to take them to training. They said they are short-staffed, whereas they are prioritizing other departments like other than TOP.*" (TOP Provider, Non-Objector, Gauteng Province)

Another complaint from some TOP providers was the lack of debriefing, or insufficient debriefing. Debriefing is a session where a safe environment, often off-site, is created for TOP providers to express their feelings, achievements, challenges, constraints, and lessons learned related to the provision of TOP in the presence of a psychologist, peers, and provincial and health district managers. Debriefings are especially important to abortion providers who, like many of the respondents in this study, work in settings where they experience stigma from objectors and others opposed to abortion. Debriefings are recommended to take place at least on a quarterly basis. Most providers requested debriefing biannually, or annually, but do not receive it due to lack of time to attend or facility managers that are unsupportive of the practice. Debriefing was seen as one of the primary support systems for TOP providers working in stressful and stigmatising environments.

"*I was left behind. I was so disappointed … Because we really need this. Sometimes it's so nice just to meet with the providers, and you just talk about you know what are the challenges that you are having.*" (TOP Provider, Non-Objector, Gauteng Province)

Shifting attitudes on TOP through training

Several participants noted that knowledge of the actual procedures and counselling process of TOP were deficient among facility personnel who are not directly involved in TOP service delivery. Providers felt this lack of awareness may contribute to negative attitudes towards TOP and dissuade staff from receiving training in or supporting TOP. To address this, participants repeatedly recommended onsite training or workshops on TOP for all facility staff, including support staff. They suggested that increased knowledge of abortion among staff who do not approve of TOP could assist in enrolling or retaining potential TOP providers.

"*Maybe I object to TOP because I don't have enough information about termination of pregnancy. Maybe if they can provide more training, like they can provide more training to the staff, maybe most of the staff members can change their minds about this termination of pregnancy.*" (Healthcare Provider, Objector, Gauteng Province)

Offering TOP awareness-raising activities had tangible effects on increasing provider support for TOP service provision. Several participants gave first-hand accounts of their own transformation from objectors to TOP non-objectors as a result of participating in values clarification workshops (VCAT) offered by Ipas.

"*When I first went for [values clarification] training, I was a bit negative about termination. I wasn't sure exactly if I am doing the right thing, according to my religion, but then when I went to training, it was so interesting in a way that there were so many answers that I got … That's when I changed my mind and say I mustn't take my religion and put it in a patient.*" (Facility Manager, Non-Objector, KwaZulu-Natal Province)

"*As much as I thought I was against [TOP], but when we [went for training] … I see that it's wrong for us as healthcare workers to put our values and needs first before a client … It's not as if I am doing TOP. It's the client. I am only providing the service to her.*" (Healthcare Providers, Mixed Attitudes towards TOP, KwaZulu-Natal Province)

Discussion

By examining the context in which South African healthcare providers, facility managers, and support staff define, understand, and use CO, this study demonstrated that in some cases invocation of CO may be entirely unrelated to the legal basis for objection. Stigma against women and girls who seek TOP and providers who offer TOP remains substantial. Such factors combined with operational barriers to offering abortion care (such as lack of training support or financial incentives) and a lack of clarity on CO definitions and procedures may incentivise some providers to invoke CO inappropriately, thereby limiting the availability of abortion services in the public sector. Many of these findings, including the use of CO outside the limits of the law, stigma towards women and girls who seek abortion and providers who provide abortion, lack of financial incentives for TOP provision, and the lack of clarity on CO procedures have been echoed in literature from other settings, from Argentina to Zambia to Ireland.[5,34,40] Our study adds to the research base the perspectives and inappropriate uses of CO among facility managers and support staff in South Africa.

Of particular concern is that few study participants could name the parameters for CO and only a minority of providers or managers indicated there was a formal written process for objecting. Confusion about what constitutes CO and lack of understanding of guidelines may lead to uneven application of CO across facilities. Procedural variability and reliance on informal, verbal processes may foster abuse of CO or, at the very least, reduce accountability for providers and managers in the CO process, all of which may lead to limited abortion availability for women.[8] Data for this study were collected in 2019, prior to dissemination of the national SRHR guidelines[30] and the national clinical guidelines for implementation of the CTOP Act[31] in 2020, which provide clearer guidance on CO; future research should assess the impact of these guidelines on understanding and application of CO in the public sector. Despite a lack of clarity on CO procedures, it is promising that no respondents reported obstruction of abortion services, and that a number of respondents pointed to the effect of VCAT in changing their perspectives on abortion and an overall "softening" of attitudes towards abortion. As has been identified in other countries, VCAT is an important tool in ensuring abortion services remain available in the context of CO.[41]

