EXPLORING PSYCHOSOCIAL ISSUES AND COPING STRATEGIES OF HEALTH CARE PROVIDERS AT TERMINATION OF PREGNANCY SERVICES IN TWO SOUTH AFRICAN PROVINCES

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DECLARATION

This thesis is submitted in the integrating narrative format, approved by the Faculty of Health Sciences, of published work.

I, Mantshi Elizabeth Teffo, declare that this thesis is my original work. It is being submitted for the degree of Doctor of Philosophy in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University. I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong. I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.

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Signature:

Mantshi Elizabeth Teffo

01 April 2019

DEDICATION

In dedication to my son

Lehlohonolo Pule *Tsonka* Menziwa

for the love and support

You have been part of my journey through and through, be inspired!

To my mother whom I am blessed to share this great achievement with at age 93. Kea' leboga Mma!

PUBLICATIONS ARISING FROM THIS THESIS

Published

1. **Mantshi E. Teffo,** Laetitia C. Rispel**:** '*I am all alone*': factors influencing the provision of termination of pregnancy services in two South African provinces. *Global Health Action 2017,* **10**:1, 1347369, DOI: 10.1080/16549716.2017.1347369

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ABSTRACT

Background: In South Africa, the implementation of the Choice on Termination of Pregnancy Act depends on the availability of willing, competent and responsive health care providers. However, there is a dearth of scholarly studies on the psychosocial issues faced by these providers, their coping strategies, and the availability of organisational support systems.

Objective: The aim of this PhD was to investigate the psychosocial issues and coping strategies of health care providers at termination of pregnancy (TOP) services in two South African provinces. The specific objectives were to: explore health care providers' individual experiences of TOP provision, their workload and organisational factors that influence TOP provision; determine the coping strategies used by these health care providers; determine the mechanisms that exist within the organisation to help TOP providers cope with their work; and determine the views of managers on psychosocial support and/or programmes for TOP service providers.

Methods: During 2014 - 2015, a cross sectional, convergent parallel mixed methods study was conducted at all designated TOP facilities in Gauteng and North West Provinces. The methods combined the completion of a facility checklist; indepth interviews with 30 TOP providers; a survey of 103 TOP providers; a survey among 50 managers of TOP services or facilities, as well as indepth interviews with these managers. STATA® 13 and Microsoft Excel were used for quantitative data analysis, while Interpretative Phenomenological Analysis was used to analyse the qualitative data. The computer software, MAXQDA® 12 was used to support the qualitative data analysis.

Results: Only 77% of the 61 designated facilities on the national database were providing TOP services (Gauteng =28/32; North West = 19/29), and an additional four facilities not on the database were providing TOP services. Hence the total number of studied facilities was 51. The TOP provider survey obtained a response rate of 98%. The majority of TOP providers

were female (82%), professional nurses (70.9%), with a mean age of 43.4 (SD = 8.7). The overall compassion satisfaction score among TOP providers was high at 42 (SD = 5.5). The predictors of compassion satisfaction were finding work stimulating, the belief in making a difference, positive relationships with other nurses and years of TOP service ($p<0.05$). Burnout mean scores were average at 33 (SD = 4.0), with the belief in helping women to make informed choices a marginally significant predictor of burnout. The overall secondary traumatic stress (STS) mean score was average at 23 (SD = 6.8). Significant predictors of STS scores were finding work stimulating, the belief in women's rights, the belief in allowing women to make informed choices, age and gender. TOP providers reported both positive coping strategies (support seeking, self -control, professionalism and belief systems), and negative coping strategies (silence and concealing emotions, work avoidance).

In Gauteng only two hospitals (12.5%), and in North West, only one hospital (10%) reported the availability of dedicated psychosocial support programmes. The majority of managers interviewed reported indifference or ambivalence about the availability of psychosocial programmes for TOP providers.

Conclusion: The psychosocial issues of TOP providers need prioritisation through supportive management, positive practice environments, and the development and implementation of effective and sustainable employee wellness programmes that enhance compassion satisfaction and reduce burnout and STS among these providers.

Key words: abortion, termination of pregnancy; health care provider; compassion satisfaction, compassion fatigue; coping; South Africa.

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I thank the managers in Gauteng and North West for study approval. I acknowledge gratefully the TOP service providers for their invaluable insights and hope that the study will contribute to positive changes for them in the health care system.

Finally, I would like to thank my brother, Nkgoele Conrad Teffo for the time, compassion and effort you selflessly availed to support me through to this point, despite all trials and tribulations of life. All my siblings: Dorothy "Sedo" Mashishi, Mokoko Augustine Teffo, Simon Modise, Mawilly Teffo, Kgomotso "Wesho" Moema and other family members, thank you for your understanding, support and love in many different ways.

To the departed, my beloved brothers Chris “Broer” Teffo and Oupa Chris Mabusela, my sister Ous Mary Sekgobela, my godmother Rakgadi Rose Moema, who passed on at critical times of my PhD journey, may you find Eternal peace in the Lord.

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FOREWORD

I am a nurse midwife and a trained psychiatric nurse with extensive experience in sexual and reproductive health, operational research and management of HIV programmes. At the start of my career I worked at a mental health hospital, and then proceeded to work at the government district health office overseeing mental health and sexual and reproductive health programmes. Between 2004 and 2007, I was employed in positions that included responsibilities for policy development, implementation, monitoring and quality improvement on sexual and reproductive health, sexual assault and HIV at the National Department of Health. Following government service, my subsequent employment was with various non-governmental organisations. From 2007 to 2011, I was at the Population Council where I managed the sexual and reproductive health, prevention of gender-based violence programmes and engagement of traditional leaders' programmes. From August 2011 until July 2014, I worked as a project manager at Marie Stopes, a private organisation that provides termination of pregnancy (TOP) services at a fee. Following Marie Stopes, I worked at mothers2mothers with the primary focus on women's empowerment on the integration of HIV programme into sexual and reproductive health until 2016. Currently I work at BroadReach as a technical advisor on the prevention of mother to child HIV transmission, and integrated sexual and reproductive health services.

My experience of the burden of caring in sexual and reproductive health services made me realise the need for psychological support for health professionals, specifically at programme implementation level. The lack of such support sparked my interest in the "Care of the Carer" programme. I initially wanted to focus on caring for mental health professionals, until I worked at Marie Stopes.

As a practising Catholic, working at Marie Stopes, I experienced a lot of ambivalence. At the same time, as an experienced public health practitioner, I understand the contribution of safe TOP services to the reduction of maternal mortality. As a manager in the field I got to understand the need for support interventions for TOP service providers. In my day-to-day interactions with TOP providers at the coalface, it made me want to have an in-depth understanding of what psychosocial issues these providers face or experience, the availability or necessity of support programmes, especially in public health facilities in South Africa, which

provides health care to the majority of South Africans. It is against this background that I was keen to do a PhD and examine the psychosocial issues and coping strategies among termination of pregnancy providers.

My PhD journey

With extensive support from my supervisor, this thesis is a culmination of years of research, struggles and extensive efforts in the two South African provinces of Gauteng and North West. My PhD journey started in November 2011 when I first registered in the School of Public Health at the University of the Witwatersrand (WITS). At the time, I was working for the Population Council managing the sexual and reproductive health programme. The Council paid for my tuition in 2011 and allowed me to attend the bi-weekly academic seminars that were held as a prerequisite for the PhD programme at WITS. The academic seminars helped me to conceptualise my PhD and allowed me the opportunity to engage with other students. However, it took 6 months to find a supervisor for my studies, the reason given at the time was that it was difficult to find a person who had the time to supervise me. However, I did not make any progress at that time with the allocated supervisor- this made me feel like the start of a struggle with my chosen topic. It took two years from first registration until 2013, and a new Head of the School of Public Health who was willing to take me on as a PhD student. My new supervisor enabled me to (1) have a PhD topic (2) get ethics approval (3), obtain funding, and (4) start with data collection. I was doing my PhD part time, and I was mostly self-funded since 2012. Managing work demands and changing jobs three times since first registration have impacted on my academic progress.

Touch points during my PhD journey

Access to the facilities for approval and data collection was difficult, especially in Gauteng Province. In one district, the manager took months to respond to the request for a meeting despite submission of all the relevant documents. I managed finally to obtain a facility approval form which facilitated access at the facilities. Two hospitals gave me such a hard and wasted time that my PhD supervisor had to intervene by contacting the chief executive officer and the relevant provincial manager responsible for the community health centre. There was success at the hospital, and none at the community health centre where the facility manager was rude,

and blatantly refused any of the staff to participate, except for a doctor who willingly participated in the provider survey.

Locating TOP service units in the field was difficult. Upon asking for directions, I was often met with "brusque" responses from different staff at the facilities. Some would point me in an unclear direction; I would sometimes ask more than one person before I could find the unit as there was no signage or clear directions. At most facilities, the TOP unit was located in the antenatal care area, mother and child unit, or gynaecology and obstetrics unit, with a shared waiting area. I felt awkward waiting for the TOP provider, I could only imagine the experiences or feelings of women seeking terminations. In some instances, the TOP provider would walk past the waiting area with used instruments to access the sluice room. Surely this cannot be a sensitive practice for both the provider and the women?

Several people who were influential in the provision of TOP services declined to be interviewed. Others were honest in saying they did not like talking about abortion. There were times where personally I felt stigmatised and isolated. Some individuals who participated in the meeting discussion and interviews appeared hostile. I could only imagine and feel for the TOP service providers who work in this "stigmatised programme".

Some managers met with the researcher, but were guarded and brief in their responses. Another manager in North West briefly listened to the research topic, and brusquely called on another manager to take over. Yes, he did give the go-ahead but said he did not want to get involved in anything to do with TOP services for personal reasons. This was an executive manager of a hospital. A similar response was given at another hospital in Gauteng. The head of a gynaecology department at one large hospital said that no doctor provided TOP services at the hospital, and it was only provided by nurses. This was a standard response from the hospitals, despite the fact that they were referral hospitals for primary health care facilities.

My PhD thesis was finally submitted in October 2018, and will be available to contribute to the body of knowledge on termination of pregnancy. I hope that my experiences will encourage other people to persevere.

ABBREVIATIONS AND ACRONYMS

CA	Cronbach's Alpha
CF	Compassion Fatigue
CHC	Community Health Centre
CS	Compassion Satisfaction
CTOPA	Choice on Termination of Pregnancy Act
DoH	Department of Health
EAP	Employee Assistance Programme
GDP	Gross Domestic Product
GP	Gauteng Province
HCP	Health Care Provider
HREC	Human Research Ethics Committee
HRH	Human Resources for Health
ICPD	International Conference on Population and Development
JDCS	Job Demands-Control-Support Model
KII	Key Informant Interview
LMICs	Low -and -Middle Income Countries
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
NCCEMD	National Committee for the Confidential Enquiry into Maternal Deaths
NDoH	National Department of Health
NSDA	Negotiated Service Delivery Agreement
NW	North West Province
PHC	Primary Health Care
PhD	Doctor of Philosophy
PN	Professional Nurse
PPE	Positive Practice Environments
PRoQOL	Professional Quality of Life
PSW	Providers Share Workshop
SD	Standard Deviation

SDG	Sustainable Development Goal
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
STS	Secondary Traumatic Stress
TOP	Termination of Pregnancy
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organization
WITS	University of the Witwatersrand

CHAPTER 1: BACKGROUND AND CONTEXT

1.1 Introduction

Abortion or termination of pregnancy (TOP) is the ending of a pregnancy due to the removal of an embryo or fetus before it is able to survive outside the uterus (1). Although abortion could be spontaneous (also called miscarriage) or induced (2, 3), the term abortion is often used to refer to those terminations that are induced (3).

My PhD thesis focuses on the psychosocial issues experienced by, and coping strategies of, health care providers who perform abortions in accordance with South Africa's Choice on Termination of Pregnancy Act (CTOPA) (Act No 92 of 1996) (4), as amended in 2008. CTOPA was amended to revise a definition, empower the provincial Member of the Executive Council to approve facilities where TOP may take place, to exempt 24 -hour maternity facilities to seek approval to provide TOP under certain circumstances, and to provide for the recording of information and submission of statistics. The CTOPA defines TOP as "the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman" (4), page 4. Medical abortion means that medication is administered to terminate the pregnancy whereas surgical abortion could include both administration of medication and a surgical procedure.

I use abortion and TOP interchangeably in this thesis. My thesis brings together three strands at conceptual and methodological levels: firstly, the discourse on abortion; secondly, the health care system that enables abortions to be performed safely and in which health care professionals' function; thirdly, the health care professionals that provide abortion services as they constitute the core focus of my thesis. Hence, this chapter aims to summarise the context, and background to my PhD research by highlighting each of these overlapping, and inter-dependent strands. In the next section of the chapter (1.2), I have summarised the scholarly literature on the different perspectives and viewpoints on abortion. In section 1.3, I have provided a brief overview of CTOPA and of the South African health system with particular focus on TOP provision in the public health sector. In section 1.4, the importance of health professionals or TOP providers, the core focus of my PhD, is discussed. This is followed by

the problem statement and the rationale for the research in Section 1.5. The concluding sections contain the research questions, aim, and objectives (Section 1.6) and the structure and outline of the remainder of the thesis (Section 1.7).

1.2 Perspectives and viewpoints on abortion

On 12 July 2018, the Sowetan newspaper in Johannesburg, South Africa, carried a story under the heading: "*Half of SA's 700-a-day abortions illegal*" (5) . The newspaper article illustrates that despite the CTOPA's enabling legal framework, abortion remains a contested topic in South Africa and there is a myriad of issues faced by women who seek abortion (5). These issues include: stigma; poor quality of care in the public health sector; scarcity of willing and competent TOP providers; unresponsive and judgemental health professionals; and unscrupulous individuals who are neither competent nor permitted by law to perform abortions.

There is a considerable body of literature on abortion, and the paradigms that influence the subject (3, 6-9). It is beyond the scope of this thesis to critique these theories. In this section, four perspectives, namely the moral; legal; reproductive justice; and health perspectives are summarised, and a critique is provided (where relevant). Although these different perspectives cannot be seen in isolation of one other, each is presented separately for the sake of clarity.

1.2.1 Moral perspective

The notion of moral is concerned with "the principles of right and wrong behaviour or the code of behaviour that is considered right or acceptable in a particular society" (10), page 54. At the core of the moral perspective on abortion are questions of life and death, right and wrong, religious beliefs, and human relationships with their God (11-13). Although there are differences across the various religions, the vast majority view abortion as morally wrong because it involves the intentional destruction of a life considered to start at conception (14-17).

Both Jews and early Christians prohibited abortion on religious grounds, informed by moral principles and the value of human life (14). In some instances the practical addition to the population was another reason for discouraging the TOP (14). In Islam, the word "abortion" does not appear in the Qur'an, but Muslim authorities consider abortion as "*an act of interfering*

with God's role as the creator of life and death" (18), page 886. The Dalai Lama is quoted as saying that from a Buddhist point of view, abortion is negative and an act of killing (19).

However, the moral argument faces difficulty when there are medical indications for the abortion or to save the life of the mother (7, 15, 20, 21). In almost all major religions, there are different views even in these medically indicated cases (12, 22-24). Some argue that it depends on the intentions of those carrying out the abortion and that abortion is permissible when it is done with compassion, kindness and respect for life, while others are against abortion regardless of the context or circumstances (25-29).

In South Africa, the moral perspective also came to the fore around the promulgation of the CTOPA (Act No.2 of 1996). The Act was challenged by the United Christian Action Group, the Christian Lawyers' Association, and Christians for Truth who argued that it was an infringement of the fetus' constitutional right to life. They requested the court to set aside the CTOPA (30). The then Minister of Health, the Reproductive Rights Alliance, and the Commission on Gender Equality opposed the court action, and the Constitutional court ruled in favour of the CTOPA implementation (30).

1.2.2 Legal perspective

Worldwide, the legality of abortion has changed substantially between 1950 and 2018 because of a range of factors that include demographic changes, advocacy for women's rights, religion, scientific and medical developments, changing regimens and systems (26, 31-37). This is because a political regime could either facilitate abortion through the passage of more liberal laws or restrict women's access by enacting additional restrictions. The legal definition of induced abortion is safe abortion permitted by law and performed by a licenced physician, or an appropriately licenced mid-level practitioner acting under the supervision of a licenced physician, with the intention of terminating a pregnancy" (3), page 235.

In 1994, 179 governments made a global commitment to prevent unsafe abortion and liberalise their abortion laws by signing the Cairo International Conference on Population and Development Programme of Action (38). However, there are wide variations in abortion laws among regions, and countries (39). The Centre for Reproductive Rights in the United States of

America produces annual maps (Figure1.1), with four categories of abortion laws: Category 1 includes those countries where abortion is prohibited or only permitted to save the woman's life; Category II includes countries where abortion is permitted to preserve health; Category III includes countries where abortion is permitted on socio economic grounds; and Category IV are those countries where abortion is unrestricted or permitted for a wide range of reasons (39).

However, the categorisation does not reflect country-level implementation which is influenced by resource availability, women's access to abortion services, understanding or commitment to women's rights, health professionals' interpretation of the law, culture and societal norms (37, 39-41).

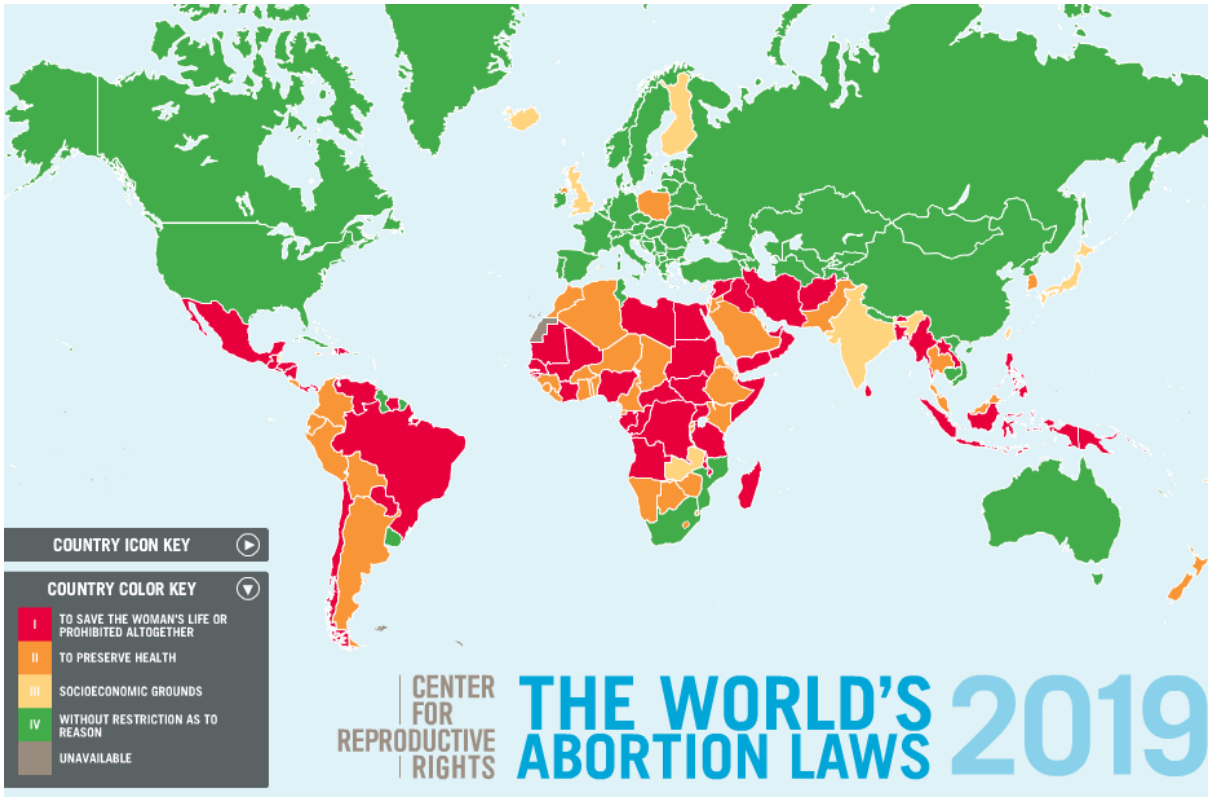

Figure 1.1: Map highlighting the legal status on abortion in different countries.
Source: Centre for Reproductive Rights (2019), USA. www.worldabortionlaws.com

As can be seen from Figure 1.1, the majority of the countries in the Global North and Central and Eastern Asia and Oceania have liberal abortion laws, as they permit abortion either without restriction as to reason or on broad grounds, such as for socioeconomic reasons (39).

The exceptions are Poland, Malta, and the Republic of Korea, that continue to have very restrictive abortion laws (29, 39, 42, 43).

In contrast to the Global North, the majority of countries in the Global South, notably in Africa, South America, the Middle East, and southern Asia have restrictive abortion laws. In sub-Saharan Africa, South Africa and Mozambique are the exception with liberal abortion laws (39). In Kenya, the 2010 Constitution permits abortion when the life or health of the woman is in danger although there is ambiguity on the meaning or interpretation of abortion "to protect the health of a woman" (41). In Malawi, abortion can only be done to save a woman's life, with a 7 to 14-year imprisonment as punishment should abortion be performed for any other reason (44). The penal code of abortion in Tanzania permits abortion to save a woman's life, but lacks clarity on its legality to preserve the woman's physical or mental health, and whether more than one provider needs to give authorisation (45). Rwanda's penal code restricts abortion to protect a woman's physical health or to save her life, including pregnancy from rape, incest or forced marriage (20). Abortion outside these conditions is a criminal and punishable offence (20).

In South Africa, the CTOPA transformed the legal framework for abortion that was limited to certain medical indications and that was defined by race and class, thereby enabling improved access to abortion for all women in the country (46). This is elaborated below.

1.2.3 Reproductive justice perspective

Reproductive justice refers to an approach that links sexuality, health, and human rights to social justice movements, thus placing abortion and reproductive health issues in the larger context of the well-being and health of women, families and communities (47). Globally, reproductive justice has gained increased attention following the Cairo International Conference on Population and Development (Cairo ICPD) in 1994 (48). This conference was a victory for women's movements as it put the spotlight on the intersection between women's rights as human rights, choice and health. However, the existence of reproductive rights does not mean that women are able to exercise those rights (48).

In 1995, the Programme of Action of the Cairo ICPD called for governments to review restrictive abortion laws to ensure that women were able to access abortion safely, and with access to quality services for management of abortion complications (49). However, as can be seen from Figure 1.1, wide variations in abortion laws among regions and countries remain. Notwithstanding a worldwide decline in unsafe abortions (50), these remain a challenge contributing to estimated millions of maternal deaths globally (51).

1.2.4 Health perspective

The health perspective is concerned with reducing maternal mortality due to unsafe abortions. Globally, it is estimated that around 25 million unsafe abortions take place every year (51). Approximately eight million or a third of these unsafe abortions were performed under unsafe conditions by untrained persons using dangerous and invasive methods (52). The majority of unsafe abortions (97%) occurred in low and middle-income countries (LMICs) in Asia, Africa, and South America (53).

The 2015 Sustainable Development Goals (SDGs) underscore safe, legal abortion to ensure universal access to sexual and reproductive health (SRH) services (target 3.7) in order to prevent avoidable maternal deaths (54). Post abortion family planning has been found to be an integral service that can strengthen national programmes to avert avoidable maternal deaths (55, 56). Strengthened health systems are a prerequisite to the provision of comprehensive abortion services through improved access, choice and quality care (57). These in turn are dependent on skilled, competent and willing health care providers.

In summary, I have simplified the moral, legal, reproductive justice and health perspectives on abortion. These perspectives are interrelated, but they highlight the complexities of abortion provision that is influenced by individual and/or communal notion of morality, rights and justice. The psychosocial issues and coping strategies of TOP providers cannot be examined in isolation of, and without understanding, these perspectives on abortion.

1.3 CTOPA and the South African health system

1.3.1 Brief overview of CTOPA

In South Africa, CTOPA permits abortion without restriction and for a wide range of reasons (4). The Act replaced the Abortion and Sterilisation Act (Act No.2 of 1975), which was very restrictive: abortion was only legal if the life of the woman was in danger; or if the woman would suffer permanent mental damage, which had to be assessed by a state-employed psychiatrist; in cases of proven fetal abnormalities; or in cases of rape or incest (58). Even if these conditions were met, the woman had to obtain certificates from two doctors before receiving treatment from a third, unrelated doctor (58). Hence, the Abortion and Sterilisation Act primarily served the white minority population who had the knowledge about these conditions or who could afford access to trained providers (30, 35).

The gestational restrictions in CTOPA are among the most liberal in Africa (59). CTOPA allows a woman abortion on request up to 12 weeks of gestation, and from 13 through to 20 weeks' gestation if the pregnancy poses a risk to the woman's mental or physical health or affects the woman's social and economic situation (4). After 20 weeks of gestation, the pregnancy can only be terminated if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy would: endanger the woman's life; result in severe malformation of the fetus; or pose a risk of injury to the fetus; or the pregnancy has been the result of rape (4).

1.3.2 The South African health system and TOP provision

The South African Constitution lists health services as a concurrent functional area of national and provincial government (60). There is a large private health sector in the country that accounts for half of the health care spending, but serves only 16% of the population (61). The private health sector is not the focus of my thesis, and hence this section provides a brief overview of TOP provision in the public health sector.

The Bill of Rights in section 27 of the Constitution obliges government to ensure the rights of all citizens to have access to health care services, including reproductive health services (60). Each province has a network of hospitals, that includes regional, district and specialised hospitals. Although there are ten central hospitals, these are seen as national assets, linked to

health science faculties(62). Each province also has a network of primary health care (PHC) facilities, that consists of community health centre, day clinics, and mobile clinics.

In South Africa, TOP is provided at designated public health facilities. These facilities consist of both hospitals, and community health centres, and are certified by the National Department of Health (NDoH) as facilities that meet the requirements to provide TOP services that include first and/or second trimester, including post abortion care in terms of section 3 of the CTOPA, whether as stand-alone or as integrated SRH services (4). The pregnancy gestation and post abortion care is not the focus on my thesis, hence these will only be referred to in the context of the psychosocial issues of TOP providers.

It has been very difficult to determine the number of designated facilities in South Africa. Even the relevant manager in the NDoH could not provide information of the number of designated facilities providing TOP services. Nonetheless, as at 31 July 2018, there were an estimated 197 designated TOP facilities in the South African public health sector (63).

1.4 The importance of human resources for health in TOP provision

There is global recognition that the health targets of the SDGs, including universal health coverage (UHC), cannot be achieved without adequate numbers of motivated, competent, empowered and equitably distributed human resources for health (HRH) (64). Similarly, the United Nations strategy for women's, children's and adolescent's health, 2016-2030 underscores the importance of competent and willing health care providers to the provision of safe abortion and post-abortion care (65). Despite this recognition that HRH are critical to the achievement of health goals and the performance of health systems, there is under-investment in HRH (64). Importantly, there is a global HRH crisis, characterised by health professional shortages, skills imbalances, inadequate performance, and poor human resource management and support systems (64). Similarly, the HRH crisis in South Africa manifests itself as leadership and management failures, staff shortages, inequities between urban and rural areas, and between public and private health sectors, inadequate human resource information systems, and many unresponsive health care providers (66).

This HRH crisis is even more acute in the case of TOP, given the stigmatised nature of abortion provision, and refusal of the majority health care providers to be associated with it (67). Other factors that influence the HRH crisis in TOP provision include the category of health care provider (which might enhance or restrict access), psychosocial issues faced by willing providers and management and support systems (the latter two constituting the focus of this PhD). My definition of psychosocial issues is both the psychological aspects (e.g. compassion satisfaction, perceived stress, burnout, frustration, as well as social issues (e.g. peer or management support) that influence the quality of work life of TOP providers, and hence abortion service provision.

The category of TOP provider (Table 1.1) in turn is influenced by the level of income of a country, legislation (which influences both abortion provision as well as health professional scope of practice), actual scope of practice, and the willingness of health workers (68).

Table 1.1: Categories of providers for termination of pregnancy in different countries

*Medical ϕSurgical

Country	Category of provider	
	Medical and/or surgical abortion	**Post-abortion care**
High income countries (developed)		
Sweden	*Midwives ϕPhysicians	Not stated explicitly
France	*Midwives ϕPhysicians	Not stated explicitly
United Kingdom	*ϕPhysicians (nurse if prescribed by physicians)	Not stated explicitly
United States	*Nurse-midwives, nurse practitioners, and physician assistants/ advanced practice clinicians ϕPhysicians	Not stated explicitly
Low and middle - income countries (developing)		
Cambodia	*ϕQualified doctors, midwife or medical assistants	Not stated explicitly
Bangladesh	ϕFemale paramedics	Not stated explicitly
Vietnam	ϕNurse practitioners and physician assistants	Not stated explicitly
Myanmar	ϕMidwives	Midwives
Mozambique	ϕSurgical technicians	Not stated explicitly
Kenya	ϕMidwives	Midwives
Uganda	ϕMidwives	Midwives
Zambia	ϕNurses and Midwives	Nurses and Midwives
Ghana	ϕMidwives	Midwives
South Africa	*ϕPhysicians, *TOP trained nurses and midwives	Trained nurses and midwives

Compiled from multiple sources: (4, 69-73)

There is a dearth of studies on HRH and TOP provision in South Africa. The few studies that are available tend to focus on the negative attitudes of providers to abortion, including conscientious objection, their lack of training on or knowledge of CTOPA and its enabling provisions (74-77), and how these aspects hinder women's access to abortion. In light of the global emphasis on universal access to SRH services (65), and South Africa's efforts towards

UHC (78), a scholarly focus on the health care providers that enable women's access to abortion services in the public sector of South Africa is crucial.

1.5 Study rationale

Notwithstanding the enabling provision of CTOPA, it is estimated that fewer than 50 percent of licensed facilities are providing abortion services (67). Although these access gaps could be explained by a combination of factors, my assumption is that it reflects primarily an HRH crisis in TOP provision, specifically a failure to address the psychosocial needs of existing health care providers who are willing to provide abortion services. Given my own journey as a public health professional, where I witnessed the burden of care experienced by TOP providers, I asked myself several critical questions. What are the psycho-social issues that are experienced by TOP providers, which if addressed, could lead to a bigger number of health professionals willing to provide these services? Are there individual and/or organisational issues that facilitate or constrain TOP provision? What meaning do TOP providers attach to their work? Do they cope with their work? How do they cope with their abortion provision? What support mechanisms are in place to address TOP provider psycho-social needs?

Hence, the rationale for my PhD was premised on the following:

a. There is a dearth of studies that explore the psychosocial issues that health care providers of TOP services face or experience in the public health sector in South Africa
b. The generation of new knowledge on:
    i. The professional quality of life experienced by TOP providers
    ii. Coping strategies used by TOP health care providers
    iii. Support mechanisms available in the health care system.
c. Contribute directly to health policy or health system improvements targeted at HRH for TOP provision, and indirectly to strategies needed to enhance access to abortion services for women.

1.6 Study aim and objectives

The aim of the study was to investigate the psychosocial issues and coping strategies of health care providers at TOP services in two South African provinces, thereby contributing to the

establishment of a more supportive work environment, and the retention of existing health care providers.

The specific study objectives were to:

1. Explore psychosocial issues faced by health care providers of TOP services in terms of:
    a. Individual experiences of TOP provision, and their reasons for providing TOP
    b. Work characteristics e.g. workload, type of TOP procedure performed, positive aspects of work, and challenges experienced
    c. Professional quality of life of TOP providers, specifically notions of compassion satisfaction and/or compassion fatigue
    d. Organisational factors e.g. management support, peer support, and availability of infrastructure and resources
2. Determine the coping strategies used by health care providers of TOP services.
3. Determine the mechanisms that exist within the organisation to help TOP providers cope with their work, including the availability of psychosocial support programmes
4. Determine the views of managers on psychosocial support and/or programmes for TOP providers

1.7 Structure of integrating narrative

Chapter 1 introduces abortion as a globally contested topic, and the various abortion perspectives as a backdrop to the focus on HRH and abortion provision. The chapter provides an overview of CTOPA and the importance of HRH and TOP, and outlines the aim and objectives of my PhD.

Chapter 2 reviews and critiques the relevant literature on the psychosocial issues and coping strategies of TOP providers.

Chapter 3 describes the methods that were used in the PhD study.

Chapters 4 to 7 present the study findings under the following headings:

Chapter 4: Factors influencing the provision of termination of pregnancy services. (Published in Global Health Action in 2017)

Chapter 5: Compassion satisfaction, burnout and secondary traumatic stress among termination of pregnancy providers. (Published in the Journal of Obstetrics and Gynaecology Research in 2018)

Chapter 6: Coping strategies of termination of pregnancy health care providers. (Accepted for publication by Culture, Health and Sexuality)

Chapter 7: Availability, reported utilisation of, and management perspectives on psychosocial support programmes for termination of pregnancy providers.

Chapter 8 provides an integrated discussion and conclusion and brings together all the elements of the PhD thesis, including recommendations for health policy and practice. The chapter concludes with proposals for future research.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

In this chapter, I review and critique the literature relevant to my PhD, I identify the gaps, and highlight which aspects my PhD will address. The definition of terms is contained in Section 2.2. In section 2.3, I review and critique the literature on psychosocial issues among termination of pregnancy (TOP) providers. Section 2. 4 reviews literature on coping strategies among TOP providers. Section 2. 5 reviews literature on psychosocial support programmes among TOP providers.

2.2 Definition of terms

Abortion	Termination of a pregnancy, whether spontaneous (79), or induced (80), occurring before 22 weeks of gestation.
Burnout	A component of compassion fatigue characterised by feelings of unhappiness, disconnectedness and insensitivity to the work environment. It can include exhaustion, feelings of being overwhelmed, bogged down, being "out-of-touch" with the person he or she wants to be, while having no sustaining beliefs (81).
Compassion fatigue	The negative aspects of providing care which include feelings of being overwhelmed by the work or feelings of fear associated with the work (81).
Compassion satisfaction	The positive feelings a person derives from helping or caring for others (81).
Conscientious objection	The refusal on moral or religious grounds to participate in abortion service provision. (4).
Coping strategies	The cognitive and behavioural strategies that individuals engage in when faced with stress (82).
Courtesy stigma	The stigma or public disapproval of those people who are associated with a stigmatised condition, person or group (83).

Designated facility	A standalone or an integrated sexual and reproductive health care facility that is certified by the national Department of Health to provide TOP services, in terms of section 3 of the CTOPA (4).
Health care provider	A medical doctor or professional nurse with at least four years of training.
Induced abortion	A procedure permitted by law and performed by a licenced physician, or an appropriately licenced mid-level practitioner acting under the supervision of a licenced physician, with the intention of terminating a pregnancy (3), page 235.
Legitimacy paradox	Refers to the contradiction that in public discourse abortion providers are seen as dangerous, deviant or illegitimate health practitioners, yet in practice they are highly skilled and competent professionals who have provided safe abortion care to women (84).
Professional Quality of Life	The quality one feels in relation to work as a health care provider (81).
Psychosocial issues	Both the psychological aspects, such as compassion satisfaction, perceived stress, burnout, frustration, as well as social issues, such as peer or management support that influence the quality of work life of TOP providers, and hence abortion service provision.
Secondary Traumatic Stress	An element of compassion fatigue that is characterised by preoccupation with thoughts of people one has helped. It includes an inability to sleep, forgetting important things, and an inability to separate private and work life (81).
Termination of pregnancy	The separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman (4).
Unsafe abortion	Any procedure with the purpose of terminating a pregnancy that is performed by persons lacking the proper skills and/or that is performed in an unhygienic, non-medical setting (55).

2.3 Psychosocial issues faced by TOP providers

There is a substantial body of literature on the psychosocial issues affecting women accessing abortion care (85-91). The feminist movement has played a big role in liberalising abortion laws,

emphasising women's rights, ethical standards of care, the necessity for health care resources, and the importance of training to ensure the competencies of health professionals (39, 67, 92-95). WHO continues to underscore the role of health workers in safe abortion care, in order to reduce maternal deaths (68, 96).

Across the world, the discourse on abortion and health care providers has been largely negative, focusing on those providers who are refusing to deliver abortion and other sexual and reproductive health (SRH) services (67, 74, 95, 97, 98). This is because the behaviour and action of these health professionals have dire consequences for the women who seek abortion, especially those who are poor, the majority of whom are in LMICs (67, 99). Hence, there is a significant body of literature on the negative attitudes of health care workers and the reasons they do not provide or cease provision of termination of pregnancy (TOP) services (70, 74, 77, 97, 100-107).

Health care providers are core to the successful provision of safe abortion care (67, 68, 96, 108), hence the importance of a scholarly focus on the psychosocial issues that they face or experience. The positive emotions experienced from helping others, also known as compassion satisfaction, have been studied among health professionals (109-112). However, there is a dearth of studies on compassion satisfaction among TOP providers. A study in the United States among TOP providers found that there was a direct correlation between compassion satisfaction and perceptions or experiences of stigma (113). I could not find empirical studies in South Africa, or in other LMICs that have focused on compassion satisfaction among abortion providers.

Studies on the negative aspects of helping individuals who experience suffering, trauma or stress-known as compassion fatigue, burnout, vicarious trauma, secondary traumatic stress- are plentiful (114-119). However, compassion fatigue and burnout among TOP providers have been studied mostly in high income countries (113, 120, 121) and there has been little scholarly attention on compassion fatigue among TOP providers in an African setting. This is a knowledge gap that my PhD will begin to address.

Some studies have focused on the relationship between moral reason and willingness of health professionals to provide abortion services. Studies in different country settings have found that health professionals expressed strong views, and either refused to provide the TOP services or limited their involvement to counselling of women before or after the procedure or the provision of general nursing care duties (30, 75, 92, 122-127). Other studies have found that providers may remain silent or censor their views on second trimester abortion for fear that they would be labelled as anti-abortionists. This self-censorship has both negative personal or psychological health consequences (128-130). At the same time, the silence prevents judgemental attitudes from others, while inadvertently preserving the belief that TOP is illegitimate and substandard to other sexual and reproductive health services (84, 131, 132).

The phenomenon of legitimacy paradox, where highly trained and compassionate physicians are portrayed as illegitimate, deviant or substandard providers, also impact on the well-being of TOP providers (84, 129, 131). These providers deal with the paradox in different and complex ways, ranging from reports of professional ambivalence (70, 94, 133), conscientious objection (105, 106, 122, 134), and/or blaming the woman for seeking the service (135, 136).

Numerous studies have elucidated TOP providers' experiences of marginalisation, harassment, threats, violence, victimisation and condemnation (101, 137-139). A constant threat from many studies is provider reports of real and perceived stigma, characterised by labels, rejection and/or stereotypes at individual, institutional and community levels (26, 70, 140-142). In some instances, societal condemnation has resulted in violence, arrests, attacks at the homes of health professionals, and there have been instances in the USA of murders of doctors who provide abortions (143-146). The range of abortion laws that allow states to decide how abortion services are implemented also contribute to the condemnation, hence these TOP providers have legitimate concerns about their safety in abortion provision (147-149).

Furthermore, these negative experiences often result in adverse consequences for providers. One study found that medical practitioners who provided abortion services were excluded from promotions, with ongoing rejection and labelling of these providers by their peers and managers (102). A 2006 study among 30 physicians in the USA found that a combination of unsupportive policies, envisaged strained relationships with managers and co-workers, and fear

of violence and stigma (129) led to their decision not to integrate TOP into their medical practice. The negative experiences are made worse by prejudice from colleagues, managers and the community for reasons that vary from poor knowledge of the benefits of the safe TOP services, and moral and religious beliefs. A systematic review that focused on developed countries has found that these experiences take their toll on the health and well-being of TOP providers, resulting in poor mental health, stress, burnout, frustration, and compromised service provision (138).

There is an emerging body of literature on abortion providers in LMICs, notably in sub-Saharan Africa (101, 137). Similar to the contestations on abortion services globally, in South Africa, studies on the implementation of CTOPA have focused primarily on the negative attitudes of health care providers, their conscientious objection and refusal to provide TOP services (75, 150), amidst the challenges of staff shortages, lack of information or training on CTOPA, stigma, poor access to facilities especially in rural areas, that create various barriers to the implementation of CTOPA (126, 151). These studies were not focused on TOP provider psychosocial issues, and this set these studies apart from my PhD, which focused on TOP providers. A study conducted in 2000 found that the few willing health care providers felt alienated and unsupported and may have burnout from the negative attitudes towards them (124). However, the study did not measure burnout and was conducted almost two decades ago.

Between 2011 and 2012, Harries *et al* conducted a qualitative study among 19 abortion providers and managers in the Western Cape Province of South Africa to obtain perspectives on the availability of second trimester abortion services and recommendations for improved access (93). However, the Western Cape is quite different from the rest of South Africa, and the sample included a small group of providers. Although it provides useful insights, it cannot be generalised to the rest of the country. My PhD study is extensive, focusing on two South African provinces, all the TOP designated health facilities in these provinces, and using a combination of qualitative and quantitative methods.

2.4 Coping strategies of TOP providers

The notion of coping, or the cognitive and behavioural strategies that individuals engage in when faced with stress (82), is important to explore within the context of the moral and social conflicts surrounding abortion provision and the health care providers who enable such provision. Coping strategies can be either positive and/ or negative. Positive coping strategies, also known as problem-focused coping, refer to efforts aimed at managing or solving the problem causing the distress. These include information gathering strategies, decision making, planning, conflict resolution, or directing efforts to obtain knowledge, skills and tools (82). Negative or maladaptive coping strategies are linked to emotion-focused responses that attempt to maintain affective equilibrium and include escape, avoidance, emotional outbursts or ruminations which may heighten stress or lead to greater dysfunction (152).

There is significant body of literature on coping strategies used by health professionals (153-155), especially those who work in mental health services (156, 157), critical care (158-160) or emergency services (161-163), where there are high levels of occupational stress because of life and death situations.

In high income countries, there is an emerging body of literature on the coping strategies used by TOP service providers (128, 132, 164-166). These studies have found that the reported coping strategies of TOP providers were self-preservation, silence, viewing TOP as a technical or clinical procedure, 'switching off', suppression of emotions, or distancing themselves emotionally and physically from the procedure (121, 128, 167, 168). Researchers in the USA found that health care providers gave different accounts of their experiences: some recounted the emotional burden of service provision, the difficulties of unconditional acceptance of women seeking abortion and not judging them, while others indicated that the compassion satisfaction they experienced from caring for women and increasing years of experience assisted them to cope with abortion provision (130, 166). Also in the USA, Freedman found that training of all staff, even if they did not provide abortion, facilitated better coping among TOP providers, because training normalised the otherwise highly contested procedure (141). A 2011 study in the USA found that abortion providers used avoidance as a way of coping in order to resist or alter the negative attitudes about being a TOP provider, and to deal with courtesy stigma (169). In Canada, a small study conducted among nurses found that those nurses who cared for women after the procedure coped well, because there were high levels of

collegial support for these nurses (170), while another study among Canadian doctors found they resigned as TOP providers due to their experiences of stigma and harassment (138).

Stigma and violence or fear thereof often result in TOP providers not talking about their work, and this silence and self-censorship are their ways of coping and protecting the pro-choice movement (130, 171). Several studies found that a supportive practice environment and collegial support enhanced the positive coping strategies of TOP providers (172-174).

The knowledge gaps on coping and TOP providers are more pronounced in LMICs (101). A study among 36 health workers in Ghana found that they concealed the correct diagnosis and misclassified abortion cases to avoid being labelled and judged by colleagues (101). In South Africa, there is a dearth of studies on coping strategies among TOP providers. The few studies that have been done found that collegial support assisted the few doctors that provided second trimester abortions (175).

My PhD study makes an important scholarly contribution by focusing explicitly on the coping strategies of TOP providers in two South African provinces.