A principal reason cited for objecting to abortion among participants was bias against women and girls who are viewed as using abortion "in lieu of" a contraceptive method. Judgment is particularly strong towards women and girls who have more than one abortion and are viewed as abusing the system. This is in stark contrast to cases where the woman's life is in danger or she became pregnant as a result of rape, which were seen as more acceptable reasons for seeking abortion. This finding is in line with research from other settings, including Brazil, Mexico, Bolivia, and Zambia, which show that discrimination against women and girls is common when abortion is seen as a "choice" rather than a medical necessity.[20,21,42,43] Furthermore, bias of this kind

can severely restrict availability of public-sector abortion care as providers cajole and coerce women and girls away from abortion or refuse outright to perform TOP, resulting in staff shortages.[21,44,45] Young women and girls are at acute risk of provider bias and subsequent impacts on abortion availability, as stigma against abortion is compounded by moralistic attitudes towards adolescent sexuality and agency.[46] Applying personal criteria for who is qualified to receive an abortion may lead providers to misuse CO as a means of imposing their own values and denying choice to women and girls.

Another significant obstacle to TOP provision is the rejection and discrimination that TOP providers experience from other facility staff. Providers working in TOP units reported verbal abuse and social isolation, not only from other health providers but from facility support staff. As seen in other settings, such mistreatment may lead to reduced professional quality of life, lower morale or burnout for existing TOP staff, and discourage other providers from training in TOP.[47] While study respondents did not directly mention a link between abuse of TOP providers and CO use, mistreatment of TOP staff has been documented in other contexts as reducing staff willingness or capacity to perform abortions, and may incentivise misuse of CO to safeguard against stigma in the workplace[48].

Lack of financial remuneration and poor levels of facility support for provider debriefing and training were also cited as reducing provider motivation to perform TOP and prompting CO misuse. Participants shared examples of cases where TOP providers invoked CO as a means of protesting poor pay or refusing to work under difficult facility conditions, which echoed findings in Glenton et al. (2017) that South African nurses and midwives were unwilling to provide abortion services due to their heavy workload and no additional remuneration in recognition of their additional training and certification in abortion provision.[49] For some, poor pay in the public sector may encourage referrals to private facilities where providers can earn more per procedure, which may delay or obstruct women's access to safe abortion. Shortage of staff and lack of managerial support for TOP providers may further enhance conditions for CO exploitation. Physician advocates in Ireland successfully campaigned for financial remuneration for abortion, which has proved pivotal in recruiting abortion providers after their law change,[40] and could be considered as a way to mitigate misuse of CO in settings like South Africa. Ipas's experience in South Africa has shown how critical debriefing is for abortion providers to feel supported and continue providing public-sector abortion services. It is particularly concerning that respondents reported facility managers obstructing access to TOP training or debriefing support due to their bias against abortion provision, a phenomenon shown to have especially damaging effects on abortion availability in other settings[5,20] but which is a novel finding in South Africa. Importantly, most management obstruction observed in South Africa was indirect and related to deprioritising TOP training and resourcing rather than direct obstruction of TOP services (such as disallowing TOP-trained providers from offering services). There was no mention of intra-facility disagreements between managers and TOP providers, likely because many participants, including objectors, discussed access to TOP services at public facilities as a right enshrined in the Constitution that should be respected despite personal beliefs.

In light of the findings, this study offers several recommendations for improving TOP access and reducing CO misuse. First and foremost, facilities and staff must understand and follow guidelines for lodging objections and put in place contingency planning to reduce interruptions in women's care in the event of CO. Properly registering CO will enhance accountability to ensure that legally required services are being provided and that women and girls are being referred to a facility that is functioning. Whole site orientations and TOP VCAT[2] may also improve access to abortion care and minimise CO misuse. Providers in this study recounted that attending VCAT changed their perspectives on TOP and even encouraged some to train in the field. Similar experiences have been documented among providers in other countries.[41] Offering whole-site orientation

[2]Ipas values clarification and attitude transformation (VCAT) process is designed to move participants toward support, acceptance and advocacy for comprehensive abortion care and related sexual and reproductive health care and rights through examination of personal moral beliefs and sensitisation to the needs of women. Whole-site orientation is a process by which all members of a facility, including support staff, are given VCAT or other sensitisation training to reduce obstacles to women's abortion care at the facility level.

for all staff aims to create a supportive environment for TOP care among all facility staff, including support staff and managers, and reduce incidence of taunting and shaming of abortion providers. However, these types of training are optional, and objectors may choose not to attend. Additional supportive structures for TOP provision, such as financial remuneration, regular debriefing, and establishing TOP referral networks within a district or region can decrease isolation of TOP staff and distribute the burden of TOP provision for resource-poor areas, increasing timely access to quality TOP care for all women. Conversations about misuse of CO and abortion availability must also acknowledge the fact that, where providers are not gatekeepers to care, the problem of CO misuse is sidestepped. Self-managed abortion has shown great promise in expanding access to safe abortion, especially in the context of the COVID-19 pandemic,[50,51] and is immune to misuse of CO by centring women themselves as providers. This does not of course negate our obligation to ensure availability of in-clinic, public-sector abortion services for those who want them or who need to access surgical abortion, but it is another tool in our arsenal to ensure the availability of safe and timely abortion care for all women and girls.

These findings should be viewed in light of the study limitations. Although we interviewed a substantial number of participants from multiple regions and facilities, the findings are not generalisable due to the purposive nature of the sampling and total number of participants. However, similar findings from other settings suggest that many of our conclusions are not unique to South Africa. There may also be bias toward facilities with higher functioning TOP units. Most facility non-participation was due to requirements for additional ethics reviews, but the reason for declining was not documented for all facilities. Facilities that declined to participate for unknown reasons may have had less previous interaction with Ipas and be less interested and engaged in TOP service provision compared to participating facilities. Bias may also have been introduced through use of local translators for some of the interviews as translation quality was not checked. Finally, due to the highly sensitive topic of abortion, there may be the presence of social desirability bias, especially for TOP providers who have prior experience working with Ipas and may be less inclined to report instances of denial or obstruction of abortion care. However, interviews were conducted by non-Ipas staff and all other facility staff had limited to no experience with Ipas, which likely mitigated social desirability bias.

Conclusion

Since the passing of the CTOP Act in 1996, South Africa has made strides to increase access to quality abortion care across the country. Lack of understanding of the CO clause undermines these advances by creating conditions for CO misuse, particularly due to stigma against women and girls requesting TOP and TOP providers, by a range of health facility staff from managers to support staff. Dissemination of national guidelines on CO should be prioritised to reduce ambiguity, and implementation of whole site orientations and VCAT trainings should be considered for all staff to safeguard abortion availability in South Africa in the context of CO.

Acknowledgements

We would like to acknowledge the work done by CADRE on five unpublished reports, which serve as the basis for this paper.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by Ipas.

Authors' contributions

MM, JvR, RC, JM, and EP contributed to the study design and conceptualisation. HH, NN, and NO contributed to the situational assessment, participant recruitment, data collection, analysis, and writing of findings. All authors (MM, RC, AJ, JvR, HH, NN, NO, JM, and EP) participated in the writing and review of the manuscript. All authors (MM, RC, AJ, JvR, HH, NN, NO, JM, and EP) have read and approved the final manuscript.