2.5 Psychosocial support programmes for TOP service providers

The WHO has pointed out that the availability of health workers is insufficient on its own, and that health workers need to be supported by the health system as a whole (64). Although one of the key strategies of the 2030 HRH strategy is to strengthen the institutional environment for health workforce retention and performance management, there are few practical details on how to achieve this (64). Global federations of professional associations and the Global Health Workforce Alliance have argued that positive practice environments (PPEs) are critical both for patient safety and the wellbeing of health workers (176, 177). These organisations have provided detailed guidelines for such PPEs, including: professional recognition, management practices, education, supportive structures, and occupational health and safety (176, 177)

Although a range of support programmes have been developed for health professionals in mental health services (178-181), there is a dearth of studies on psychosocial support

programmes or PPEs for TOP providers. The Providers Share Workshop (PSW) is one of a few psychosocial programmes found to be preferred by abortion providers (172), because they created a safe space to discuss work experiences, assisted with enhancing their compassion satisfaction, and reduced abortion stigma over time (113). Veage et al found that values clarification workshops, which focus on personal values, moral dilemmas and saving women's lives, may enhance the meaning of TOP providers' work, increasing wellbeing and reducing staff burnout (182). Other scholars have also argued for the prioritisation of psychosocial support programmes in the TOP environment (165), although the nature and details of such programme are lacking.

In the context of LMICs with resource constraints the knowledge gaps are huge. A five country case study has found that the expansion of abortion services was influenced by health systems factors such as workloads and incentives, training, supervision and support, supplies, referral systems, and monitoring and evaluation (103). Strategies used, with varying success, included values clarification workshops, health worker rotation, access to emotional support for health workers, the incorporation of abortion care services into pre-service curricula, and in-service training strategies. However, the study did not focus on the availability and nature of psychosocial support programmes (103).

In South Africa, the initial implementation of the CTOPA after its promulgation was associated with values clarification workshops. There have been a few qualitative studies that looked at challenges in second trimester provision and provider attitudes to abortion provision. Recommendations included the provision of clinical and psychosocial support programmes to motivate and attract TOP providers, specifically financial compensation for providers, ongoing training, values clarification, emotional support, and team building (75, 93).

I could not find any published South African studies that have examined the available psychosocial support programmes for TOP providers, and the narratives of managers on whether and what type of programme should be available to TOP providers. Hence, my study is one of the first to examine these issues, in tandem with exploring psychosocial issues, and coping strategies of abortion providers.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter describes the approach and methods used in my PhD study, which combined qualitative and quantitative research methods to explore the psychosocial issues and coping strategies of termination of pregnancy (TOP) providers. The use of mixed methods enabled me to complement the strengths of qualitative methods, such as the ability to obtain rich narratives and in-depth information from TOP providers, and of quantitative methods that enabled the empirical measurement of compassion satisfaction and compassion fatigue among TOP providers (183, 184).

Section 3.2 presents the conceptual framework of the study, and describes the linkages of the framework to the study objectives, the data collection methods and the research outputs. Section 3.3 describes the cross-cutting methodological elements (study setting, study population, ethical considerations). In section 3.4, I present the components of the mixed methods study. This is followed by the description of the quantitative component (section 3.5) and then the qualitative component (Section 3.6). Section 3.7 describes the integration of qualitative and quantitative findings. Section 3.8 describes the potential sources of bias and limitations and how these were addressed. The concluding section 3.8 highlights the strengths of my PhD study.

3.2 Conceptual framework

The conceptual framework for this PhD study (Figure 3.1) draws on the WHO's health systems strengthening framework (185), the job demands-control-support (JDCS) model (186) and the professional quality of life model of compassion satisfaction, (CS) and compassion fatigue (CF) (81).

3.2.1 Brief overview of frameworks

The WHO Framework defines six building blocks of a health system: leadership and governance, service delivery: human resources (health workforce); finances; medical products, vaccines and technology; and information (185). Although there are limitations of the framework, these building blocks are useful in promoting a common, global understanding of what a health system is and the essential elements needed to improve the performance of health systems (185). The WHO Framework is relevant for my PhD because the TOP providers function within South Africa's health care system.

The JDCS model, originally proposed by Karasek in 1979 (187), is one of the most widely studied models of occupational stress (186, 188). The JDCS model proposes that job demands (workload, time pressure, effort, difficulty), job control (decision-making authority, freedom to organise work, competence) and support (supervisor, management or social support) are key work characteristics that predict health workforce outcomes in both negative terms (e.g. stress, illness) and positive terms (motivation, job satisfaction, productivity, and ability to cope) (186, 188, 189). The JDCS model is relevant for my PhD because it focuses on psychosocial issues and the coping strategies of TOP providers.

The professional quality of life (PRoQOL) model of compassion satisfaction, (CS) and compassion fatigue was developed in 1990, and is used extensively in the caring professions such as medicine, nursing, social work, psychology, emergency medicine to measure the positive and negative effects of helping others (81). Other advantages are the tool is available free of charge and has been shown to have good validity and reliability (81). PRoQOL consists of three subscales: compassion satisfaction which is the pleasure a provider derives from doing his/her work with a high score denoting compassion satisfaction, burnout which is related to feelings of hopelessness, not coping with work or carrying tasks ineffectively, and compassion fatigue/secondary trauma scales which is work-related secondary exposure to traumatic events (81). The PRoQOL model is relevant for my PhD because it focuses on the caring professions, namely TOP health care providers.

3.2.2 Description of my conceptual framework

Figure 3.1 shows the conceptual framework for my PhD. The left side of my conceptual framework illustrates that the six building blocks, as proposed by WHO, are essential to the provision of TOP and for a well- functioning health care system, in which TOP providers are located.

In my conceptual framework, I hypothesise that there are multiple relationships among the health system building blocks and the three sub-components of job characteristics: job demands or job control; management or supervisor support, and collegial support. A well-functioning health system is more likely to reduce workload of TOP providers or could lessen the pressures associated with the difficulties of TOP provision, given the stigma associated with abortion. On the other hand, staff shortages or infrastructure difficulties are more likely to increase job demands of TOP providers. A well-functioning health system is also more likely to ensure competent TOP providers, who have some flexibility to organise their work, thus giving them some job control. A well-functioning health system is also likely to ensure management support for health care providers, and encourage team work, so that there is collegial support.

On the extreme right of my conceptual frameworks are the health workforce outcomes, which could be either positive (compassion satisfaction, positive coping strategies) or negative (burnout, secondary traumatic stress, negative coping strategies). These outcomes are mediated by the six building blocks and job characteristics of TOP provision.

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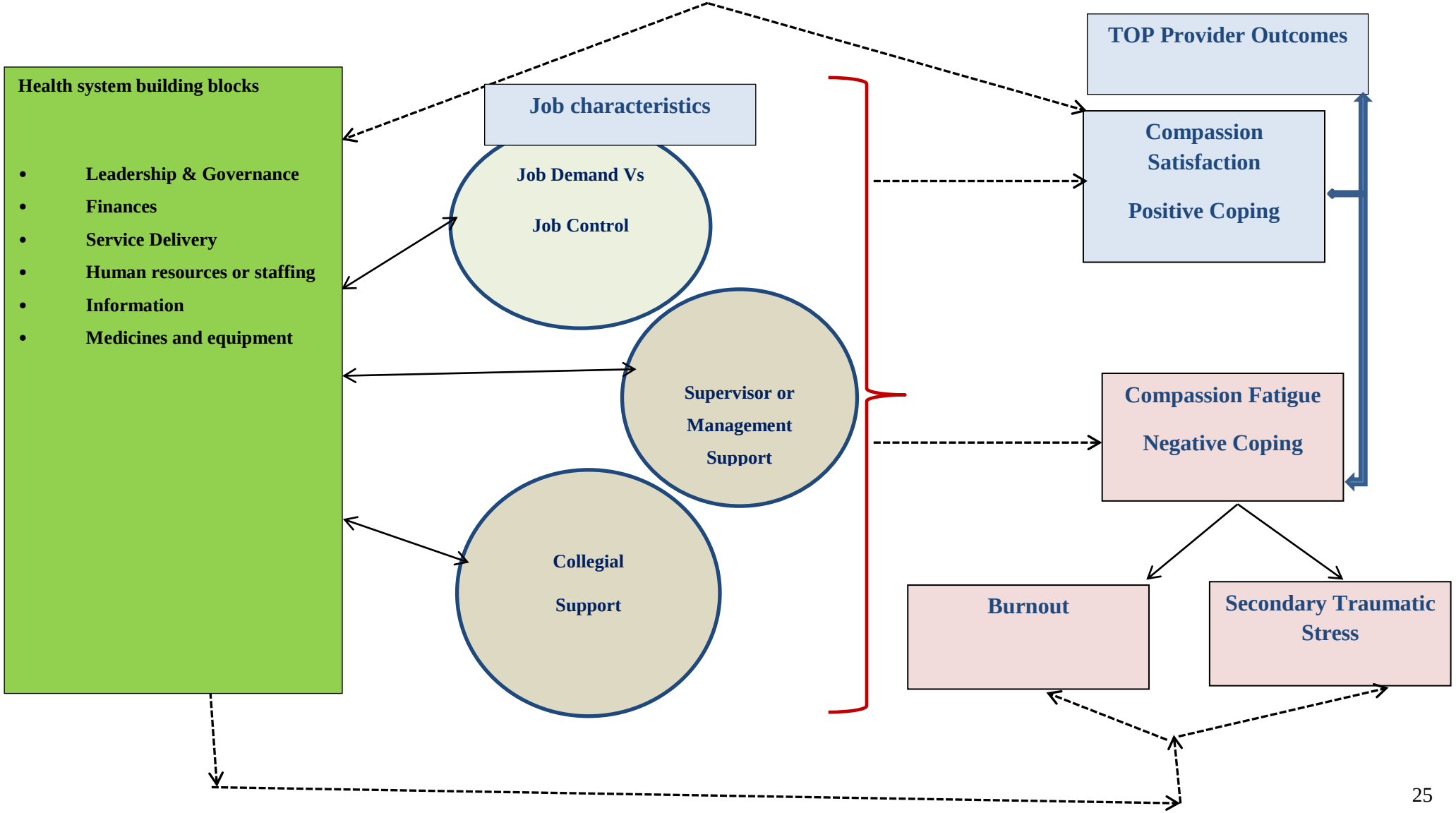

Figure 3.1: PhD Conceptual Framework. Adapted from: Health systems strengthening framework (WHO 2007); Job Demands-Control-Support model (Luchman et al 2013); Professional Quality of life model of compassion satisfaction and compassion fatigue (Stamm 2010)

3.2.3 Aligning conceptual framework and PhD methodology

The table below illustrates the alignment of the study objectives, methods, and data collection instruments, while Table 3.3 shows an overview of the mixed methods study.

Table 3.1: Alignment of objectives, conceptual framework, methods, data collection and research outputs

Objective	**Elements of conceptual framework**	**Methods**	**Data collection**	**Research outputs**
1. Explore TOP service provider psychosocial issues, specifically: individual experiences of TOP provision, workload and organisational factors that influence TOP provision	• Health system building blocks • Job demands • Job control • Management support • Collegial support	• Facility visits • Observation • Semi-structured interviews with TOP providers	• Facility checklist • Fieldwork notes and reflection • Semi structured interview guide	• '*I am all alone'*: factors influencing the provision of termination of pregnancy services in two South African provinces **Chapter 4**
	• Professional quality of life: compassion satisfaction & compassion fatigue	• TOP Provider survey	• Self-administered professional quality of life (PRoQOL) questionnaire	• Compassion satisfaction, burnout and secondary traumatic stress among termination of pregnancy providers in two South African provinces **Chapter 5**
2. Determine the coping strategies used by health care providers of TOP services	• Job demands • Job control • Management support • Collegial support	• Semi-structured interview with TOP providers	• Semi-structured interview guide	• *Resilience or detachment*? Coping strategies of termination of pregnancy health care providers in two South African provinces **Chapter 6**

Objective	Elements of conceptual framework	Methods	Data collection	Research outputs
3. Determine the mechanisms that exist within the organisation to help termination of pregnancy health care providers cope with their work 4. Determine the views of managers on psychosocial support and/or programmes for termination of pregnancy service providers	• Health system building blocks • Job demands • Job control • Management support • Collegial support	• Self-administered questionnaire completed by facility managers • Semi-structured interview with facility manager	• Self-administered questionnaire combined with semi-structured interview guide	• Ambivalence, indifference or support: Availability, reported utilisation and management perspectives on psychosocial support programmes for termination of pregnancy providers in two South African provinces **Chapter 7**

3.3 Cross-cutting methodological elements

3.3.1 Ethical considerations

I obtained ethics approval for my PhD study from the University of the Witwatersrand Human Research Ethics Committee (HREC) (medical) in June 2014 (M 1405443), before commencing the research (Appendix 1). Study permission was also obtained from the relevant provincial health authorities: Gauteng Province (Appendix 2), the District Research Committees of Ekurhuleni (Appendix 3) and Sedibeng (Appendix 4); and North West Province (Appendix 5). In North West and Tshwane districts, the district health authorities accepted the provincial approvals, and advised the researcher to engage the facility executive managers.

At each institution, the chief executive officer or community health centre manager also provided study approval by email, verbal or written form (see appendices 6 to 11). Other facilities requested an introductory meeting prior to the study approval, and these were held with the relevant manager to explain the study. At two hospitals in Gauteng, a presentation was made at the medical officers' weekly clinical meetings, in order to encourage participation by doctors.

In line with the standard ethical principles, I ensured the voluntary participation of TOP providers, and informed consent was obtained. Anonymity and confidentiality were maintained. I am an experienced psychiatric nurse: I dealt with each study participant with compassion, I was able to allay the participants' anxiety, and offered referral for psychosocial support to the participants' own counsellors, as and when needed. I ensured that written information was provided to all study participants. My contact details, those of the HREC and my supervisor were provided to all study participants in case of any questions or requests for further information. The steps that were taken to ensure and maintain an ethical approach to the study are listed in Table 3.2 below.

Table 3.2: Summary of steps taken to ensure an ethical approach to the study

Ethical approval was obtained from the University's Human Research Ethics Committee (Medical)
Study approval was obtained from all health care authorities and health facility managers
Information sheet was provided to all study participants prior to the survey or interviews
Voluntary participation was emphasised
Eligible participants provided informed consent
Research tools did not contain information that identified respondents
All participants were treated with respect
Confidentiality was maintained throughout the study. Interviews were conducted in a private area, the data that were collected through the tools were kept on a password protected computer
Participants were given the name and contact details of the principal investigator, supervisor and Chair of HREC
As an experienced psychiatric nurse, I dealt with participants with compassion, allayed their anxiety and offered referral for psychosocial support as necessary
Questions raised by participants and health authorities were addressed

3.3.2 Study setting

The study was conducted at designated TOP facilities in Gauteng and North West provinces of South Africa, as defined in Chapter 4 (Table 4.1). The study provinces and districts are shown on the map of South Africa (Figure 3. 2).

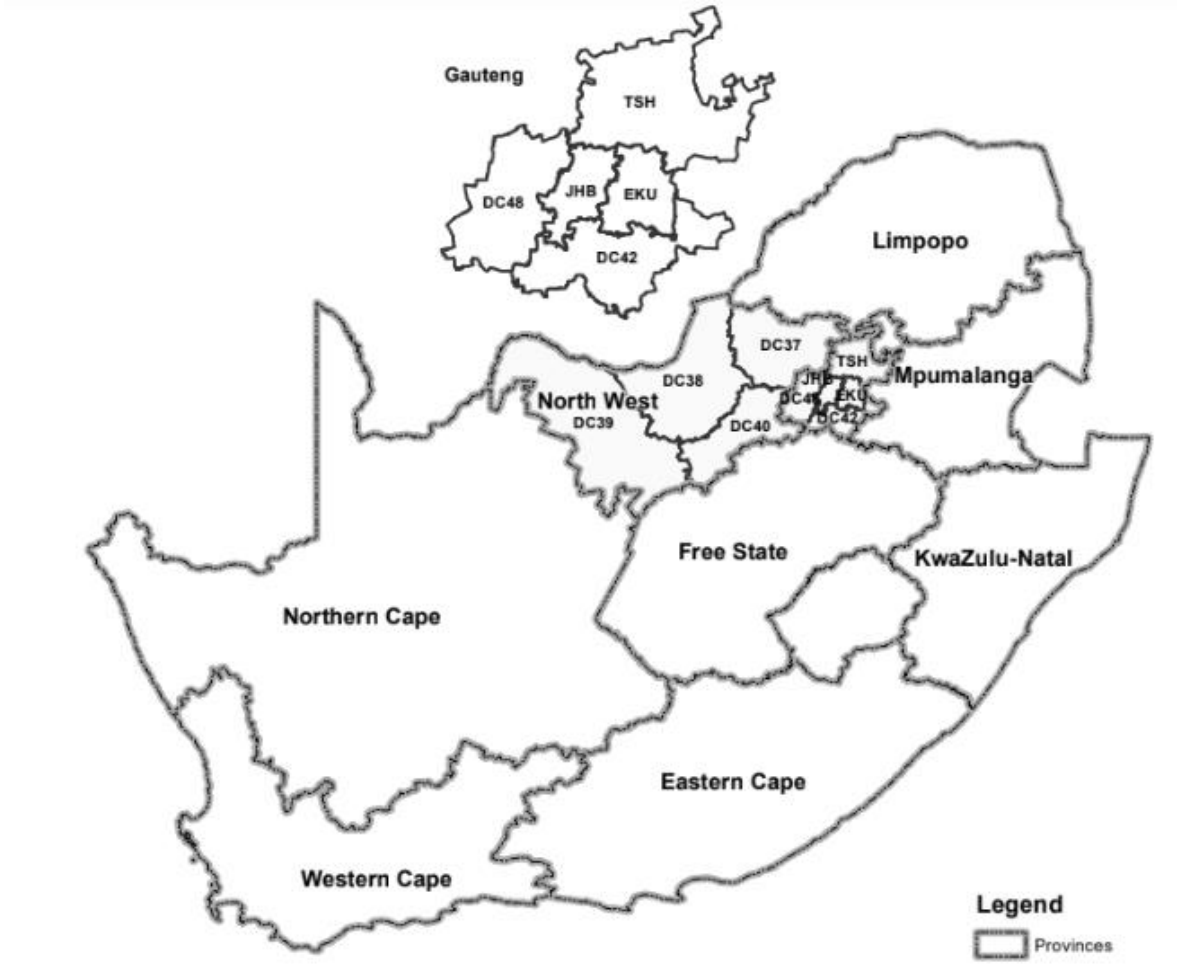

Figure 3.2: Study provinces and districts shown on map of South Africa

Source: Map created by Ms N. Ndlovu, Researcher at the Health Systems Trust.

Gauteng	North West
DC48: West Rand District Municipality	DC37: Bojanala Platinum District Municipality
DC42: Sedibeng District Municipality	DC38: Ngaka Modiri Molema District Municipality
EKU: Ekurhuleni Metropolitan Municipality	DC39: Dr Ruth Segomotsi Mompati District Municipality
TSH: Tshwane Metropolitan Municipality	DC40: Dr Kenneth Kaunda District Municipality
JHB: Johannesburg Metropolitan Municipality	

The selection of the two provinces was influenced by a combination of factors: urban Gauteng combined with a mixed urban-rural North West setting, logistical factors (e.g. travel distance, number of facilities) and budgetary constraints. The approval from the provincial health departments to participate in the study in these two provinces also influenced the study selection.

Gauteng is a highly urbanised and populous province with an estimated population of 14.7 million, accounting for 25.4% of the total South African population (190). It is the economic powerhouse of South Africa contributing one third to the gross domestic product (GDP). During the study period, Gauteng had five municipalities: City of Johannesburg; City of Tshwane; Ekurhuleni Metro; Sedibeng; and the West Rand.

North West is located to the west of Gauteng. The population of North West is estimated at 3.9 million (190). Mining is the main economic activity that contributes 50% to the province's GDP, and 6.5% to the country's GDP (190). At the time of the study, North West had four district municipalities: Ngaka Modiri Molema, Bojanala Platinum, Dr Ruth Segomotsi Mompati and Dr Kenneth Kaunda.

3.3.3 Sampling Frame

The sampling frame consisted of all public health facilities (hospitals and clinics) in Gauteng and North West provinces that are designated by the national Department of Health (DoH) to provide TOP services. I obtained a 2014 list of these designated TOP facilities from the national DoH. At the time of the study, 61 facilities were designated: 37 in Gauteng Province and 24 in North West Province. This national list was compared with the 2014 list from the provincial database from each of the study provinces. The different data set required visits to all facilities to verify whether facility designation meant actual TOP provision. A consolidated list was generated, and this constituted the final sampling frame.

3.3.4 Study population

The population of interest was all doctors and professional nurses (i.e. nurses with four years of training) providing TOP services. Staff not directly involved in TOP services (e.g. enrolled nurses, administrators and general assistants) working in the selected facilities were excluded.

3.4 Components of the mixed methods study

The use of mixed methods was appropriate for my PhD because it allowed me to consider multiple viewpoints, and perspectives, given the complexity of and contestations surrounding TOP. I used a convergent parallel mixed method study design (191), where I collected quantitative data, and at the same time conducted interviews to obtain qualitative data, and then analysed and compared the findings after the completion of the fieldwork.

The mixed methods design is shown in Table 3.3.

Table 3.3: Overview of PhD mixed methods study components

Convergent Parallel Mixed Methods Design	
Quantitative component	**Qualitative component**
Completion of checklist	Facility visits, observation at TOP facilities and taking detailed fieldnotes
TOP provider survey	Indepth interviews with TOP providers
Survey of psychosocial support programmes	Indepth interviews with TOP providers
Data analysis happened both concurrently and sequentially	

3.5 Quantitative component

3.5.1 Completion of facility checklist

I developed a facility checklist for use during the facility site visits to verify the provision of TOP services at each of the designated facilities, and determine the number and category of the TOP provider at each facility. At each facility, I verified with the chief executive officer

(in case of a hospital), and the operational manager (in case of the community health centre) whether TOP service was provided at the time. Facilities that did not provide TOP were then removed from the list, and those that were not on the list, but providing TOP were added to the list of facilities to be visited for possible inclusion in the study. I also obtained the reasons for not providing TOP. This information was captured on a spreadsheet to complement other data collection methods of my PhD. I used Microsoft Excel to analyse the information on TOP provision. Further details are provided in Chapter 4.

3.5.2 TOP provider

a. Self-administered professional quality of life (PRoQOL) questionnaire

Following an extensive literature review, the PRoQOL questionnaire was adapted and used in its original form (81), with additional questions on socio -demographic information and possible reasons for working as TOP provider (Appendix14).

The PRoQOL tool consists of 30 questions and includes three subscales on compassion satisfaction, burnout, and secondary traumatic stress. PRoQOL scores are pre-determined in the following way: a score of 22 or less denotes a low level, 23-41 an average level and 42 or above denotes a higher level. Additional questions were included: socio-demographics such as age, gender, TOP experience, etc., and a Likert scale to explore possible reasons for working as a TOP health care provider, staying in the current job, and provider interest in psychosocial support programme. An open- ended question was included to allow TOP providers to add any comments about psychosocial issues and coping strategies and any other issues related to their job.

b. Data collection

At each designated facility, all the TOP providers were given an information sheet (Appendix 16), and invited to participate in the survey. Following informed consent, the

TOP provider was requested to complete the self-administered questionnaire (Appendix 14). The questionnaire took 15 minutes to complete.

c. Data analysis

STATA® 13 was used for data analysis. Both descriptive and inferential statistics were performed. Individual participant scores were allocated as per PRoQOL instruction (81), and mean scores and standard deviation were calculated. We further analysed for factors associated with each score through multiple linear regression model. Further details on the TOP provider survey are contained in Chapter 5 of the thesis.

3.5.3 Survey of psychosocial support programmes

The purpose of the survey among managers of the designated facilities or of TOP providers was to obtain information on the availability and utilisation of psychosocial support programmes (see appendix 21). A combined structured questionnaire and interview schedule was developed that consisted of two portions: a self-administered questionnaire that elicited information on the number of TOP providers at the facility, number of health care providers trained on TOP provision, average number of patients seen per day at the facility, type of TOP procedure done (whether medical or surgical), maximum gestational age for TOP provided at the facility. The questionnaire also obtained information on the availability of a support programme or support mechanism to TOP providers, whether TOP providers used the programme, how often the programme was available to TOP providers, and who provided the programme. The self- administered questionnaire took around 10 minutes to complete. The self-administered questionnaire was analysed using Microsoft Excel.

The second portion consisted of an interview schedule (see below and Appendix 21). Chapter 7 of this thesis contains further information on the survey among managers.

3.5.4 Data management and quality assurance

Table 3.4 summarises the data management and quality assurance used for the quantitative component of my PhD.

Table 3.4: Data management and quality assurance

TOP provider survey • Each file was assigned specific codes according to the province and hospital • Cleaning of data set, addressing errors and missing values • Capturing of data on Micro Excel spreadsheet to perform basic descriptive analysis • Developing coding sheets on all responses for all items, and ensuring that skip patterns (where applicable) were followed • Dependable data capturer was contracted to do double data entry to ensure accuracy • Labelling of all the variables before importing them into STATA for analysis
Survey of psychosocial support programmes • Capturing of data on Micro Excel spreadsheet to perform basic descriptive analysis

3.5.5 Pilot study

A pilot study to pre- test all study instruments was conducted towards the end of 2014. The pilot study was conducted in three non-sampled facilities that were not designated to provide TOP but with similar characteristics to those from the actual study sample. The purpose of the pilot study was to test the study instruments, determine feasibility of the study including logistics, time taken, and possible challenges during the study. The instruments did not require any changes.

During the pilot, I discovered that having approval from the province, the district, and the chief executive officer or the facility manager, did not guarantee access to a functional designated facility or TOP providers for participation. In addition to a lot of patience, I realised that I would need to do more than one visit to a facility for recruitment. I estimated two days for data collection at each facility, with an additional day for North West because it is further away from Gauteng.

3.5.6 Internal consistency and reliability of study instruments

Following the piloting of the facility checklist, PRoQOL and the survey of psychosocial programmes, Cronbach's alpha coefficients were computed to determine the validity and reliability of the PRoQOL. The Cronbach alpha obtained had moderate internal consistency at 0.77 (192).

3.6 Qualitative component

Denzin et al described qualitative research as "a set of interpretive material practices that turn the world into a series of representations, including fieldnotes, interviews, memos to self, and recordings" (193). The qualitative component of my PhD helped to clarify, explain and add depth to the quantitative information obtained through the self-administered questionnaires and the checklist. The methods used in the qualitative component of my thesis are summarised below, with further details in Chapters 4, 6 and 7.

3.6.1 Observation at TOP facilities and detailed fieldnotes

During the site visits which I personally conducted at all designated facilities, I made detailed fieldnotes, and I observed the dynamics of TOP provision at each facility, the location and space of the TOP unit within the facility, communication between TOP providers and other staff members, including facility managers and/or the managers of reproductive health services. The findings have been included in the discussion sections of Chapter 4 to 6, and the different settings for TOP provision are shown as Appendix 24.

3.6.2 In-depth interviews with TOP providers

a. Selection and recruitment

I selected health care providers purposively in the order in which the facilities were visited during fieldwork. This means that I set up appointments at the different facilities depending on the availability of the individual facility managers, rather than in a random manner. Once

an appointment was secured, I completed all the study components at the facility. Hence I recruited and interviewed the TOP providers at the first 30 facilities visited.

b. Development of the interview schedules

A semi-structured interview schedule was developed to obtain qualitative information that would add depth and possibly explain some of the findings of the self -administered questionnaire (Appendix 20). The interview questions focused on the TOP provider' perceptions of their work; psychosocial issues they faced in the workplace; coping strategies; availability of support mechanisms in the workplace; and possible interventions or recommendations, whether directed at the TOP providers, their managers or the health system.

c. Data collection

The 30 TOP providers were provided with an information sheet explaining the voluntary nature of participating in the interviews. Following informed consent, interviews were conducted with these selected TOP providers. I assured participants of confidentiality and anonymity. The interviews lasted for 40 minutes, with a time range of 30 to 60 minutes. Where necessary, probes and clarification of responses was used. The information sheet, consent form, and the interview schedule are attached as Appendices 18 to 20. The interviews were tape recorded with informed consent. In addition, I wrote down the fieldnotes, my observations, and impressions immediately after the interviews, on a spreadsheet designed for this purpose.

3.6.3 In-depth interviews with managers of facilities or TOP services

a. Selection and Recruitment

All managers at the final sample of designated facilities were invited to participate in the study. These included the facility managers (in case of the community health centre), or the managers responsible for sexual reproductive health services (in case of a hospital).

b. Development of the interview schedules

The first part of the combined questionnaire and interview schedule consisted of the quantitative data on the TOP facility staffing and client load, and the second portion consisted of the semi-structured questions (Appendix 21).

The questions focused on the strengths and weaknesses of the support programme (where available), the areas that needed improvement, their thoughts on a psychosocial programme for TOP providers, what the programme should entail, who should provide it, their role in the provision of psychosocial support for TOP providers, their opinion on the elements to be included in the recommendations for a psychosocial programme. Participants were asked to give any additional comments about psychosocial support to TOP providers.

c. Data collection

All managers were provided with an information sheet explaining the voluntary nature of the study, as well as assurance on anonymity and confidentiality. Following informed consent, interviews were conducted with the relevant managers. Each interview lasted an average of 35 minutes, with each interview ranging between 30 to 60 minutes depending on the responses of facility managers. Where necessary, probes and clarification of responses was used. The interview schedule, consent form, and the information sheet are attached as Appendices 21 to 23.

The interviews were tape recorded with informed consent. In addition, the fieldnotes, observations, and impressions were written immediately after the interviews, while still fresh in my mind.

3.6.4 Data management and analysis

Each recorded interview was transcribed verbatim by an experienced transcriber. The principal researcher (MT) coded the transcripts to uphold participants' anonymity and to ensure confidentiality. She consolidated the transcripts into one file for ease of analysis. An

extensive data cleaning was done where transcripts were checked against the original recordings with corrections made as applicable. For reliability in qualitative data analysis, two other researchers (the supervisor and another researcher) read through four transcripts independently, and developed a set of codes, and avoided applying pre - existing codes to the data (194). Once the codes were allocated we met to reach consensus on the codes and themes.

I used Interpretative Phenomenological Analysis, an approach of qualitative enquiry that focuses on the detailed analysis of each individual interview, and seeks to explore how individuals make sense of their major life experiences (195) to analyse the TOP provider and management interviews. I used the agreed upon codes and themes to analyse all the interviews. I merged the codes and themes into one consolidated code book, and used MAXQDA® 12 to complement the manual process of data analysis. The process of sifting and analysis of the data took approximately six months. Additional information about semi-structured interviews for TOP providers and facility managers are presented in Chapters 4, 6 and 7.

3.6.5 Reliability and validity

In qualitative research, appropriateness of the tools, process and data; and consistency of the processes and the results are a prerequisite (196). Appropriateness was achieved through the verification of and site visits at the designated facilities; inclusion of facilities and providers working in TOP provision; and engagement of the managers at the facilities. The rigorous data analysis included verbatim transcription of recorded interviews, recording and reflecting on the detailed fieldnotes and observations during the facility visits.

3.7 Integration of qualitative and quantitative findings

The integration of quantitative and qualitative findings was the final step of my PhD. Triangulation was used to increase the credibility and validity of my study results. Data from different research methods can be integrated at several stages in the research process,

namely at data collection, analysis, interpretation or a combination of places (197). In this study, triangulation was done both at the stage of data collection and at analysis. The themes obtained from the qualitative data were compared to the quantitative findings, in order to check the consistency of the evidence on the psychosocial issues faced by TOP providers. This was done by comparing findings from the TOP provider survey (Chapter 5), with the three qualitative studies (Chapters 4, 6 and 7). An iterative process of examining the findings, checking inconsistencies, and linking the findings to the original study objectives was done. Lastly, the triangulated findings were reviewed in light of the existing literature. The concluding chapter of this thesis integrates the findings and presents the recommendations.

3.8 Potential bias, limitations and amelioration

This section describes the PhD study's bias (198), limitations, strengths and steps taken to address these.

3.8.1 Possible study bias

a. Selection bias

The possible selection bias was the inclusion of certain facilities only, with characteristics that differ from the universe of TOP facilities in the two provinces. However, this bias did not arise in my study because I chose all designated facilities in Gauteng and North West Provinces. The survey was done among all TOP providers at the designated facilities in the two provinces. I obtained a 98% response rate which is excellent. Hence, sampling or selection bias did not arise in the survey.

The managers' survey and interviews covered 50/51 TOP facilities and captured the views of the majority of managers.

The in -depth interviews with 30 providers were done in the order in which facilities were visited for fieldwork, rather than in a random manner. This could have introduced some form of selection bias because the views of TOP providers at these facilities might differ from those at other facilities. However, this potential bias was offset by the survey which captured

the universe of TOP providers in the two provinces, and my visits and field observations at every single facility.

b. Observation bias

Observation bias occurs when two or more interviewers are used for data collection, or when questions are asked differently during each interview. In my study, I took responsibility for all the interviews and survey administration. I used the same interview schedule and posed the questions in the same way. Hence there were no inter -observer variations.

c. Social desirability bias

Social desirability bias (199) occurs when participants give responses that they think the researcher wants to hear. Although this type of bias can never be eliminated, I used a combination of self - administered questionnaires (which allowed for privacy in responses), and in – depth interviews which I conducted. I combined the survey and interviews with visits to every TOP facility, completed a facility checklist and took detailed fieldnotes. The mixed methods allowed me to pick up inconsistencies and contradictions, thus minimising the impact of social desirability bias.

3.8.2 Study limitations

a. Inclusion of two provinces

Budgetary and logical constraints prevented me from focusing on more than two provinces. Nonetheless, this study met all the requirements of a PhD in terms of scale and scope. A combination of the urban populous Gauteng, and a mixed urban– rural North West gave me the opportunity to explore psychosocial issues of TOP providers in both a relatively well-resourced, and under-resourced geographical settings.

In addition, Gauteng Province is the economic powerhouse of South Africa and any developments influence those not only in the country, but also in other African countries.

b. Cross-sectional nature of the study

This was a cross sectional study that analysed the psychosocial issues and coping strategies of TOP providers in two South African provinces during 2014 and 2015. Hence the results represent the perspectives and views of TOP providers at a point in time. Some information may have changed between data collection and the time of writing this thesis. Although cross sectional studies are relatively cheap and they provide a general description of how the study population views the issues under investigation at a point in time, they do not allow the researcher to establish causal relationships between different exposures (e.g. health systems constraints, lack of management support) and outcomes (e.g. compassion satisfaction and compassion fatigue among TOP providers) (198, 200). However, my PhD study has numerous strengths, summarised in the next section.

3.8.3 Strengths of the study

My PhD study has numerous strengths. Firstly, I visited every designated TOP health facility personally, and was able to verify whether facility designation meant actual TOP provision. I discovered the discrepancies between the national and provincial health department databases, and the shortcomings of the existing national database. I also got a first-hand account of the health care system and organisational issues faced by TOP providers, and that influence provision. I experienced the courtesy stigma of conducting research on abortion.

Secondly, this is one of the first comprehensive studies that generated new knowledge on the professional quality of life experienced by TOP providers, their coping strategies, and the support mechanisms available in the health system. The measurement of compassion satisfaction, burnout and secondary traumatic stress has provided baseline information that could be used for future studies. Combined with indepth qualitative methods, I have been able to generate rich data from TOP providers, who have been hitherto been neglected in the discourse on improving access to SRH services. Thirdly, the utilisation of various research

methods has enhanced the credibility of the research findings. The tools used in my study could be adapted by other researchers in South Africa, as well as in other LMICs.

Fourthly, this study is one of the few studies in South Africa, and in an African setting that explored the perspectives of managers on the availability of psychosocial support programmes for TOP providers. The study has provided rich data on how these managers might enhance or constrain the ability of the health care system to support TOP providers. The narratives of managers in turn affect the provision of safe abortion services.

Lastly, the study has generated policy-relevant knowledge that can guide health system improvements for abortion and other SRH services. Such improvements are likely to benefit both the health professionals who provide TOP (through better support mechanisms, staff retention, etc.), and the women seeking abortion.

CHAPTER 4: FACTORS INFLUENCING THE PROVISION OF TERMINATION OF PREGNANCY SERVICES

4.1 Introduction[a]

Globally efforts to achieve gender equality and to reduce high levels of maternal mortality were given renewed impetus with Millennium Development Goals 3 (gender) and 5 (maternal mortality) (201). The target for MDG 5 was to achieve a 75% reduction of the maternal mortality ratio (MMR) between 1990 and 2015 (201). Notwithstanding encouraging progress on the reduction of maternal mortality by the end of 2015, millions of women continue to die from unsafe abortion, the majority in low and middle - income countries (99). The 2015 Sustainable Development Goals (SDGs) emphasise the importance of universal access to sexual and reproductive health care services in order to prevent avoidable maternal deaths (54). Maternal deaths could be averted significantly by addressing unmet family planning needs, and improving access to safe abortion or termination of pregnancy (TOP) services (55, 202).

It has been estimated that the proportion of all unsafe abortions has increased between 1995 and 2008 (203), while the World Health Organization (WHO) has estimated that worldwide, around 22 million unsafe abortions take place every year, thus contributing to the global burden of maternal mortality and morbidity (68). An adequately skilled and motivated health workforce remains the most important strategy to ensure women's access to sexual and reproductive health services and a reduction of avoidable maternal deaths (68).

[a] This chapter is based on the published paper: Teffo ME, Rispel LC. 'I am all alone': Factors influencing the provision of termination of pregnancy services in two South African provinces. Global Health Action. 2017. https://doi.org/10.1080/16549716.2017.1347369

In South Africa, the Choice of Termination of Pregnancy Act (CTOPA) was promulgated in 1996, and amended in 2008, in recognition of women's reproductive rights, and to contribute to an improvement in woman's health and a reduction in maternal mortality from illegal abortions (4). A 2000 evaluation on the implementation of the CTOPA found that within the first three years of the promulgation of the Act, more than 40 000 women had benefited from the improved access to TOP services (204). However, maternal mortality in South Africa remains unacceptably high at an estimated 155 per 100 000 live births in 2013 (205). Difficulties in access to safe TOP services add to HIV and obstetric causes of maternal mortality (206). The factors that have influenced access to TOP services include: negative attitudes towards TOP services and the staff who provide TOP services; poor infrastructure; staff shortages and lack of support programmes for the few health care providers in existing TOP services (74, 93).

There is a significant body of literature on abortion, which remains a hotly contested and debated issue (92, 207). Research on abortion has focused on: the legal and ethical standards for protecting women's human rights (92, 95, 207); global and regional estimates of the incidence of unsafe abortion and associated mortality (55, 203) the relationship between induced abortion and adverse psychological outcomes among women undergoing the procedure (88); conscientious objection and health care providers' attitudes towards TOP services (77, 95); and strategies to reduce the incidence of unintended pregnancy and unsafe abortion (208). Studies among health care providers have reported feelings of anxiety, professional ambivalence and conscientious objection, experiences of courtesy stigma and discrimination, violence or fear of violence, often resulting in health care providers not talking about their work or not advocating for the provision of TOP services, and fear of being labelled or rejected (70, 84, 209). These negative emotions or experiences are exacerbated by health system deficiencies, insufficient or lack of peer support, lack of understanding of consequences of stigma for abortion providers, potential risks of the procedure and request for abortion from women with advanced pregnancies (138, 210)

In South Africa, studies conducted since the implementation of CTOPA have reported on the progress made in providing TOP services, notably the increase in the number of

designated facilities and staff capacity building, as well as the ongoing challenges of negative provider attitudes (126, 204, 211). However, there has been insufficient scholarly focus on the psychosocial issues faced by health care providers of abortion services .

In light of the importance of health care providers to improving women's access to safe abortion services, the objectives of this paper are threefold: to determine the proportion of designated TOP facilities in the public sector that actually provide these services; explore the factors that influence the provision of TOP services; and explore the work experiences of TOP providers at designated facilities in two South African provinces. The research forms part of a larger doctoral study on psychosocial issues experienced and coping strategies used by health professionals that provide TOP services.

4.2 Methods

4.2.1 Study setting

The study was carried out at designated TOP facilities in Gauteng (GP), an urban province and North West (NW), a mixed rural- urban province. These two provinces were selected because of geographical proximity to the researchers, logistical considerations and budgetary constraints.

4.2.2 Study design

During 2014 and 2015, we conducted a cross-sectional study that used a combination of methods: site visits to and observation of all designated TOP facilities in two GP and NW, using a checklist; surveys among TOP service providers and facility managers, and in-depth interviews with a sub-set of TOP service providers.

In this paper, we only focus on the site visits to, and observation of, all designated TOP facilities and the in-depth interviews with TOP service providers

4.2.3 Sampling, study population and recruitment

The sampling frame consisted of all public health facilities (hospitals and clinics) in Gauteng and North West Provinces that are designated by the national Department of Health (DoH) to provide termination of pregnancy (TOP) services, whether as stand-alone or as integrated sexual and reproductive health services, were included in the study. We obtained a 2014 list of these designated TOP facilities from the national DoH, which was compared with the 2014 list from the provincial data base from each of the study provinces. A designated facility is defined as one that meets the requirements to provide TOP services in terms of section 3 of the CTOPA, and is certified as such by the national DOH in terms of the CTOPA (4). In each province, we verified the provincial data base by interviewing the overall manager responsible for all sexual and reproductive health services.

The population of interest was all TOP health care providers, defined as professional nurses (with four years of training) or medical doctors (practitioners), whether full time or part time, providing TOP services in the public health sector at the designated facilities in the two provinces.

We selected a sub-set of 30 TOP service providers from the designated facilities that included a mix of GP and NW hospitals and clinics, for in-depth interviews, using a purposive sampling technique.

4.2.4 Ethical considerations

The University of the Witwatersrand's Human Research Ethics Committee (Medical) provided ethics approval for the study. The relevant provincial health authorities, including hospital and health centre managers also provided study approval. We adhered to standard ethical requirements including participant informed consent, detailed study information sheets, voluntary participation, and maintaining confidentiality of information.

4.2.5 Data collection

We designed a spreadsheet/ facility checklist for the site visit and observation with the following details: province identification number, name of the district, facility number, health care provider identity number, whether TOP services were provided, and the number and category (professional nurse or doctor) of TOP providers at each facility.
The principal researcher visited each of the designated facilities between July 2014 and August 2015. In addition to the information on the spreadsheet, the principal researcher took detailed fieldnotes. In those instances where TOP services were not provided at a designated facility, the researcher recorded the stated reasons for non-provision. The researcher also ascertained whether there were any facilities that were not on the original list of designated facilities, but that were providing TOP services. These additional facilities were also visited, and detailed fieldnotes were recorded.

We designed a semi-structured interview schedule to explore the work experiences of TOP providers and their perspectives on the factors that influence TOP provision. The questions focused on: perceptions of their work as TOP providers, including rewarding and challenging aspects; psychosocial issues faced in the workplace, coping strategies, availability of support mechanisms in the work-place, the factors that influence TOP provision; and their recommendations for change.

The principal researcher invited the selected TOP providers to participate in the interview, and gave each person an information sheet and consent form. She explained the voluntary nature of the study, informed participants that no names would be used during the interview, and assured them of confidentiality, and anonymity. Following informed consent, the researcher conducted semi-structured interviews with these TOP providers in English, which is the official business language of South Africa.

Each interview lasted around 40 minutes, although the length of time ranged from 30 minutes to 60 minutes. The researcher also took detailed notes during the interview and wrote a synopsis summarising the interview after each interview.