ORCID

Erin Pearson http://orcid.org/0000-0002-6056-1454

References

1. Singh S, Maddow-Zimet I. Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries. BJOG. 2015;123:1489–1498.
2. Abortion Worldwide 2017. Uneven progress and unequal access. New York: Guttmacher Institute; 2018.
3. Ganatra B, Gerdts C, Rossier C, et al. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. Lancet. 2017;390(10110):2346.
4. Chavkin W, Swerdlow L, Fifield J. Regulation of conscientious objection to abortion: an international comparative multiple-case study. Health Hum Rights. 2017;19(1):55–68.
5. Michel AR, Kung S, López-Salm A, et al. Regulating conscientious objection to legal abortion in Argentina: taking into consideration its uses and consequences. Health Hum Rights. 2020;22(2):271–283.
6. Fleming V, Ramsayer B, Škodič Zakšek T. Freedom of conscience in Europe? An analysis of three cases of midwives with conscientious objection to abortion. J Med Ethics. 2018;44:104–108.
7. International Women's Health Coalition. Unconscionable: when providers deny abortion care. New York: IWHC; 2018.
8. Chavkin W, Leitman L, Polin K. Conscientious objection and refusal to provide reproductive healthcare: a white paper examining prevalence, health consequences, and policy responses. Int J Gynaecol Obstet. 2013;123:S41–S56.
9. World Health Organization. Safe abortion: technical and policy guidance for health systems. Second ed. Geneva: WHO; 2012.
10. Harries J, Cooper D, Strebel A, et al. Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study. Reprod Health. 2014;11 (16):1–7.
11. International Covenant on Civil and Political Rights. G.A. Res. 1966;2200A(XXI).
12. Center for Reproductive Rights. Law and policy guide: conscientious objection. Accessed on 10 August 2020 at: https://reproductiverights.org/law-and-policy-guide-conscientious-objection.
13. FIGO. Resolution on "Conscientious Objection" (Kuala Lumpur). (2006). Accessed on 23 January 2022 at: https://www.figo.org/sites/default/files/2020-08/FIGO%202006%20Resolution%20on%20Conscientious%20Objection-EN.pdf.
14. Faundes A, Duarte GA, Neto JA, et al. The closer you are, the better you understand: the reaction of Brazilian obstetrician-gynaecologists to unwanted pregnancy. Reprod Health Matters. 2004;12(24 Suppl):47–56.
15. De Zordo S, Mishtal J. Physicians and abortion: provision, political participation and conflicts on the ground – the cases of Brazil and Poland. Women's Health Issues. 2011;21(Suppl 3):S32–S36.
16. Goyal M, Zhao H, Mollen C. Exploring emergency contraception knowledge, prescription practices, and barriers to prescription for adolescents in the emergency department. Pediatrics. 2009;123(3):765–770.
17. Cohen SA. Facts and consequences: legality, incidence and safety of abortion worldwide. Guttmacher Policy Review. 2009;12(4):2–6.
18. Navarrete SA, Ramón Michel A. "Re-thinking the use of conscientious objection by health professionals: a regulatory proposal based on legal abortion practices in Argentina." Available at SSRN 3380668 (2019).
19. Harries J, Constant D. Providing safe abortion services: experiences and perspectives of providers in South Africa. Clin Obstet Gynaecol. 2020;62:79–89.
20. Kung SA, Wilkins JD, de Leon F D, et al. "We don't want problems": reasons for denial of legal abortion based on conscientious objection in Mexico and Bolivia. Reprod Health. 2021;18(44):1–11.
21. Awoonor-Williams JK, et al. Exploring conscientious objection to abortion among health providers in Ghana. Int Perspect Sex Reprod Health. 2020;46:51–59.
22. Choice on Termination of Pregnancy Bill. Section 2, Gazette, 45. 1997.
23. Blanchard K, Fonn S, Xaba M. Abortion law in South Africa: passage of a progressive law and challenges for implementation. Gaceta Médica de México. 2003;139(1): S109–114.
24. Jewkes R, Brown H, Dickson-Tetteh K, et al. Prevalence of morbidity associated with abortion before and after legalization in South Africa. Br Med J. 2002;324:1252–1253.
25. Amnesty International. Barriers to safe and legal abortion in South Africa. London, England: Amnesty International; 2017.
26. Guttmacher Institute. Making abortion services accessible in the wake of legal reforms: a framework and six case studies. http://www.guttmacher.org/pubs/abortion-services-laws.pdf. Published 2012. Accessed June 15, 2020.
27. Chiwandire D. Conscientious objection and South African medical practitioners' constructions of termination of pregnancy and emergency contraception. Master's thesis, Rhodes University. Published 2015. Accessed on 6 March 2023 at: http://vital.seals.ac.za:8080/vital/access/manager/Repository/vital:2888?site_name=GlobalView&exact=sm_creator%3A%22Chiwandire%2C+Desire%22&f0=sm_type%3A%22MSocSc%22&sort=sort_ss_title%2F.