4.3. Data analysis

The information from the site visits was collected on a Microsoft Excel spreadsheet, and this programme was used to analyse the data from the site visits. We transcribed the recorded interviews verbatim. Data cleaning took one month and consisted of an iterative process of checking the transcribed interviews against the original recordings, correcting the text, checking the recordings again and making final corrections. Prior to analysis, an audit of provider interviews was done, and each provider was allocated a code number to ensure confidentiality of information. The coded interviews were consolidated into one file for ease of analysis. Three issues of trustworthiness demand attention in qualitative research: reliability (researchers should at least strive to enable a future investigator to repeat the study), conformability (researchers must take steps to demonstrate that findings emerge from the data and not their own predispositions), and credibility (investigators attempt to demonstrate that a true picture of the phenomenon under scrutiny is being presented) (212). To ensure reliability, trustworthiness, and credibility, two other researchers (one a medical anthropologist and the other the research supervisor of the principal investigator) participated in the development of the themes by reading four diverse transcripts. Each researcher examined the meaning of the words of participants, and developed a set of codes, rather than using a pre-existing theory to identify codes that could be applied to the data (213, 214). We held a meeting of the three researchers, to discuss the codes, and to reach agreement on the codes and themes, namely the recurring patterns of meaning (ideas, thoughts, and feelings) that emerged throughout the provider interviews. The principal investigator merged the codes and themes into one consolidated code book, prior to analysing the data using MAXQDA® 12.

4.4 Results

4.4.1 Provision of TOP services by designated facilities

In 2014, the number of designated TOP facilities in the two provinces was 61. Fourteen of designated facilities did not provide TOP services, while we found four facilities in North West Province that were not on the national data-base, but providing TOP services. Hence

the total number of facilities that were providing TOP services was 51 (Table 4.1). In general, I found two models of TOP provision: as part of sexual and reproductive health services or as stand – alone facilities. Further details are provided in Appendix 24.

Table 4.1: TOP service provision in Gauteng and North West Provinces

Indicator	**Gauteng**	**North West**	**Total**
Facilities designated to provide TOP services according to national database	32 (52%)	29 (48%)	61 (100%)
Facilities designated but NOT providing TOP services	4 (28.6%)	10 (71.4%)	14 (100%)
Facilities not on national database, but providing TOP services	0	4 (100%)	4 (100%)
Facilities providing TOP services	28 (55%)	23 (45%)	51 (100%)
Type of facility providing TOP services			
- Hospital	16 (57%)	10 (43%)	26 (100%)
- Community health centre	12 (43%)	13 (57%)	25 (100%)
Proportion of designated facilities that provide TOP services	28/32 (87.5%)	19/29 (65.5%)	47/61 (77%)

As can be seen from Table 4.1, 28/32 (87.5%) of designated facilities in Gauteng Province, and 19/29 (65.5%) of designated facilities in North West Province, provided TOP services. This means that 77% of the original designated facilities on the national database provided TOP services. If the four TOP facilities in North West are included, the proportion of designated facilities providing TOP services increases to 83.6%.

4.4.2 Reported reasons for non-provision of TOP services

There were three reported reasons by the 14 facilities that did not provide TOP services in the two provinces: human resource challenges, health system deficiencies, and lack of management support.

The human resource challenges included: TOP provider resignation or retirement, and not been replaced by other staff; and allocation of nurses to other health programmes, or sending them for training to support other programmes (such as primary health care), because TOP services were not considered to be a priority. Health system deficiencies included the lack of equipment such as sonar machines or manual vacuum extractors, and lack of space to provide services. The lack of management support for TOP services meant that managers were often reluctant to recruit staff or procure equipment or supplies for TOP service provision. During the field work to the 51 facilities, the principal researcher personally observed the lack of management interest and support at the health care facilities. Some managers did not know when TOP services were provided, how many clients on average were seen per day, the type of psychosocial support TOP providers get if any, and the difference between first and second trimester protocols. In some instances the animosity between the manager and TOP provider was evident, and verbalised by providers or managers.

4.4.3 Profile of TOP service providers interviewed

A total of 30 TOP providers were interviewed, 12 in Gauteng and 18 in North West Province. All the respondents were professional nurses, the majority were female (26/30=86.6%), with a mean age of 45.8 years. The TOP provision experience of participants ranged from 1 to 13 years.

4.4.4 Work experiences and perspectives of health care providers on TOP service provision

Although inter-related, five major themes emerged from the interviews with TOP providers: rewarding aspects of the job, relationships with colleagues, unsupportive management, lack of an enabling environment, and the emotional impact of TOP provision. The themes and sub-themes are shown in Table 4.2 and reported on separately for the sake of clarity.

Table 4.2: Themes emerging from the interviews

Theme	Sub-theme
Rewarding aspects of the job	• Preventing complications • Preventing teenage or unwanted pregnancy • Providing professional help to prevent complications and reduce client stress • Understanding people's problems • Duty to provide TOP
Negative relationships with colleagues	• Name calling and stigmatisation • Colleagues negative attitudes • Unsupportive colleagues • Being undermined by other colleagues • Refusal to provide TOP services despite being trained • Lack of medical doctor support
Unsupportive management	• TOP services not prioritised • No interest from management • Lack of support • No appreciation or rewards for work done • No debriefing or support services provided
Lack of enabling environment	• Lack of equipment e.g. sonar machines • Lack of medication • Lack of space • Large workload • Staff shortages
Emotional burden of TOP provision	• Loneliness of TOP provider • Emotional trauma/traumatic experience • Feeling demoralised

4.4.5 Rewarding aspects of the job

The majority of the providers considered it their professional duty and responsibility to provide TOP services. In response to the question on the rewarding aspects of their work, participants reported that they get satisfaction from their ability to understand and respond sensitively to women's health care needs, prevent teenage or unwanted pregnancies, ensure access to safe services and prevent complications of backstreet abortions, such as septicaemia, hysterectomy and even death. The sense of meaning that TOP providers attach to their work is reflected in the two quotes, one from each of the study provinces, below:

Seeing our young and black sisters dying from doing backstreet abortion, I decided to join TOP and help them to do medical TOP in a professional manner… That is how I developed the love for TOP; it was so I could help these young ones… Secondly some kids at schools have their future doomed by unwanted teenage pregnancies or staying at home with unwanted babies; they could have aborted the babies and continued with their studies and have babies later on after completing their education…or when they are being financially stable and mentally mature and ready. (Respondent 11, North West Province).

Helping children that come for TOP who are mostly rape survivors... Again helping parents make a choice for their young and immature children…One cannot help but want to spare the girl the pain and suffering especially when she refuses abortion saying she wants to keep the baby to play with her. (Respondent 20, Gauteng Province).

4.4.6 Negative relationships with colleagues

The second major theme that emerged was the negative relationships with colleagues. The study participants reported judgemental attitudes from their colleagues, labelling, and being called names such as "murderers, killers, baby killers". They reported that their colleagues often mock them asked how they (TOP providers) are able to sleep at night. The quotes below are illustrative of TOP provider narratives.

We get labelled as killers as we get associated with all sorts of bad to say the least… The patient comes to seek service and they will just say to (name) those are your people, they (other colleagues) *do not want anything to do with them* (women requesting abortion). *We also get judged and people think that I am promoting promiscuity by doing TOP…* (Respondent 12, North West Province).

… For a long time I was called an undertaker, a killer amongst other things… (Respondent 14, North West Province).

The problem starts when we knock off at 4pm and colleagues in the ward must take care of these patients… they get upset because they are not "killers". They say 'I am not going to touch them because I am not a killer'… (Respondent 27, Gauteng Province).

In some instances, participants reported that their colleagues discouraged clients from obtaining TOP services and refuse to support it, or to provide services even though they might have received approximately two weeks of theoretical and practical TOP training. They reported that many of their colleagues were unsupportive, undermined their work and made sarcastic comments about them. Their colleagues also say that "TOP is a deterrent to family planning service provision". This attitude and lack of understanding of TOP processes often resulted in conflict and strained relationships between TOP providers and their other nursing colleagues, and one indicated that she gets no support '*from my colleagues, especially not in this ward, oh here I am in hell.'* (Respondent 27, Gauteng Province)

Others said the following:

> *Ahhhaaa… there is no appreciation from colleagues at all, we get nicknames, you will never get assistance and that is why I am always there alone, there is totally no appreciation from colleagues.* (Respondent 13, North West).

> *When you're alone and having to turn away patients; that is just not right because the patient has nothing to do with staff shortages and it is so unfair for the patients*. (Respondent 20, Gauteng Province).

The TOP service providers reported that medical support for TOP services was inadequate, and that there were few doctors available to assist with emergencies. Some doctors, despite being trained, refused to be called TOP providers, and sometimes shifted their responsibility of managing complications and second trimester TOPs to the nurse provider. At some facilities doctors would send patients from pillar to post, and even refer patients to a referral facility that does not provide TOP. In North West province, one doctor refused to do a sonar, saying they (women requesting abortion) should have prevented the pregnancies if they did not want babies. The study participants indicated that they often had to "fight" before they could get a facility manager or doctor to respond.

4.4.7 Unsupportive management

The third major theme that emerged from the interviews was unsupportive facility management. Participants reported that hospital or community health centre managers showed little appreciation for the work that they were doing, or an interest in knowing about TOP. Providers reported that they were often left all alone "*in their little corner*" and nobody cared about them. Providers were frustrated that managers were supposed to support them, but instead these managers did not visit the TOP units, they did not address interpersonal relationship issues affecting TOP service provision, and did not take time to find out whether the few TOP providers were coping with the job.

While some providers attended one debriefing sessions at the end of the year, some reported that they never had any debriefing sessions in the preceding years. The study participants reported that the facility managers only visited the unit when they (managers) wanted statistics, followed up on a complaint or showed visitors around. One of the TOP providers reported that a Gauteng facility manager was overheard saying that '*if TOP units were shut down, nobody would die, and other patients would use that space*'.

Participants reported that they are often called upon to relieve in other wards or unit, because TOP services are not prioritised. The unsupportive management and lack of prioritisation of TOP services in turn increase the stress and workload of existing TOP providers.

> *My major issue is that as an advanced midwife, I work at all units in the facility especially labour ward and relieve the operational manager… Additionally I am the only one trained to insert and remove IUCD and Implants. My hands are full… In case of an emergency I am expected to leave the TOP unit and run. I become confused as I am expected to be everywhere… TOP is not prioritised anyway.* (Respondent 29, North West Province).

> *I am all alone, it is just me. It is difficult because I play a dual role as both the provider and the manager… I work within a structure that is not well equipped… my colleagues are judgemental and look down on me as a TOP provider… Sometimes you come across situations whereby you really should consider leaving the client but then again if you leave*

her you realise that the person is going through a lot and you may have to recommend that she carries the pregnancy to full term and take the baby for adoption and other options… but then if she doesn't want to, you cannot deny her the service. There is no social worker or psychologist at the hospital to support clients. (Respondent 5, North West Province).

The Department (of Health) *needs to realise that TOP is one of their services… We didn't initiate this service, it was initiated by the department because there was a need but now it is like it addresses our need and we have to see to finish... Patients come for a service whether or not there is a provider*. (Respondent 15, North West Province).

4.4.8 Lack of an enabling environment

Participants reported on the lack of an enabling environment that ranged from the unavailability of medication, malfunctioning or unavailable equipment especially sonar machines, lack of working space, staff shortages, all which increase workload. The lack of medication in turn affects the women that request TOP services, as they have to return to the facility, as shown by the quote below:

The problem is when we don't have medication because there are those times where you get that Misoprostol is finished and then people will have to go back because we don't have medication. (Respondent 6, North West Province).

TOP providers also complained about equipment, and one said:

…honestly we lack equipment and even the beds malfunction when it comes to adjusting them up and down. Some of these beds are very old… (Respondent 22, Gauteng Province).

TOP providers reported that they were expected to share work space and/or sonar machines with other units, and in some instances they had to take clients to other units to do sonars. The lack of equipment impacts on client privacy and confidentiality, as illustrated by the quote below:

Lack of equipment and supplies and having to move with patient to maternity for sonar. When we get there everybody already knows what they have come for. There is no privacy

at all… I also have to carry instruments from theatre to wash at the TOP unit. If only management can give me what I want, for once. (Respondent 28, Gauteng Province).

The lack of equipment also resulted in more time spent in preparations rather than the actual service provision, and resentful colleagues who felt that their work was delayed by sharing the sonar machine. They reported that sometimes TOP clients would be postponed until antenatal care and postnatal care patients were seen.

Respondents complained about staff shortages and about working alone. In some instances, women have to wait for abortions until the TOP providers returned from sick leave, which was stressful and they indicated that it increased provider workload. Inadequate management support and delayed or non- supply of essential equipment were adding to the perceptions of a disabling environment.

There is just too much that goes in TOP service… we are the only 2 providers, when the patient comes through we have to conduct sonar to examine the gestation… only when the patient qualifies do we then counsel, do observations only then book the patient… On the day of admission, you do the same procedure and initiate TOP with pills… you have to prepare or do the procedure and provide post abortion care… while you attend to other issues in between. Phew! (Provider 19, Gauteng).

4.4.9 Emotional burden of TOP provision

Notwithstanding the rewarding aspects of TOP service provision, and the desire to make a difference, participants reported that the strained relationship with colleagues, unsupportive management and lack of an enabling environment take an emotional toll on them. An overwhelming negative emotion expressed was one of "loneliness".

…unfortunately people are not interested in knowing what we do… we are just left all alone in our little corner and nobody cares about us and what we do. (Respondent 12, North West Province).

Participants reported that the constant reminders by colleagues and comments that "*TOP is a dirty job and providers are killers*" were traumatic. At times the participants reported that they experience contradictory feelings of lack of interest or regret that they are TOP providers.

More people must be trained because this is stressful… we volunteer to come to this department but after some time you feel as if you have made a mistake, you think you need a break but then again no one will come …(hence) *you are forced to stay in the TOP department.* (Respondent 18, Gauteng Province).

I am no longer interested to work in this department. Truly speaking it is stressful and there is no appreciation or no incentive like OSD (occupation specific dispensation, a public health sector financial incentive) *or additional money.* (Respondent 25, Gauteng Province).

The study participants reported examples of TOP providers who have left because they could not handle the stigma and discrimination from other colleagues and managers. In addition, some study participants said that the lack of understanding from colleagues, the lack of management support and the emotional experience result in "abnormal coping mechanisms" such as staying away from work without authority, request to be transferred to other departments, dreading to go to work on some days, or not wanting to listen to anybody's story.

Normally I stay away from work, I request some days off but if they don't give me those days off… I will just stay by myself and maybe go to the doctor and just to relax… because I have asked them at least once in a month to go for debriefing sessions whether either a psychologist or someone…but they don't allow that but I have been going there by myself. (Respondent 16, North West Province).

The providers reported that they were disturbed by manual vacuum aspiration which is quite mechanical, the associated pain women experience during the procedure, the dangers of doing the procedure with a possibility of uterine rupture or subsequent death, and the fact that the procedure makes them see the limbs, hands and arms of dead foetuses which they find very traumatic. They narrated loss of sleep because of the traumatic experience, and the inability to share their feelings with colleagues made it more difficult. At the same time, the majority of providers indicated that they keep their emotions to themselves for fear of judgement or prejudice.

I have to introduce the cannula right into the cervix, that's when the woman starts to feel more pain when I am doing the aspiration and I don't know if I am damaging her inside and when they are in pain that's when it affects me the most. (Respondent 16, North West Province).

Sometimes we get burnout …you feel like resigning… or if not resigning you feel like going on leave for a very long time. If I can make an example, last week I was talking to my colleague telling her that I had a bad dream… This week I dreamt of doing the procedure which is not nice, we sleep knowing that we are doing TOP but we don't want to wake up to it you know… (Respondent 18, Gauteng Province).

4.5 Discussion

This empirical study was conducted to explore TOP service provision by designated facilities, the factors that influence the provision of such services, and the work experiences and perceptions of TOP providers in two South African Provinces.

This study found that around 77% of designated facilities (or 84% when four from North West were included) in the two provinces were providing TOP. At face value, it is encouraging that the majority of designated facilities in the two provinces actually provided TOP services, as intended. More designated facilities were providing TOP services in the urban province of Gauteng (87%), compared to the mixed urban-rural province of North

West (65.5%). The higher proportion of functional TOP facilities in Gauteng is supported by information from the District Health Information System. In 2014, 18 465 TOPs were done in Gauteng Province, compared to 8 294 in North West Province (215). The differences could be due to the ease of geographical access and better financial and human resource availability in urban Gauteng (216).

We found that 14 designated facilities in the two provinces or almost one quarter (23%) of the total number of designated TOP facilities (14/61) were not providing TOP services at the time of the study, with the majority of these in North West Province. A 2015 rapid review found that fewer than half of government designated facilities provide abortion services, because of conscientious objection by health care providers (211). However, our study that used a combination of site visits, observation, and in-depth interviews with health care providers, found that a complex set of overlapping factors influenced the provision of TOP services in Gauteng and North West Provinces. In essence these factors were: lack of an enabling environment because of the many health system deficiencies, and human resource challenges, exacerbated by the lack of management support for TOP services.

Although the CTOPA in South Africa provides an enabling legal framework for safe abortion services, study participants complained about a range of health system problems, including the lack of equipment, lack of medication, and lack of space. WHO has pointed out that access to safe abortion services are dependent on the availability of services, the manner in which they are delivered, well-equipped facilities and trained health care providers (79). Other studies have also found that health system deficiencies hinder safe abortion services. A 2015 systematic review to analyse factors that influence first-trimester abortion services for women in high income countries found that despite supportive legislation, insufficient hospital resources, particularly in rural areas were a major barrier to care and contributed to inequities in quality and access to TOP services (138). Studies in low and middle - income countries found inadequate health care and infrastructure, unavailability of medical abortion including restricted laws and high cost were barriers to access TOP services despite the feasibility, effectiveness and acceptability of medical abortion in low resource settings (217, 218).

An enabling environment which includes infrastructure, availability of medicines and equipment, has quality of care and lower cost benefits (219, 220) and is essential for safe abortion care. South Africa's progressive abortion legislation necessitates that provincial health authorities ensure that systems are in place for procurement and distribution of all medical equipment, drugs and supplies necessary for the safe delivery of TOP services.

WHO has pointed out that the lack of trained health care providers is one of the most critical barriers to safe abortion care (221). A 2015 systematic review on factors influencing the provision of TOP services in high countries, that found that lack of trained providers were an obstacle to safe abortion care (138). In our study, professional nurses were the primary TOP providers. It has been pointed out that the implementation of the CTOPA in South Africa would not have been possible without the extensive support and involvement of a small group of committed nurses (108). Our study participants complained of excessive workload and staff shortages. Other South African studies have also found a severe shortage of willing TOP providers (74, 75). These shortages were exacerbated by lack of management support observed and reported in the majority of designated facilities.

The provincial health authorities, together with health facility managers have the responsibility of ensuring resource availability, staff support and supervision, and procurement of needed equipment and medication (205). They are also responsible for protecting the rights of women seeking TOP services and ensuring quality of care is provided. They must oversee and enforce accountability by doctors and nurses towards their professional and ethical responsibilities on TOP provision, with consequences if their duties are neglected.

An overwhelming feeling expressed by TOP providers was one of loneliness, and lack of support from their nursing and medical colleagues. These TOP providers reported the heavy burden of care provision, which they felt even when off- duty. They lamented the unrealistic expectations from facility managers to assist with nursing duties in other units. Their experiences of stigma and discrimination added to the health system barriers to TOP service

provision. All these factors combined to take a huge emotional toll on TOP service providers, despite their accounts of the rewarding aspects of the job. They reported that their willingness to become TOP providers and commitment to safe abortion care were met with judgmental attitudes from their colleagues, labelling and name calling such as murderers, killers, baby killers. These provider experiences of courtesy stigma, or stigma by association, increased their feelings of loneliness, and often resulted in conflict and strained relationships between TOP providers and other nurses. The refusal of other colleagues to provide TOP or to refer women to access TOP services added to provider loneliness. Furthermore, the non-responsiveness of doctors to provide clinical or referral support, and from managers for equipment, additional staff or medication, left many of the few TOP providers despondent.

There is evidence on the loneliness experienced by women who choose TOP (88, 222). Many authors have reported on the problems of conscientious objection and the unwillingness of doctors or midwives to provide TOP services (77). Similarly in South Africa, scholars have highlighted the access barriers experienced by women seeking safe abortions (77, 211, 223). However, there is a dearth of studies in South Africa on the *loneliness* or the psychosocial issues experienced by providers of TOP services.

In this study, participants gave a moving account of their experiences of courtesy stigma from their colleagues and health facility managers. The sociologist Goffman coined the term "courtesy *stigma*" and defined it as the stigma or public disapproval of those people who are merely associated with a *stigmatised* disease, person or group (83). In the case of abortion, courtesy stigma is the name-calling or discrediting of individuals (in this case health care providers) as a result of their with women who request or are in need of abortion or TOP services (144). In Ghana, a 2016 study also found that courtesy stigma resulted in health care provider reluctance to provide TOP (209). In the United States, Harris et al have advanced the concept of courtesy stigma, by describing both the negative stereotypes of abortion providers and the multiple levels in which providers experience stigma, as well as developing tools to measure abortion stigma (172). Importantly, abortion provider stigmatisation has implications for the psychosocial well-being of TOP providers, availability of scarce human resources, and patient safety, and health policy (84).

The solutions to the problems reported by study participants require decisive actions from South African policy-makers, health service managers and gender activists. Similar to efforts to combat HIV stigma and discrimination (224), strategies should include social mobilisation programmes and advocacy for women's rights in the health sector and in society at large.

There are limitations of this study, which was undertaken among a sub-sample of 30 TOP service providers in two South African provinces. The cross-sectional nature of the study means that we obtained the views and perceptions of the providers at a point in time.

Nonetheless, this study is novel in conducting multi-site visits to 61 TOP facilities to determine whether designation means actual provision. The triangulation of data from the site visits, observation, combined with the narratives and perspectives of TOP service providers gives unique insights into TOP service provision. This provides an opportunity to revisit and address TOP service provision needs, and to ensure that the enabling provisions of CTOPA in South Africa are implemented. Another matter requiring attention is the re-introduction of value clarification workshops and training of healthcare workers on CTOPA, women's rights, and the ethical duties and responsibilities of health professionals. Lastly, the study findings suggest the need for employee wellness programmes that take into account the psychosocial needs of TOP providers.