28. Naylor N, O'Sullivan M. Conscientious objection and the implementation of the choice on termination of Pregnancy Act 92 of 1996 in South Africa. Cape Town: Women's Legal Centre; 2005.
29. Ngwena C. Conscientious objection and legal abortion in South Africa: delineating the parameters. J Jurid Sci. 2003;28(1):1–18.
30. National Department of Health Republic of South Africa. National Integrated Sexual and Reproductive Health and Rights Policy. Edition 1. https://www.knowledgehub.org.za/system/files/elibdownloads/2021-03/National%20Integrated%20SRHR%20Policy_Final_2021.pdf. Published 2019. Accessed February 18, 2022.
31. National Department of Health Republic of South Africa. National clinical guideline for implementation of the choice on termination of Pregnancy Act. Edition 1. https://www.knowledgehub.org.za/system/files/elibdownloads/2021-03/Termination%20of%20Pregnancy%20Guideline_Final_2021.pdf. Published 2019. Accessed February 18, 2022.
32. Harries J, Stinson K, Orner P. Health care providers' attitudes towards termination of pregnancy: a qualitative study in South Africa. BMC Public Health. 2009;9(296):1–11.
33. Favier M, Greenberg JM, Stevens M. Safe abortion in South Africa: "we have wonderful laws but we don't have people to implement those laws". Int J Gynaecol Obstet. 2018 Oct;143:38–44.
34. Freeman E, Coast E. Conscientious objection to abortion: Zambian healthcare practitioners' beliefs and practices. Soc Sci Med. 2019;221:106–114.
35. Trueman KA, Magwentshu M. Abortion in a progressive legal environment: the need for vigilance in protecting and promoting access to safe abortion services in South Africa. Am J Public Health. 2013;103(3):397–399.
36. Massyn N, et al. District health barometer 2016/2017. Durban: Health Systems Trust; 2017.
37. All4Women. KZN increases abortion clinics in bid to stamp out illegal practices, December 2015. Available from: https://www.all4women.co.za/586633/news/south-african-news/kzn-increases-abortion-clinics-in-bid-to-stamp-out-illegal-practices.
38. Meel BL, Kaswa RP. The impact of the choice on termination of Pregnancy Act of 1996 (Act 92 of 1996) on criminal abortions in the Mthatha area of South Africa. Afr J Prim Health Care Fam Med. 2009;1(1):79–81.
39. Turner KL, Page KC. Abortion attitude transformation: a values clarification toolkit for global audiences. Chapel Hill, NC: Ipas; 2008.
40. National Women's Council. Accessing Abortion in Ireland: Meeting the Needs of Every Woman. Available from: https://www.nwci.ie/images/uploads/15572_NWC_Abortion_Paper_WEB.pdf.
41. Turner KL, Pearson E, George A, et al. Values clarification workshops to improve abortion knowledge, attitudes and intentions: a pre-post assessment in 12 countries. Reprod Health. 2018;15(40):1–11.
42. Hanschmidt F, Linde K, Hilbert A, et al. Abortion stigma: a systematic review. Perspect Sex Reprod Health. 2016 Dec;48(4):169–177.
43. Diniz D, Madeiro A, Rosas C. Conscientious objection, barriers, and abortion in the case of rape: a study among physicians in Brazil. Reprod Health Matters. 2014;22(43):141–148.
44. Norris A, Bessett D, Steinberg JR, et al. Abortion stigma: a reconceptualization of constituents, causes, and consequences. Womens Health Issues. 2011 May 1;21(3):S49–S54.
45. Homaifar N, Freedman L, French V. "She's on her own": a thematic analysis of clinicians' comments on abortion referral. Contraception. 2017 May 1;95(5):470–476.
46. Kumar A, Hessini L, Mitchell EM. Conceptualising abortion stigma. Cult Health Sex. 2009 Aug 1;11(6):625–639.
47. Martin LA, Debbink M, Hassinger J, et al. Abortion providers, stigma and professional quality of life. Contraception. 2014 Dec 1;90(6):581–587.
48. Harris LH, et al. Dynamics of stigma in abortion work: findings from a pilot study of the Providers Share Workshop. Soc Sci Med. 2011;73(7):1062–1070.
49. Glenton C, Sorhaindo AM, Ganatra B, et al. Implementation considerations when expanding health worker roles to include safe abortion care: a five-country case study synthesis. BMC Public Health. 2017 Dec 1;17(1):730.
50. Aiken ARA, Starling JE, Gomperts R, et al. Demand for self-managed online telemedicine abortion in the United States during the coronavirus disease 2019 (COVID-19) pandemic. Obstet Gynecol. 2020 Oct;136(4):835–837.
51. Aiken ARA, Starling JE, Gomperts R, et al. Demand for self-managed online telemedicine abortion in eight European countries during the COVID-19 pandemic: a regression discontinuity analysis. BMJ Sex Reprod Health. 2021;47(4):238–245.

Résumé

L'objection de conscience de la part des prestataires de soins de santé est une menace croissante

Resumen

La objeción de conciencia (OC) por parte de prestadores de servicios de salud es una creciente

pour l'accès à un avortement sans risque. En Afrique du Sud, il a été constaté que cette clause juridique peut être manipulée comme justification permettant aux prestataires de soins de santé du secteur public de s'exempter de leur devoir d'assurer des services de santé reproductifs essentiels, ainsi que prévu par la législation et les protocoles nationaux. Cette étude qualitative améliore notre compréhension de la définition, des perspectives et de l'utilisation de l'objection de conscience parmi les prestataires, les personnels et les administrateurs d'établissements en Afrique du Sud et des conséquences de l'objection de conscience sur la disponibilité de l'avortement dans le secteur public. Au cours de 18 discussions par groupe d'intérêt et 23 entretiens approfondis, nous avons examiné les attitudes et comportements en matière d'objection de conscience du personnel d'établissements de santé qui assurent des soins pour avortement dans les provinces de Gauteng, de Limpopo, du KwaZulu-Natal et du Cap-Oriental. Nous avons observé que l'objection de conscience est invoquée pour différentes raisons, certaines sans rapport avec sa base juridique. Les attitudes sur l'avortement ont progressivement évolué au fil du temps, mais la stigmatisation à l'encontre des femmes et des filles qui souhaitent interrompre leur grossesse reste vive parmi les personnels dans les établissements qui pratiquent les avortements. Les prestataires qui assurent des services d'avortement font aussi état de niveaux élevés de discrimination et d'isolement de la part de leurs collègues. Ces facteurs, associés aux obstacles opérationnels à l'offre de soins de qualité en cas d'avortement (comme l'insuffisance du soutien à la formation ou de mesures financières d'encouragement) et le manque de clarté sur les définitions et les procédures de l'objection de conscience, peuvent encourager certains prestataires à invoquer indûment l'objection de conscience. La diffusion de directives nationales sur l'objection de conscience devrait être prioritaire pour réduire l'ambiguïté, et il faudrait envisager des interventions s'attaquant à la stigmatisation de l'avortement pour tout le personnel des établissements de santé afin de protéger la disponibilité de l'avortement en Afrique du Sud.

amenaza al acceso a los servicios de aborto seguro. En Sudáfrica, la evidencia indica que esta cláusula jurídica podría ser manipulada como justificación para que los prestadores de servicios de salud del sector público se excusen de sus deberes de proporcionar servicios de salud reproductiva esenciales según lo disponen las leyes y los protocolos nacionales. Este estudio cualitativo mejora nuestra comprensión de las definiciones, las perspectivas y el uso de la OC entre prestadores de servicios, personal y administradores de establecimientos de salud en Sudáfrica, y el efecto de la OC en la disponibilidad de servicios de aborto en el sector público. Utilizando 18 discusiones en grupos focales y 23 entrevistas a profundidad, examinamos las actitudes y los comportamientos del personal con relación a la OC en establecimientos de salud que proporcionan servicios de aborto en las provincias de Gauteng, Limpopo, KwaZulu-Natal y Cabo oriental. Encontramos que la OC es invocada por una variedad de razones, algunas no relacionadas con la base legislativa para la objeción. Con el paso del tiempo, se ha visto cambios progresistas en las actitudes hacia el aborto, pero el estigma contra las mujeres y niñas que buscan servicios de aborto continúa siendo sustancial entre el personal y los establecimientos de salud que proporcionan servicios de aborto. Además, los prestadores de servicios de aborto informan altos niveles de discriminación y aislamiento de sus colegas. Tales factores, combinados con las barreras operativas para ofrecer servicios de aborto de calidad (como la falta de apoyo capacitante o de incentivos financieros) y la falta de claridad sobre las definiciones y los procedimientos de OC, podrían incentivar a algunos prestadores de servicios a invocar OC indebidamente. Se debe priorizar la difusión de directrices nacionales sobre la OC para reducir la ambigüedad, y se debe considerar intervenciones que aborden el estigma del aborto para todo el personal de los establecimientos de salud, con el fin de salvaguardar la disponibilidad de los servicios de aborto en Sudáfrica.