4.6 Conclusion

South Africa has an enabling legal environment for the provision of TOP services. The study finding that three quarters of designated facilities were functional as TOP facilities is encouraging. At the same time, this study highlighted the multiple, and overlapping barriers to TOP service provision, that included health system deficiencies, human resource challenges, lack of prioritisation and insufficient management support. The experiences of courtesy stigma and feelings of loneliness further threaten safe abortion services by a few willing and committed health workers. Although strengthening health systems and human

resources is important, supportive management and prioritisation of TOP services are critical elements of an enabling health policy environment.

4.7 Authors' contributions

Both MT and LCR designed and conceptualised the study, LCR is the PhD supervisor. MT and LCR analysed the data with input from a third researcher. Both authors contributed equally to the interpretation of study findings, the writing, substantial revision and editing of the manuscript. Both authors read and approved the final draft of the manuscript.

4.8 Acknowledgements

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4.9 Conflict of interest

Neither author has any competing interests.

CHAPTER 5: COMPASSION SATISFACTION, BURNOUT AND SECONDARY TRAUMATIC STRESS AMONG TERMINATION OF PREGNANCY PROVIDERS

5.1 Introduction[b]

The global quest for universal access to sexual and reproductive health care services, including safe abortion services (54) necessitates a skilled, compassionate and motivated health workforce (68) that is sensitive to women's needs. The availability of trained and willing health care providers remains the most important determinant of safe abortion or termination of pregnancy (TOP) services (68).

South Africa has enabling legislation in the form of the Choice of Termination of Pregnancy Act (CTOPA) to ensure access to safe abortion services (218). However, it has been estimated that 50% of abortions in South Africa continue to occur outside of designated health facilities, and that the majority of government-designated facilities do not provide abortion services (211). Difficulties in access to safe TOP services include: negative attitudes by other staff members and the community towards TOP services and the staff who provide TOP services; staff shortages including skilled TOP providers (75), and lack of an enabling environment, including insufficient management support (79, 225).

The notion of "compassion satisfaction" has been well described in the literature, and refers to the positive feelings a person derives from helping or caring for others (109). In contrast, compassion fatigue, first described by Joinson in 1992, refers to the negative aspect of helping people who experience suffering, trauma or stress (115). Many different terms are used to describe the negative aspects of helping people who experience suffering, trauma or stress namely compassion fatigue (CF), vicarious trauma, or secondary traumatic stress

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(STS). In this study, the terms compassion fatigue and secondary traumatic stress will be used interchangeably.

Compassion fatigue has both individual and organisational implications. At the individual level, compassion fatigue includes possible mental and/or physical illness, as well as interpersonal conflicts (114, 115). At an organisational level, compassion fatigue contributes to higher rates of absenteeism, higher staff turnover rates, and lower morale and productivity (116). These individual and organisational consequences in turn influence the quality of patient care, and the responsiveness of the health system to women's needs (117).

There is a significant body of literature describing compassion fatigue among front-line health care professionals, namely nurses, social workers, clinical psychologists, psychiatrists, case managers and mental health workers (115, 226). Compassion fatigue and burnout are often used interchangeably. However, while compassion fatigue has far reaching effects that are not easily reversible, burnout is linked to environmental stressors with a quick resolve once the stressor is removed (115). Several studies conducted in high income countries also focused on compassion satisfaction, burnout and compassion fatigue among midwives, emergency response or aid workers (118, 119). In the United States, Potter et al highlighted the importance of burnout and compassion fatigue among oncology nurses (227), while Martin et al studied compassion satisfaction and burnout among TOP providers (113).

The predictors of compassion satisfaction and compassion fatigue are complex. Although the research methods and study populations differ, the factors that influence compassion satisfaction or fatigue include type of profession (109), type of patients cared for (115), health system problems (228), personal issues such as previous experience of trauma, demographic characteristics, geographical setting, with staff in rural areas experiencing greater levels of trauma (229), and stigma in the case of TOP providers (113).

Despite the importance of trained health care providers to the provision of safe abortion services, there has been insufficient scholarly focus on the psychosocial issues faced by

health care providers of abortion services, especially in low and middle-income countries (108). Given the importance of health care providers to improving women's access to safe abortion services, this paper explores the notions of compassion satisfaction, burnout and compassion fatigue among TOP service providers in two South African provinces. This is important to inform health workforce management strategies and to contribute to the creation of positive practice environments. The research forms part of a larger doctoral study on psychosocial issues experienced and coping strategies used by health professionals that provide TOP services.

5.2 Materials and methods

The study was approved by the University of the Witwatersrand's Human Research Ethics Committee (Medical) and the relevant provincial health authorities including health facility managers. We adhered to standard ethical requirements including participant informed consent, study information sheets and maintaining confidentiality of information.

This was a cross-sectional study conducted during 2014 and 2015 among TOP service providers at designated TOP facilities in Gauteng, a densely populated urban province, and North West, a mixed rural-urban province (230). These provinces were selected because of geographical proximity to the researchers, logistical considerations and budgetary constraints. Although there are several tools that measure compassion satisfaction and/or compassion fatigue, or related terms such as burnout, vicarious trauma, or secondary traumatic stress (202), the professional quality of life (PRoQOL) tool is the most commonly used measure of the positive and negative effects of helping others, it is available free of charge and has been shown to have good validity and reliability (81).

PRoQOL consists of three subscales: compassion satisfaction which is the pleasure a provider derives from doing his/her work with a high score denoting compassion satisfaction, burnout which is related to feelings of hopelessness, not coping with work or carrying tasks ineffectively, and secondary traumatic stress scales which is work-related secondary exposure to traumatic events (81). For each of the sub-scales, a score of 22 or less

denotes a low level, 23-41 an average level and 42 or above denotes a higher level. The PRoQOL has been in use since 1995, and there have been several revisions, with PRoQOL 5 being the latest available version (81).

All public health facilities (hospitals and clinics) in Gauteng and North West provinces that were designated to provide termination of pregnancy (TOP) services were included in the study. We obtained a 2014 list of these designated TOP facilities from the national department of health, which was compared with the provincial data base from each of the study provinces. The details of these TOP facilities are described elsewhere (225).

The principal researcher visited each of the designated facilities between July 2014 and August 2015. All TOP service providers constituted the population of interest. A TOP service provider was defined as a medical doctor or a professional nurse with four years of nurse training, and additional training in TOP service provision. Some of the nurse TOP providers also functioned as facility managers. The exclusion criteria were staff not directly involved in TOP services (e.g. enrolled nurses, administrators and general assistants) working in the selected facilities, and designated facilities that do not provide TOP services.

All the managers of the selected TOP facilities were contacted between July 2014 and September 2015 to solicit their participation and to plan the date for fieldwork. At each TOP facility, an introductory meeting was held with the manager to explain the study. At some facilities, a presentation was made at the medical officers' weekly clinical meetings. After obtaining informed consent, a self-administered PRoQOL questionnaire was given to each TOP provider for completion. The PRoQOL was used in its original form, but expanded to include demographic factors (age, sex, marital status, etc.) and a set of questions using a Likert scale to determine possible reasons for working as a TOP health care provider. Each questionnaire took around 15 minutes to complete.

5.3. Validity and reliability

After piloting, to determine validity and reliability of the PRoQOL instrument, Cronbach's alpha (CA) coefficient was used to assess the reliability of the scale and 0.77 was obtained signifying that it had moderate internal consistency (192). The lowest CA was 0.66.

5.4 Data analysis

We analysed the data using STATA® 13. A descriptive analysis of socio-demographic characteristics was conducted, using frequency tabulations and summary measures.

For each participant, the scores for each of the sub-scales of compassion satisfaction, burnout and secondary traumatic stress were allocated according to the instructions on the PRoQOL questionnaire (81). The mean scores and standard deviation (SD) for each sub-scale were then calculated for all the study participants. The ProQOL instructions suggest categorising participants into three categories for each sub-scale namely low, average and high. However, because of the non-discriminatory nature of these categories, in this analysis we have used the actual scores on each sub-scale in order to increase the statistical power to detect associations among the explanatory variables.

Separate multiple linear regression models were fitted to find factors associated with each score, namely compassion satisfaction, burnout and secondary traumatic stress). The potential explanatory variables considered were: province, sex, age, marital status, number of children, professional category, years of TOP service, training in TOP, self-perception of religiosity, religious type, type of facility, including the ten questions on the reasons for working as a TOP provider. Model selection was carried out using backward elimination, with a 15% significance level for inclusion. This level was selected to take account of possible confounders (231). We then checked for interaction between pairs of variables included in the final model.

5.5 Results

5.5.1 Demographic characteristics

We recruited 105 TOP providers, 103 agreed to participate in the study (Gauteng = 70; North West = 33) at 51 facilities, resulting in a 98% response rate.

Table 5. 1: Socio-demographic characteristics of participants n = 100			
Characteristic	**Gauteng**	**North West**	**Total**
Sample size	70	33	103
Mean age (standard deviation)	46.5 (10.4)	43.4 (8.6)	43.4 (8.71)
Sex			
Male (%)	12 (17.1)	7 (21.2)	19 (18.5)
Female (%)	58 (82.9)	26 (78.8)	84 (81.6)
Age group (years)			
24- 39 (%)	17 (24.3)	13 (39.4)	30 (29.1)
40 - 49 (%)	23 (32.9)	10 (30.3)	33 (32.0)
50 - 64 (%)	29 (41.4)	8 (24.2)	37 (35.9)
Missing (%)	1 (1.4)	2 (6.1)	3 (2.9)
Marital status (%)			
Married (%)	34 (48.6)	15 (45.5)	49 (47.6)
Living together (%)	4 (5.7)	2 (6.1)	6 (5.8)
Single (%)	17 (24.3)	13 (39.4)	30 (29.1)
Divorced/separated (%)	9 (12.9)	2 (6.1)	11 (10.7)
Widowed (%)	6 (8.6)	1 (3.0)	7 (6.8)
Median number of children (IQR)	3 (2- 3)	3 (2 – 4)	3 (2 – 3)
Professional category			
Professional nurse (%)	45 (64.3)	28 (84.9)	73 (70.9)
Doctor (%)	20 (28.6)	2 (6.1)	22 (21.4)
Manager (%)	5 (7.1)	3 (9.1)	8 (7.8)
Median years at TOP service (IQR)	4 (3 -5)	3 (2 – 4)	4 (2 -4)
TOP trained			
No	3 (4.3)	0 (0.0)	3 (2.9)
Yes	67 (95.7)	33 (100.0)	100 (97.1)
Consider self as religious			
No (%)	9 (12.9)	2 (6.1)	11 (10.7)
Yes (%)	61 (87.1)	31 (93.9)	92 (89.3)
Religious type			
Christian (%)	63 (90.0)	29 (87.9)	92 (89.3)

African indigenous –based (%)	1 (1.4)	2 (6.1)	3 (2.9)
Others (%)	2 (2.9)	1 (3.0)	3 (2.9)
Missing	4 (5.71)	1(3.03)	5 (4.85)
Type of facility			
Community Health Centre	21 (30.0)	17 (51.5)	38 (36.9)
Hospital	49 (70.0)	16 (48.5)	65 (63.1)

Table 5.1 shows the social and demographic characteristics of study participants. The mean age of participants was 43.4 (SD=8.7). The majority of participants were nurses (70.9%), female (82%), married (47.6%) and 63% were working in hospitals. The median number of children per participant was 3. All participants in the North West province (100%) reported that they received training to provide TOP, while 95.7% of participants in Gauteng reported that they received training.

5.5.2 Reasons for working as a TOP health care provider

Table 5.2 shows the mean scores for participants' reported reasons for working as a TOP provider. The highest mean scores were obtained for the statements on helping clients make informed choices; feeling strongly about women's health; belief in making a difference; and feeling strongly about women's rights. The lowest scores were obtained for quality of supervision and the availability of an employee wellness programme.

Table 5. 2: Reason for working as a TOP provider (n = 100)

Reason	**Mean score**
Helping clients make informed choices	6.8
Feeling strongly about women's health	6.9
Belief in making a difference	6.7
Feeling strongly about women's rights	6.7
Enjoying relationship with other nurses	6.0
Enjoying relationship with doctors	5.9
Finding work stimulating	5.5
Getting feedback on quality of work	5.0
Quality of supervision	4.7
Employee wellness programme available	4.3

5.5.3 Mean scores for compassion satisfaction, burnout and secondary traumatic stress by socio – demographic factors

Table 5.3 shows the mean scores for the compassion satisfaction, burnout and secondary traumatic stress by socio – demographic characteristics. The overall mean score for compassion satisfaction was 42 (SD 5.5), which PRoQOL denotes as high. Compassion satisfaction scores were similar in Gauteng and North West provinces, and for males and females. Compassion satisfaction scores increased with an increased number of children. Providers with managerial responsibilities had higher compassion satisfaction scores with a mean score of 47 (SD 1.9) compared with doctors (mean 42; SD 4.8) and nurses (mean 41; SD 5.7). Compassion satisfaction scores were not different between participants who considered themselves religious and those who did not, and by type of health facility.

PRoQOL burnout mean scores were average and seemed consistent across all categories. Participants with four or more children had lower burnout with mean score of 30 (SD 2.4), compared with those with one child (mean 33; SD 3.5), two children (mean 33; SD 4.7), and three children (mean 33; SD 3.4). Burnout scores were higher among participants who were TOP trained with mean of 33 (SD 4.0), compared to those that were not TOP trained (mean 30; SD 4.7).

The overall PRoQOL secondary traumatic mean score was average with a mean of 23 (SD 6.8). Widowed participants showed the highest secondary traumatic stress mean score of 30 (SD 10.99), compared to other groups. Participants with four or more children showed the lowest secondary traumatic stress mean score of 17 (SD 5.2), compared to those with no children with a mean score of 26 (SD 7.5).

Participants with two or more years of TOP service showed a higher secondary traumatic mean score compared to those with one year of TOP service provision. Secondary traumatic stress mean scores were comparable for religious and non – religious participants and by type of health facility (hospital or community health centre).

Predictors of compassion satisfaction, burnout and secondary traumatic stress

Table 5. 3: Mean scores of compassion satisfaction, burnout and secondary traumatic stress by socio-demographic factors (n =102)

			compassion satisfaction		burnout		secondary traumatic stress	
Variable	**Level**	**n**	**mean**	**SD**	**mean**	**SD**	**mean**	**SD**
Overall score			42	5.5	33	4.0	23	6.8
Province	Gauteng	70	42	5.2	33	4.0	23	7.0
	North West	32	42	6.0	34	3.9	24	6.7
Sex	Male	19	42	3.7	33	3.5	22	6.3
	Female	83	42	5.8	33	4.1	24	6.9
Age group (years)	24 - 39	29	40	6.1	32	3.9	22	6.3
	40 - 49	33	41	5.0	34	3.5	25	6.7
	50 -64	37	43	5.1	33	4.3	23	7.4
Marital status	Married	48	42	5.7	33	4.1	23	7.2
	Living together	6	44	2.4	32	4.8	21	4.9
	Single	30	41	5.6	33	3.5	23	5.7
	Divorced/separated	11	43	3.9	33	3.9	21	3.4
	Widowed	7	41	7.7	34	5.3	30	10.99
Child	No	10	40	6.7	33	3.5	24	6.6
	Yes	92	42	5.3	33	4.1	23	7.0
Number of children	0	11	40	6.4	33	3.4	26	7.5
	1	24	41	5.6	33	3.5	24	7.4
	2	44	42	5.4	33	4.7	24	6.5
	3	16	43	4.9	33	3.4	23	6.4
	≥4	6	46	3.4	30	2.4	17	5.2
Professional category	Professional nurse	73	41	5.7	33	4.1	24	7.0
	Doctor	21	42	4.8	33	3.4	23	6.1
	Manager	8	47	1.9	34	5.0	20	7.3)
TOP service (years)	1	10	44	4.2	32	3.7	20	3.5
	2 -3	36	41	5.7	32	3.7	24	7.5
	4	32	41	5.4	34	4.1	24	5.7
	5 or more	22	43	5.0	34	4.1	24	8.0
TOP trained	No	3	37	4.2	30	4.7	23	13.6
	Yes	99	42	5.4	33	4.0	23	6.7
Religious	No	11	42	5.2	32	3.9	22	8.5
	Yes	91	42	5.5	33	4.0	24	6.7
Type of facility	Community Health Centre	38	42	6.0	34	3.8	24	6.7
	Hospital	64	42	5.1	33	4.1	23	7.0

Table 5. 4 summarises the results of the models for compassion satisfaction (5.4a), burnout (5.4b) and secondary traumatic stress (5.4c).

For compassion satisfaction, factors found to be significant at 5% level were finding work stimulating, belief in making a difference, enjoying relationship with nurses and years of TOP service. In addition, province and sex were significant, with a significant interaction between these two variables. The compassion satisfaction score increased by 3.72 for every unit increase for TOP provider belief in making a difference. Similarly, a unit increase in finding work stimulating resulted in an increase of 1.03 in compassion satisfaction, and a unit increase in enjoying relationship with other nurses resulted in an increase of 1.02 in compassion satisfaction. For service providers who had two or more years of TOP service, the compassion satisfaction score was lower than for those who had worked for one year.

There were gender differences between the two provinces, with higher compassion satisfaction scores for females in Gauteng compared to males, while in North West, females had lower compassion satisfaction scores than males (Table 5.4a).

Table 5. 4 (a): Predictors of compassion satisfaction score

	Variable	Coefficient	(95% CI)	p	
Province & sex	North West male	0	baseline	0.037	*
	North West female	-5.88	-9.94; -1.83		
	Gauteng male	-4.47	-9.08; 0.14		
	Gauteng female	6.25	1.34; 11.16		
Professional category	Nurse	0	0	0.14	NS
	Doctor	0.32	-2.50; 3.15		
	Manager	3.23	-0.004; 6.45		
TOP service (years)	1	0	0	0.023	*
	2-3	-3.99	-6.86; -1.11		
	4	-4.66	-7.64; -1.67		
	5 or more	-3.29	-6.35; -0.23		
Feeling strongly about women's rights	Per unit increase	-0.99	-2.34; 0.36	0.149	NS
Find work stimulating	Per unit increase	1.03	0.42; 1.65	0.001	*
Belief in making a difference	Per unit increase	3.72	2.31; 5.12	<0.001	***
Enjoy relationship with other nurses	Per unit increase	1.02	0.31; 1.72	0.005	*

*NS: Non-significant, *p <0.05, **p< 0.01, ***p< 0.001*

Table 5. 4 (b): Predictors of burnout score

	Variable	Coefficient	(95% CI)	p	
Province	North West	0	0	0.114	NS
	Gauteng	-1.45	-3.24; 0.35		
Age group (years)	24 - 39	0	baseline	0.11	NS
	40 - 49	1.96	-0.13;4.04		
	50 - 64	0.085	-1.95; 2.12		
Belief in allowing informed choices	Per unit increase	1.84	-0.037; 3.72	0.055	NS

*NS: Non-significant, *p <0.05, **p< 0.01, ***p< 0.001*

The only factor that was marginally significant in predicting burnout was the belief in helping women to make informed choices (Table 5.4b).

The significant predictors of secondary traumatic stress scores were finding work stimulating, belief in women's rights, belief in allowing informed choices, age and sex (Table 5.4c) For each unit increase in finding work stimulating, secondary traumatic stress score decreased by 2.17, and a unit increase in the belief in women's rights, the secondary traumatic stress decreased by 3.17. For every unit increase in provider belief to allow for informed choices, secondary traumatic stress scores increased by 3.91. The scores for secondary traumatic stress increased by 4.31 and 4.18 when the providers were female and aged 40 -49 years respectively.

Table 5.4 (c): Predictors of secondary traumatic stress score

	Variable	Coefficient	(95% CI)	p	
Province	North West	0	baseline	0.062	NS
	Gauteng	-2.81	0.15; 5.76		
Sex	Male	0	baseline	0.02	*
	Female	4.31	0.70; 7.92		
Age group (years)	24 -39	0	baseline	0.019	*
	40 -49	4.18	0.87; 7.49		
	50 - 64	-0.04	3.37; 3.46		
Belief in allowing informed choices	Per unit increase	3.91	0.90; 6.93	0.011	*
Belief in women's rights	Per unit increase	-3.17	0.95; 5.39	0.006	*
Find work stimulating	Per unit increase	-2.17	1.11; 3.23	<0.001	***
Getting feedback on quality of work	Per unit increase	0.88	-0.005; 1.77	0.051	NS

*NS: Non-significant, *p <0.05, **p< 0.01, ***p< 0.001*

5.6 Discussion

Our study is one of a few empirical studies in an African setting that used PRoQOL to examine compassion satisfaction, burnout and secondary traumatic stress among TOP providers in two South African provinces.

Our study found that the majority of TOP providers were middle-aged, female nurses, who were working in hospitals. In both provinces, the majority of providers indicated that they had received TOP training, and this is encouraging. The WHO's technical guidelines on safe abortion care underscores the importance of training to ensure competent providers who are able to provide high quality care that is responsive to women's needs (232). Similar to other studies, this study found that the mean age of participants was 43 years, suggesting that TOP provision in these two provinces is dependent on an ageing nursing workforce. This is of concern, and needs to be addressed by health policy makers to ensure long term sustainability of TOP services (233).

Our study found that the predictors of compassion satisfaction were: finding work stimulating, belief in making a difference, and collegial relationships with other nurses. We could not find other studies that have examined the relationship between compassion satisfaction and the philosophical reasons for working as TOP service providers. A study in the United States found that abortion providers reported higher compassion satisfaction scores compared to other health care providers, but that abortion stigma was a significant predictor of lower compassion satisfaction (113).

The finding that those health care providers with less than one year TOP service experience had higher compassion satisfaction could suggest a "dose response" relationship, between length of service and compassion satisfaction. It could be that those providers with more years of service experience more negative effects of TOP provision.

In this study, overall PRoQOL burnout scores of TOP providers were average. This is surprising as the in-depth interviews with a sub-sample of these providers found that they reported a heavy burden of care provision, felt lonely and experienced courtesy stigma from other colleagues and their managers (225). Hence, the average burnout scores in this survey could also be related to the TOP providers' interpretation of the questions in the PRoQOL tool, and/or social desirability bias. Our study found that the only factor that predicted burnout marginally was the belief in helping women to make informed choices.

A Danish study found that midwives strongly supported women's rights to choose, but were conflicted about the fetus' right to live, and this influenced their levels of burnout (234), while a study in Japan (116) found high levels of secondary traumatic stress among midwives who believed the aborted fetus was viable and those that struggled with their emotions during TOP provision. We did not ask these providers about their views on the unborn baby, which could contribute to their burnout scores. The finding suggests that these TOP providers internalise their passion for women's rights, and that this may predispose them to burnout.

In this study, overall PRoQOL secondary traumatic stress scores of TOP providers were average. The study found that being a TOP provider in Gauteng, a belief in women's rights and finding the work stimulating were protective factors (Table 5.4c). The greater availability of resources in the urban province of Gauteng could explain why this is a protective factor. WHO has pointed out that upholding human rights and the needs of women are critical requirements for safe abortion care (232). In contrast being female, aged 40-49 years and the belief in helping women make informed choices increased the secondary traumatic stress scores. These could be because female providers and those aged 40-49 years identify with women who seek TOP, and combined with the emotional burden of TOP provision (225), this influence their secondary traumatic stress levels. These findings are different to a study in Australia that found high anxiety levels among younger nurses (235).

The overall high compassion, average burnout and average secondary traumatic stress scores found in our study could be explained by a possible cohort effect. This means that those providers with low compassion satisfaction and high burnout and secondary traumatic stress levels have left the TOP services. Our study findings are contrary to the findings from studies conducted among TOP providers in the United States of America, using the PRoQOL instrument. This US study found lower compassion satisfaction, higher burnout and higher compassion fatigue among TOP providers (113), and these scores were strongly related to stigma. We did not measure stigma in the survey, and this could explain the difference in findings. However, the findings in the quantitative study contradict those in the qualitative study among a sample of TOP provides who reported on the feelings of loneliness and the courtesy stigma experienced by these providers (225).

The cross-sectional nature of the study is a limitation, as it measures providers' responses to the PRoQOL questions at a point in time. In addition, providers might have given socially desirable answers, even though the questionnaire was self-administered. The PRoQOL instrument has not been validated in an African context, and has not been used among TOP providers, and this might also explain our findings. In addition, the limited range of the scores on the PRoQOL scale makes it difficult to differentiate between the scores and categories.

Nonetheless, there are numerous strengths of this study. This study provides empirical evidence on compassion satisfaction, burnout and secondary traumatic stress among TOP providers in the South African context, and has generated new knowledge on the predictors of these phenomena. The self-administered questionnaire allowed participants the opportunity for truthful responses. The 98% response rate among TOP providers in the two provinces is a major strength of this study.

The focus on TOP providers and the predictors of compassion satisfaction, burnout and secondary traumatic stress provide unique insights into the psychosocial issues faced by TOP providers, and possible levers for intervention. The study findings suggest that health policy makers and managers should endeavour to provide employee assistance programmes that enhance compassion satisfaction, and reduce burnout and secondary traumatic stress.

5.7 Acknowledgements

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5.8 Disclosure statement

The authors declare no conflict of interest, financial or otherwise.

5.9 Ethics and Consent

Obtained and included in the main body of the manuscript

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CHAPTER 6: COPING STRATEGIES AMONG TERMINATION OF PREGNANCY HEALTH CARE PROVIDERS

6.1 Introduction[c]

The availability and equitable distribution of competent, motivated and empowered human resources for health (HRH) are at the centre of global efforts to achieve universal health coverage (UHC) (236). Similarly, the United Nations global strategy for women's, children's and adolescent's health, 2016-2030, has emphasised the criticality of HRH to saving the lives and improving the well-being of women and children (65). A key goal of the global strategy is to ensure safe abortion and post-abortion care through health system enablers, which include competent health care providers (65). This is because competent and willing health care providers are the most important determinant of safe abortion or termination of pregnancy services (68). However, the psychosocial well-being of providers is critical to the provision of responsive and respectful abortion services. Hence the World Health Organization has underscored the importance of positive practice environments for health care providers to ensure effective and quality service delivery. Such positive practice environments include manageable workloads, supportive supervision, and occupational health, safety and wellness programmes (68, 177, 236).

Health care providers, regardless of practice setting, are exposed to numerous occupational or work-related stressors (237, 238). Occupational stress is influenced by factors intrinsic to the job, the actual tasks performed, interpersonal relationships, and organisational structure and climate (239). Existing evidence suggests that occupational stress is exacerbated for termination of pregnancy providers, who also face courtesy stigma, namely, the stigma or public disapproval of those people who are associated with a stigmatised condition, person or group (83). In the USA, studies have found that stigma intersects with discrimination,

[c] This chapter is based on the paper: Resilience or detachment: Coping strategies among termination of pregnancy health care providers in two South African provinces. Culture, Health and Sexuality paper (In press)

harassment and physical violence, thus adding to the stress of health care providers (84). Other stressors include lack of support from their peers and management, and numerous health system constraints, especially in low and middle-income countries (79, 129, 225, 240). These negative experiences take their toll on the health and well-being of termination of pregnancy providers, resulting in poor mental health, stress, burnout, frustration, and compromised service provision (138).

There is also emerging evidence in South Africa of the stress experienced by termination of pregnancy providers, who are doctors, and especially trained registered nurses and midwives. The Choice on Termination of Pregnancy Act (CTOPA) makes provision for trained nurses to provide abortion during the first 12 weeks of pregnancy, whereas doctors can provide both first and second trimester abortion services (4). A 2017 study on the factors influencing the provision of termination of pregnancy services, found that providers reported intense loneliness, courtesy stigma, a heavy burden of care provision, and lack of support from their colleagues and management (225). Termination of pregnancy service providers also suffered from compassion fatigue, which in turn was influenced by their beliefs, age and gender (240). Occupational stress has negative consequences for individual health care providers and for the health care system, including availability and access to termination of pregnancy services, thus affecting the achievement of health goals (238, 241).

The notion of coping, or the cognitive and behavioural strategies that individuals engage in when faced with stress (82), is important to explore within the context of the health care providers who enable such provision, in order to prevent or mitigate occupational stress. There is significant body of literature on coping strategies used by health professionals (153, 154), especially those who work in mental health services (156, 157), critical care (160) or emergency services (162, 163), where there are high levels of occupational stress because of life and death situations.

In high income countries, there is an emerging body of literature on the coping strategies used by termination of pregnancy service providers, given the contested and stressful nature

of abortion provision (128, 132, 164-166). The reported coping strategies of termination of pregnancy providers included self-preservation, silence, viewing abortion as a technical or clinical procedure, 'switching off', suppression of emotions, or distancing themselves from the procedure (121, 128, 167, 168). Some US health care providers recounted the emotional burden of service provision, while others coped because of the compassion satisfaction they experienced from caring for women (130, 166). A 2011 USA study found that abortion providers used avoidance as a coping mechanism in order to resist or alter the negative attitudes about abortion provision, and to deal with courtesy stigma (169). In Canada, a small study found that nurses who cared for women after the abortion procedure coped well, because of high levels of collegial support (170), whereas another found that some Canadian doctors resigned because of their experiences of stigma and harassment (138).

The knowledge gaps on coping and termination of pregnancy providers are more pronounced in low and middle - income countries (101). A study among Ghanaian health workers found that they concealed the diagnosis and misclassified abortion cases to avoid labelling and judgement by colleagues (101). In South Africa, there is a dearth of studies on coping strategies among termination of pregnancy providers. One study found that collegial support enhanced the coping strategies of the few doctors who provided second trimester abortions (175). In the light of the criticality of motivated and responsive health care providers to the delivery of safe abortion services for women, this study explored the coping strategies of termination of pregnancy providers in two South African provinces, thereby contributing to the discourse on resilient health systems and human resources for health.

6.2 Methods

6.2.1 Recruitment and sampling

We conducted the study in the public sector in Gauteng and North West provinces of South Africa during 2014 and 2015. Gauteng is a highly urbanised and populous province with an estimated population of 14.7 million, accounting for one quarter of the total South African population and one third of the Gross Domestic Product (190).

North West is a rural-urban province, with an estimated population of 3.9 million and contributing around 6.5% to the country's GDP (190). The population of interest in the two

provinces was termination of pregnancy providers in designated public health care facilities. The details of these facilities are described elsewhere (225), but consist of hospitals or community health centres. whether stand – alone or as part of integrated sexual and reproductive health services, that meets the CTOPA (4).

We selected 30 termination of pregnancy providers purposively (Gauteng=12; North West =18), in the order in which the facilities were visited for fieldwork. These providers were part of a larger sample of termination of pregnancy providers, defined as those professional nurses or doctors working at all the designated health care facilities in the two provinces, who had received formal termination of pregnancy training and were providing abortion services in terms of the CTOPA. (4).

6.2.2 Ethical considerations

The Human Research Ethics Committee of the University of the Witwatersrand in Johannesburg, South Africa provided ethical approval. We also obtained permission to conduct the study from Gauteng and North West provincial health departments, and the hospital and health centre managers. We provided detailed information on the rationale and the purpose of the study to all participants. We adhered to standard ethical procedures, including voluntary participation, informed consent, participants' ability to terminate the interview at any point, confidentiality, and anonymity of responses. The principal researcher (MT) is an experienced mental health nurse, who established rapport with the participants prior to the interview, conducted the interview in a private setting, asked the questions in an open and non – judgemental manner, and listened attentively to ensure that the participants' responses were not influenced in any way.

6.2.3 Data collection

We developed the interview guide in English, which is the official business language of South Africa. The questions focused on: providers' experiences of abortion provision; whether and which aspects of the termination of pregnancy procedure affected them most; the meaning they attach to their work, how they deal with or manage their emotions as

health care providers, their coping strategies, and availability of workplace support mechanism. MT interviewed each of the selected providers after explaining the study in a private setting available within the health care facility. Each interview, recorded digitally, took between 45-60 minutes, but the duration varied depending on the providers' responses. The consent forms and digital recordings were kept on a password-protected computer.

6.2.4 Data analysis

The individual interviews were transcribed verbatim. The principal investigator verified the interviews for correctness by cross checking with the original recordings. We used interpretative phenomenological analysis to analyse the interviews (213, 214). The first step in the analysis was to read the participants' own words and phrases and without preconceived notions or classification. This means that we reflected on our own preconceptions about the data, and we tried to suspend these preconceptions and only focused on the words reflecting the experiences of the termination of pregnancy providers. We coded the transcripts in detail, with the focus shifting back and forth from the reported experiences of the participants, to our interpretation of the meaning of those experiences (213). We examined the language used by each provider in the light of the following questions: what were the providers' lived experiences with termination of pregnancy provision; how did they make sense of the services they provide; and how did they explain their coping mechanisms? Information collected from the individual interviews was then grouped into thematic categories.

To ensure reliability, two researchers - an anthropologist with reproductive health research experience and the doctoral supervisor (LR) participated in the development of the themes by reading five interviews independently from the principal researcher in order to establish inter-coder agreement (242, 243). The team met to discuss the themes generated independently, and to reach agreement on the themes and sub-themes. Once agreement was reached on the themes, MT developed a codebook, and used the computer software, MAXQDA® 12 to support the data analysis.

6.3 Results

All 30 invited termination of pregnancy providers participated in the interview representing a 100% response rate (Gauteng = 12; North West = 18). All the participants were professional nurses, and 82% were female. The mean age of participants was 45.8 years (SD = 8.8), with a range of 28 to 62 years. The number of years of experience in termination of pregnancy provision ranged from one to 13 years, with an average of 3.6 years. The majority of facilities (95%) at which the selected study participants worked provided first trimester termination of pregnancy services, while the remainder (5%) provided both first and second trimester abortion services.

Although inter-related and not mutually exclusive, the four major themes that emerged from the interviews were: silence and concealing emotions; seeking support; detachment; and belief systems. The themes are shown in Table 1 and presented separately for the sake of clarity.

Table 6.1: Themes emerging `from TOP provider interviews

Theme	**Sub-theme**
Silence or concealing emotions	• Self-control • Concealing emotions • Not sharing feelings • Silence about being a termination of pregnancy provider • Silence to avoid sharing bad things
Seeking support	• Support from colleagues • Management support • Support from family and friends • Using debriefing sessions (where available)
Detachment or disengagement	• Feelings of numbness • Staying away from work • Reluctance to go to work • Losing patience with women who seek termination of pregnancy
Belief systems	• Women's reason for obtaining termination of pregnancy • Praying for help • Belief in God's will and support

6.3.1 Silence and concealing emotions

Termination of pregnancy providers reported self-control, concealing emotions, not sharing feelings and silence as coping strategies. They explained that their self-control and concealing emotions were because of the need for professionalism and provider-client confidentiality given the sensitive nature of their work. They were of the opinion that concealing their viewpoints about women seeking abortion, and/or their experiences of termination of pregnancy provision from friends and family demonstrated their respect for women's reproductive choices. The silence about being a termination of pregnancy provider was also because of the difficulty of discussing abortion with their friends and families, especially their in-laws and their children.

> *I do not tell people that I am a TOP Provider, it is not easy. At home they do not know what I am doing here. I have been here for 13 years but nobody at home knows exactly what it is that I do.* (Respondent 17, Gauteng Province).

The fear of being judged and of being stigmatised was another reason for their silence.

> *No one knows. I do not want to be judged outside work as well.* (Respondent 25 Gauteng Province).

> *No one else knows, they just know that I work at a woman's clinic in the hospital. I do not tell anyone because I am afraid of stigma.* (Respondent 5 North West Province).

In those instances where they discussed their work with family and friends, the study participants omitted the details about the nature of their work. Prejudice and fear of stigma from colleagues and collegial refusal to engage with the subject of abortion influenced the decision of those providers to conceal their emotions. On the few occasions when these providers expressed their psychosocial needs, these were down-played or met with sarcasm.

Some colleagues do not even understand what we go through. They would ask us why we continue providing the service if it stresses us so much. They (other colleagues) *say that nobody is forcing us to continue doing TOP…* (Respondent 18 North West Province).

Despite the pressure experienced due to their colleagues' negative attitudes and lack of space, termination of pregnancy providers highlighted their own resilience. One gave an example of creating a working area to provide termination of pregnancy services after the original area was allocated for tuberculosis services.

They (managers) allocated TOP area for multi-drug resistance TB (tuberculosis), *thinking I would be frustrated. I quietly created a working space for TOP and moved on.* (Respondent 5 North West Province).

Termination of pregnancy providers reported that they ignored the rude interruptions in their consulting rooms, and the shouting from colleagues about 'your patients crowding the waiting area'. Some reported that on some occasions the women offered support to them as providers by asking them how they were feeling during the consultation.

At the same time, these providers expressed the emotional burden and psychological strain experienced because of their silence and self-censure. They recounted how they kept their feelings inside, often pushing these emotions to the back of their minds, and trying to focus their energy on pleasant activities, but being haunted by the same feelings at a later stage.

I don't discuss TOP; I just keep them in…. I am avoiding (people's) views … I already told you that I just always swallow it and I don't know if I am going to crash one day, but I just take each day as it comes. (Respondent 6 North West Province).

This emotional burden was exacerbated because providers were obliged to relieve other nurses in the maternity section, or to provide both termination of pregnancy and maternity services while on duty. Some providers reported that they cry occasionally, whether in the bathroom at work or at home, and that makes them feel better. Others reported dreaming

about doing the procedure, saying *'it is not nice',* while another provider said: *'We sleep knowing that we provide TOP, but we do not want to wake up to it.'* (Respondent 28 Gauteng Province).

6.3.2 Seeking support

Seeking support as a coping strategy took several forms, including seeking support from colleagues, management, family and friends, and using debriefing sessions, where available. Some created supportive opportunities such as sharing a meal, or spending time together. In rare instances where there would be more than one termination of pregnancy provider at a health facility, working as a team was a source of support. The freedom to talk about their work without fear of judgement or prejudice helped them to cope with the stress of termination of pregnancy provision.

*I rely on my colleagues (*termination of pregnancy providers*) for support… we use each other to debrief in most cases … the support that we as TOP providers give to each other in order to help women make their decisions is helpful.* (Respondent 10 North West Province).

We support each other as providers. ***…****we meet every 3 months; this is how we get support otherwise there is just nothing…* (Respondent 18 Gauteng Province).

Additionally, seven of the 30 providers served as both providers and facility managers, and this dual role enabled them to be a source of support.

As both a manager and provider, I am not perfect, but I strive to make my co-workers feel at ease. I make them feel comfortable. We support each other. (Respondent 29 Gauteng Province).

In a few facilities, there were employee wellness programmes, but these were considered ineffective because the person responsible was not skilled in managing termination of pregnancy psychosocial problems, and the debriefing meetings tended to focus on the

performance of individual facilities (e.g. termination of pregnancy statistics), rather than on the psychosocial issues. One provider from Gauteng said the following:

> *As far as I understand debriefing, it should address the emotions of us providers. But here, the session is more on how we facilitate the TOP programme… on how best we can implement TOP, it is more operational support. It does not address our psychosocial support issues. (*Respondent 30 Gauteng Province).

In those health facilities where debriefing sessions were provided by a psychologist or social worker, study participants reported that they avoided these institutional debriefing sessions because they were of the opinion that confidentiality was compromised, and they feared prejudice from other colleagues. Instead, these termination of pregnancy service providers reported that they opted for their own private debriefing sessions at their own cost. They also avoided perinatal meetings since their work focused on termination of pregnancies, whereas the focus of these meetings were on saving babies.

6.3.3 Detachment or disengagement

Some termination of pregnancy providers reported that they experienced feelings of numbness because they have been providing services for a long time. They indicated that they treated women's requests for terminations similar to the care of those women who needed uterine evacuations or with miscarriages, in order to cope. The provision of integrated sexual and reproductive health services that included family planning, cervical cancer screening, assisted coping because these served as a helpful emotional deterrent from termination of pregnancy provision and the collegial prejudice.

Providers' feelings of numbness were exacerbated by the reported negative, at times abusive attitudes by seemingly desperate women, especially with requests for terminations when the gestational age of the pregnancy was above 20 weeks. The providers reported that these women would cry uncontrollably, shout and yell at them. One provider said that she was forced to show these women the sonar, to see how big the baby was in utero, and that it was not possible to do the termination.

Sometimes patients above 20 weeks (of pregnancy) *insist on TOP despite the social worker intervention and options given like adoption. I end up showing them the baby on the sonar to make them understand why TOP cannot be done… I know it is wrong, but it was out of frustration.* (Respondent 5 North West Province).

This provider acknowledged that is was wrong, but felt she had no other choice. A provider in Gauteng reported scolding a patient known to her that came for 'repeat TOP'. She refused to conduct the TOP and insisted that the woman must keep the pregnancy as a lesson.

TOP patients are liars. You tell them one thing, they do a different thing. This family friend was here for the first time, she was done (TOP). *She came again… I told her no, TOP is not a method of contraception. Does it mean every time you fall pregnant you will have TOP done? You must make up your mind now this time you are going to deliver this baby…and she delivered.* (Respondent 30 Gauteng Province).

During the interview, the provider reported that she regrets the treatment of this woman who she knows, even though the baby has reportedly brought much happiness to the family concerned. Some providers reported that sometimes they would walk away from the women for a period of time "to cool down" and then continue with the "service" afterwards. This was to avoid saying negative things. However, termination of pregnancy providers reported that the women who were unable to obtain terminations complained about 'bad service' from the providers. These complaints added to their feelings of stress, compounded by lack of understanding or support from managers. At the same time, some providers felt that the repeat termination of pregnancy clients were 'abusing TOP services' and one said:

I find cases of women who come for repeated abortion are abusing the service, it seems they use TOP as a method of contraception. It is disturbing. I talk to them and find myself repeatedly asking why they come for so many TOPs. This I do despite the fact that they have a right to do TOP as many times as they wish. (Respondent 9 North West Province).

Interviewees reported reluctance to go to work on some occasions, with a feeling that they did not want to hear any woman's story on that particular day. In some instances, providers reported that they coped by staying away from work and made certain there was no contact during their time away from work, having no interaction with family and friends except watching television, reading a book or listening to music in the bedroom.

> *I just have fun and forget a little bit about work, about those women (seeking termination of pregnancy), I just switch off my cell phone. I switch off the number that is known to everyone until such a time that I go back to work.* (Respondent 16 North West Province).

However, these providers indicated that staying away from work were short-lived, because when they got back to work, they did not feel any better.

6.3.4 Belief systems

A fourth theme related to belief systems and included the providers' views on the reasons that women requested a termination of pregnancy, and locating their work within a spiritual context, such as praying for help, and adhering to the belief that their involvement in termination of pregnancy provision was God's will. These termination of pregnancy providers were cognisant of different social or economic circumstances faced by women and that led to the request for terminations. Unplanned pregnancies because of abusive relationships were considered legitimate, and made it easier to cope. In rare instances where women decided to continue with the pregnancy after the mandatory one-on-one counselling, the termination of pregnancy providers expressed relief, even though they emphasised in the interview that that they 'respected the final choice and decision of the client'.

A few providers believed that termination of pregnancy provision was a calling from God. They reported that prayer gave them strength, and they coped by going to church, listening to gospel music and sharing with some church members who knew about the work the participant does at the hospital.

He (God) *supports me and that is the reason why I am content with my job, because I feel that I have his support.* (Respondent 4 North West Province).

Basically, one must pray very hard for God to help you go through everything. (Respondent 30 Gauteng Province).

Others that expressed no religiosity also reported that they drew strength from prayer. They believed that God wanted termination of pregnancy to happen safely, and this gave them comfort. Some study participants found comfort from listening to religious songs. In addition, providers reported that 'God loved them so much' that help would emerge in time of need for clinical intervention with a difficult TOP. An example given was with the difficulty of performing the termination of pregnancy on one young woman, and refusal by the ward doctor to assist. Eventually, a medical specialist assisted, and the provider believed that this was God's intervention.

Study participants also reported the contradictory behaviour of some community members, including religious leaders, who judged them for the service they provided, yet on a few occasions discreetly sought termination of pregnancy services for their family members. Providing TOP to this judgemental group was taken to be 'God's sign' that they should continue providing the service, while *'saving women from backstreet abortion'.*

6.4 Discussion

This study was one of the first in South Africa to examine the coping strategies of termination of pregnancy service providers within the context of universal health coverage (54). These providers reported a combination of coping methods, which included both positive strategies such as support seeking, professionalism and self-control, as well as negative or maladaptive coping such as silence and concealing emotions, work avoidance, and treating women in a disparaging and at times judgemental manner.

In this study, termination of pregnancy providers sought support from colleagues, especially those providing similar services, sympathetic managers, and using debriefing sessions,

sometimes at their own cost. Studies in other countries, albeit in different settings, have also found that seeking social support was one of most utilised coping strategies (244-247). Another South African study also found that collegial support between termination of pregnancy providers enhanced coping (175). However, given that the termination of pregnancy providers often work alone in facilities there may be a risk of ineffective, inadequate and inconsistent collegial support (77, 175, 225). Combined with negative attitudes towards abortion providers, working alone without collegial support, could worsen the shortages of willing and competent termination of pregnancy providers, which in turn may impact on safe abortion service provision (77, 108, 240).

Scholars have pointed out that coping strategies are influenced by culture and context (248, 249). Some termination of pregnancy providers reported maladaptive coping strategies such as silence and concealing emotions, work avoidance, judgemental behaviour and the ill-treatment of women seeking abortions. The use of silence and concealed emotions could be because of their experiences of courtesy stigma from other colleagues and their managers (225). This was also found in a Ghanaian study that found that obstetricians misclassified or concealed abortion provision for fear of judgement by colleagues, family and society (101).

Tankink and Richters (2007) have pointed out that silence operates at different levels and is closely linked to social ethics and values of, and dominant attitudes in society (250). Notwithstanding South Africa's enabling legislation, abortion remains a contested topic, with reports of societal stigma; poor quality of care in the public health sector; scarcity of willing and competent termination of pregnancy providers; and unscrupulous individuals who are neither competent nor permitted by law to perform abortions (5, 251). At the individual level, the use of silence depends on a person's position in that society, and is influenced by role, age, gender, ethnicity and class (252). Hence, the termination of pregnancy providers' silence and concealment of emotions could be explained by this societal form of 'cultural censorship' (125).

The provider silence could also be because of the reported provider ambivalence towards termination of pregnancy provision, with some influencing women to continue the

pregnancy, while others thought that some women have repeat abortions and were ‘abusing their rights’. Other studies in sub-Saharan Africa found that nurses and midwives tend to withdraw and neglect their caregiver responsibilities because of judgemental attitudes towards termination of pregnancy clients (125, 253, 254).

Providers also reported numbness and staying away from work, in order to cope with the emotional burden of termination of pregnancy provision, the judgemental attitudes from colleagues and perceived unrealistic requests from women seeking abortions. Another study in South Africa found that courtesy stigma contributed to provider disengagement from service provision (75). This courtesy stigma was confirmed in a systematic literature review on health care providers’ attitudes on induced abortion in Sub-Saharan Africa and Southeast Asia (70).

Termination of pregnancy providers’ narratives of the emotional burden experienced should be seen in the context of their levels of compassion fatigue (240), exacerbated by their expressed loneliness (225). Other studies in South Africa have also found that termination of pregnancy providers felt drained emotionally because they have to manage both the demands and challenges of TOP provision (77, 136, 166). Given the criticality of TOP providers to access to sexual and reproductive health services, the health care system cannot afford to lose the few committed and willing providers.

The limited employee wellness programmes, and where available, the avoidance of institutional support found in our study are of concern. More comprehensive occupational health, safety and wellness programmes are needed, as part of positive practice environments (177).

Religion or prayer reportedly enhanced providers’ ability to cope with termination of pregnancy provision. Other studies in South Africa have found that religious beliefs produced contradictory views on the implementation of CTOPA (125), with some providers supporting and providing termination of pregnancy whereas others have used these beliefs to justify conscientious objection and refusal to provide termination of pregnancy (75).

At the same time, scholars have found that religion is one of the predictors of positive coping mechanisms (255, 256), and that religion plays an important role in attaching meaning to people's actions, as well as life's ambiguities and contradictions (250). Religion also helps to reduce the emotional burden or pain (257). In this study, religion may serve to make termination of pregnancy provision bearable in the face of the providers' own ambivalence, the courtesy stigma experienced, and the lack of management support.

The study is limited by the small number of interviews conducted, and being conducted at a particular point in time. However, there are many study strengths. Firstly, it is one of the few studies to focus on the coping strategies of TOP providers in South Africa, in the Sustainable Development Goals era (54). Secondly, the in-depth interviews were conducted as part of a larger study on the psychosocial issues faced and experiences by termination of pregnancy providers in an African country, thus contributing to knowledge gaps on the topic. Thirdly, the interviews had something of a therapeutic function, and gave voice to providers. In some instances, study participants asked the principal researcher to stay on after the completion of the formal interview. This happened mostly at facilities where the manager was also a termination of pregnancy provider and in few instances where there were more than one provider. Many of the providers interviewed said that they found the interview useful as it helped them to discuss their feelings and experiences. Although the researcher gave providers the option of referral for psychological support, they all declined, suggesting that the ability to talk to an independent researcher was sufficient and therapeutic. However, this is unacceptable in a health care setting, as the researcher was there for the specific purpose of the study. Hence, a more formal termination of pregnancy support programme is necessary.

6.5 Conclusion

This study generated new knowledge on the complex, and overlapping coping strategies used by termination of pregnancy providers in two South African provinces. Despite an enabling legal framework in South Africa which is uncommon in many low and middle - income countries, management support is inadequate, and employee wellness programmes are

insufficient. Both the ICN and WHO have advocated for positive practice environments, which should include, but not be limited to strong management support, minimum staffing norms to reduce isolation and loneliness, and regular and supportive debriefing sessions that enable providers to share their experiences and/or good practices at health facilities (64, 177). Ultimately, the provision of good quality termination of pregnancy services depends on competent and willing health care providers who are retained and supported within the South Africa's public health sector.

6.6 Acknowledgments

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6.7 Disclosure

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CHAPTER 7: AVAILABILITY, REPORTED UTILISATION AND MANAGEMENT PERSPECTIVES ON PSYCHOSOCIAL SUPPORT PROGRAMMES FOR TERMINATION OF PREGNANCY PROVIDERS

7.1 Introduction

Universal access to sexual and reproductive healthcare services, including abortion services cannot be achieved without competent, committed and responsive health care providers (54, 258). However, the discourse on abortion and health care providers has been largely negative, often focusing on those providers who are refusing to deliver abortion and other sexual and reproductive health care, because of the grave consequences for women seeking abortions (95, 97, 104, 259). Hence, there is a significant body of literature on the negative attitudes of health care workers and the reasons they do not provide or cease provision of termination of pregnancy (TOP) services (70, 74, 100-103).

Notwithstanding the sociocultural and political contestations regarding abortion or termination of pregnancy (TOP), an increasing number of scholars have highlighted the duality between women's equitable access to abortion services and the challenges faced, and support needed, by health professionals in providing such access (84, 103, 113, 260). Studies have found that TOP providers face stigma, harassment and violence and they fear repercussions from colleagues, friends or family (84, 129, 142, 225). TOP providers hold complicated feelings and attitudes about both abortion and the women they serve (74, 240, 261, 262). The "emotional labour" of dealing with women seeking abortions and the abortion workload on a relatively small number of health care providers exacerbate occupational stress, including burnout and secondary traumatic stress (164, 169, 227, 234, 240). Many providers cope with these challenges through positive beliefs that their work is valuable and that it contributes to women's well-being (94, 144, 225, 240), while some TOP providers engage with women undergoing abortion in different ways, ranging from emotional investment to emotional detachment, with the latter facilitating treatment of more challenging patients (261, 263). In South Africa, a few studies that have focused on providers

have found that the stress experienced by TOP providers, combined with the burden of care provision, loneliness and courtesy stigma, are made worse by the lack of management support (77, 175, 225, 264).

The manager's role in creating an enabling work environment has been highlighted as a key strategy in improving health workforce performance, which in turn enables the achievement of health system goals (258). Although there are methodological difficulties in establishing clear links between human resource management (HRM) and health workforce performance, studies in different settings have found that a combination of management or supervisory support, enabling practice environments, and good supervisor-supervisee relationships promote positive health workforce outcomes such as job satisfaction and retention (186, 260, 265-270). A systematic review in the United Kingdom health system has found that there is a positive correlation between human resource management (HRM) practices and employee outcomes (e.g. job satisfaction, reduced absenteeism and improved health), patient outcomes (e.g. quality of care) and organisational change (271).

However, there is a dearth of research on the HRM of, or management support for TOP providers, the narratives of institutional managers on abortion, and how these managers might facilitate or constrain access to TOP services. There is also insufficient knowledge on whether specific psychosocial support programmes or interventions are available for TOP providers to assist them with their work. A 2005 South African study to conduct values clarification among different stakeholders that included health facility managers, found a slight change of attitude among participants towards abortion provision among the participants that were ambivalent initially (272). However, the 2005 study is quite dated, and did not focus on TOP providers, the availability of psychosocial programmes or management perspectives on abortion.

It is against this background that this paper examines the availability and reported utilisation of psychosocial support programmes for TOP providers and the mechanisms that exist within health facilities in two South African provinces to support TOP health providers with their work. The paper also explores the perspectives of managers at these health facilities on support to TOP providers.

7.2 Methods

During 2014 and 2015, we selected all designated TOP facilities in the two South African provinces of Gauteng, an urbanised province, and North West, a mixed rural - urban province (273). These designated facilities are defined as stand- alone or integrated sexual and reproductive public health facilities, certified by the national Department of Health, to provide TOP services (4). The details of the TOP facilities have been described in a previous article (225).

The Human Research Ethics Committee (Medical) of the University of the Witwatersrand in Johannesburg provided ethical approval for the study. The relevant public health care authorities and facility managers also provided the necessary study approvals. All study participants provided written, informed consent, and we adhered to standard ethical procedures, which included voluntary participation, confidentiality and anonymity of responses.

The principal researcher (MT) visited each of the designated facilities in the two provinces to determine the availability of psychosocial support programmes, the utilisation of these programmes, and the perspectives of facility managers on appropriate support systems for TOP providers. At each of designated facilities, the relevant manager completed a short self-administered questionnaire that focused on the number of TOPs performed at the facility, TOP facility staffing, workload, the availability of a psychosocial support programme, the type and frequency of the programme and whether the TOP providers utilise the programme. The principal researcher also conducted a semi-structured interview with each facility manager (in the case of community health centres), or the manager responsible for TOP

services (in the case of hospitals). The questions focused on: strengths and weaknesses of the existing programmes, organisational and managerial support systems for TOP providers, the roles of these facility managers in the provision of psychosocial support to TOP providers, managers' perspectives of whether psychosocial support programmes were needed for TOP providers (in those facilities with no programmes) and their recommendations on appropriate support programmes.

Each interview lasted an average of 35 minutes, ranging from 30 to 60 minutes depending on the responses and extent of engagement of participants.

The principal researcher captured the information from the self-administered questionnaires onto a Micro Excel spreadsheet to perform basic descriptive analysis.

Each recorded interview was transcribed verbatim, and the principal researcher checked the correctness of the transcribed interviews against the original recordings. We used interpretative phenomenological analysis (IPA) to analyse the interviews (213, 214). To ensure reliability, two researchers (a clinical psychologist and the PhD supervisor (LR) participated in the development of the themes by reading three interviews independently from the principal researcher in order to establish inter-coder agreement (242, 243). Firstly, each person read the transcript in the participant's own words and phrases, without defined concepts or classifications. We further examined the language each manager used in their response to the questions. The team discussed the themes that were generated independently, and then reached agreement on the final themes and sub-themes. Once agreement was reached on the themes, the principal researcher analysed all the interviews in relation to the generated themes.

7.3 Results

Fifty facility managers participated in the interview, representing a 98% response rate (Gauteng = 27; North West = 23). The majority of facilities (43/50 = 86%) provided first trimester TOP (Gauteng = 21; North West = 22), and the remaining facilities provided both

first and second trimester TOP (Gauteng = 6; North West =1). In North West Province, the mean number of TOPs performed per day was four (SD = 4.7), with a range of one to 14. In Gauteng Province, the mean number of TOPs performed per day was seven (SD = 6.7), with a range of two to 18.

7.4 Availability and utilisation of TOP support programme

In both Gauteng and North West provinces, the majority of managers reported that there were no dedicated facility-based psychosocial support programmes for TOP providers (Table 7.1). In Gauteng Province, two out of 16 hospitals (12.5%) had a psychosocial support programme, and in North West Province, only one out of 10 (10.0%) hospitals had a support programme. In both provinces, there were no psychosocial support programmes at the community health centres. Despite the relative lack of dedicated facility-based support programmes, Gauteng managers reported that there were monthly psychosocial support programmes available, while in North West, there were quarterly support programmes available.

In Gauteng only, there were clinical review meetings at district level that focused primarily on clinical issues. The TOP providers attended these meetings together with providers of other health services (such as child health, or tuberculosis).

In both provinces, managers also reported that there were provincial debriefing meetings, offered as an off-site programme to TOP providers, using a private provider (s). The managers were not clear on the details or frequency of the sessions: some “thought” or heard from the providers that it was once or twice a year, and others said it happened “every now and then”.

Table 7. 1: Availability and utilisation of TOP support programme in Gauteng and North West Provinces

Indicator		**Gauteng**	**North West**	**Total**
Availability of	Facility support programme			
	Hospital	2/16 (12.5%)	1/10 (10.0%)	3/26 (11.5%)
	Community health centre	0/11 (0.0%)	0/13 (0.0%)	0 (0.0%)
	Monthly support programme	X	–	
	Quarterly support programme	–	X	
	District clinical review meeting	X	–	
	Provincial clinical review meeting	–	–	
	District clinical debriefing meeting	–	–	
	Provincial clinical debriefing meeting	X	X	

7.5 Management perspectives on psychosocial support programmes for TOP providers

Although inter- related and overlapping, the three major themes that emerged from the interviews were: ambivalence; indifference; support and empathy towards psychosocial support for TOP providers. These themes and sub-themes are listed in Table 7.2 and described separately for clarity.

Table 7.2: Management perspectives on TOP provider's psychosocial support programme

Theme	Sub theme
Ambivalence	• Dilemma created by managers' own views on TOP support vs recognition of provider stress • Uncertainty/ doubt about the adequacy or benefit of the support provided
Indifference	• Lack of TOP prioritisation • Provider victimisation • Negative attitudes towards TOP • Refusal to acknowledge that TOP provider support is a management function • Unaware of any support mechanisms
Support and empathy	• Empathy as previous TOP provider • Recognition that provider support is a management responsibility • Identify gaps in available support • Advocacy for a psycho-social support programme

7.5.1 Ambivalence

Some of the managers talked about their ambivalence of managing TOP providers and overseeing TOP programmes, given their own views on TOP. One said that: '*religion is sometimes a barrier for some of us and this can suffocate the support mechanism to TOP providers'* (Respondent 5 North West Province). Others talked about TOP provision as '*it is like they are killing people… you would not sleep if you had a conscience'* (Respondent 44 Gauteng Province), while at the same time acknowledging that the need for some kind of support to the providers. One said: '*Providers need to be supported due to the trauma... it is not nice to kill someone's kid.'* (Respondent 16 Gauteng Province).

These managers that expressed ambivalence acknowledged that on some occasions, they were aware of TOP provider shortages, but they would re-allocate staff from the TOP unit to support other services, thus undermining provision of TOP services, and adding to the stress of the providers. During the interview, one reflected on an incident as follows:

> *…we have this weakness here at (*facility name) *that even though we are aware of the TOP staff shortage, we sometimes remove the enrolled nurse that often works with X (TOP provider) to help elsewhere. We (management) often told ourselves that the job of an enrolled nurse was just for record keeping and helping out here and there… until he exploded with anger. As his manager I was surprised and shocked. It was then that I realised he has always harboured his pain inside for days and he always misled us into thinking he was ok when he was actually not.* (Respondent 10 Gauteng Province).

They also reported that they mostly engaged TOP providers to address complaints or problems on services but did not ask them about their psychosocial needs.

The ambivalence also related to a perception of these managers that they might open a proverbial can of worms of TOP provider emotions if they talked or asked about psychosocial support. One said: '*if there is no problem then you tend not to go there* (provider support).' (Respondent 32 Gauteng Province).

These "ambivalent" managers were also doubtful about the benefit of a psychosocial support programme for TOP providers and did not see a link between absenteeism and possible occupational stress. Some were of the opinion that the TOP providers should manage their workload and develop their own weekly meetings to support each other.

> *I do understand that the work that she does can be very difficult at times but because the work has to be done... she also has to develop her own coping mechanism and not always pile herself up with work... she needs to develop a schedule and develop weekly targets because otherwise the absenteeism is as a result of her struggling to cope with her work…*

seeing that there is only one provider that does TOP alone. At times she is off -sick and no one fills in for her instead we ask them (TOP clients) *to go to the nearest facility.* (Respondent 31 North West Province).

These managers disassociated themselves from the development of a support programme for providers, putting this responsibility on the provincial employee assistance programme, the district, and the individual TOP provider.

7.5.2 Indifference

The second theme on indifference included refusal to respond to the questions from the researcher, lack of knowledge on any support mechanisms, the lack of TOP prioritisation, negative attitudes to TOP provision, victimisation of providers, and refusal to acknowledge that TOP provider support is a management function. In some instances, these indifferent managers either reported that there was no psychosocial support mechanism for providers or they did not know whether a support programme existed.

In the few cases where some kind of support programme existed, these managers did not have information on the type, timing, person responsible and the level at which the support was provided. Their responses on who provides the support programme for providers vacillated between uncertainty and lack of interest, using phrases like *'that's one of the questions I won't be sure to answer'* (Respondent 50 Gauteng Province), or '*What I can say is that at the moment we don't have a structured way of assisting them, they are on their own.'* (Respondent 21 North West Province).

These indifferent managers tended to evade the questions, often referring pertinent questions about the psychosocial support to the person directly supervising TOP providers.

I haven't gone that route to find out (about the provider's psychosocial support) *because… perhaps this question would have been better answered by the person supervising the providers directly.* (Respondent 9 North West).

I don't have a specific role - after all they have a manager that side, and as for me I just oversee the area. (Respondent 28 Gauteng Province).

These indifferent managers expressed their negative attitudes towards TOP. During the interviews, these managers frequently referred to TOP as *"this thing"* and TOP providers as *"these people"*. They considered requests for equipment for TOP provision as unreasonable. One said: *'To be honest with you, this provider is already labelled as troublesome. We never had problems with the previous provider. Why does this one want her own equipment? All others previously borrowed from the nearby wards?'* (Respondent 47 Gauteng Province).

These managers also refused to acknowledge that the psychosocial support TOP providers, whether directly or indirectly, was part of their function as managers. These managers were of the opinion that it was the providers' responsibility to ask for support, or to be referred to the employee wellness programme or to the social worker.

In some cases, these indifferent managers shifted the blame onto the senior management of the health facility, and claimed that their inability to support TOP providers was because of the lack of TOP prioritisation by senior management. They made reference to the alleged victimisation by senior managers of TOP providers, and related an incident where a provider was '*nearly beaten up by the matron* (executive nursing manager) *because she* (the TOP provider) *was refusing to move to a smaller space which would mean that the TOP patients had to wait in a queue in the corridor.'* (Respondent 34 Gauteng Province).

7.5.3 Support and empathy

Support and empathy was the third theme that emerged from the managers' responses. Included in this theme was the recognition that TOP provider support is a management responsibility, that TOP provision was stressful, that there were gaps in the existing support mechanisms, and that there should be some form of psychosocial support programmes for TOP providers. This theme also included the responses of those individuals who served in a dual role as facility managers and providers, or who worked previously as TOP providers.

As a person who understands TOP service provision, having been a full-time provider myself I will say if the management is not buying it (support for TOP provider)*, then nobody will support providers. We as management get pressure from the province to submit the statistics. TOP providers are just thrown there you know… and then end up using their own resources which they will never get from the government like airtime. They* (TOP providers) *are using their own airtime phoning the clients.* (Respondent 40 North West Province).

The intensity and need for support were reiterated by another hospital manager who said:

It (TOP provision) *should not be the provider's problem. One does not have to own the programme, there must be enough manpower to relief and the sick provider can have time out to get well. It becomes a burden, this is not our service but the Department of Health's. They initiated the service because of the need. There must be support to providers*. (Respondent 5 North West Province).

A manager from North West manager shared her concern and said: *'I think our provider needs it* (psychosocial support)*, especially when she sees young children e. g 12 year old coming for TOP. It must be traumatising for her. Normally when I see a child coming for TOP, I check the file and speak to the provider to see if she is not traumatised.'* (Respondent 34 North West Province).

These managers recognised that their responsibilities as managers were to ensure the creation of an enabling environment for providers. They reported that they offered whatever measure available to support the TOP providers who had increased workloads due to the refusal of other trained staff to support the service, and the observed harassment and threats towards the providers. The reported support included allowing the provider some time to rest, meeting with the provider, rotation from TOP unit on request, calling the police in case of harassment by the client's partner, using clinical team meetings, and referral to the employee assistance programmes. One manager in North West reported that, as a way of

allowing time to rest, she discouraged a "*hardworking and flexible provider"* from assisting with other activities at the facility. Another manager showed support by taking over TOP provision when the provider seemed overwhelmed or re-allocated the provider from the TOP unit on request.

> *…last year one of the providers was all by herself, she was a nursing sister and she asked to be removed from TOP procedures and I could feel from when I was listening that she was no longer happy, and she was saying that TOP was too much for her and I had to remove her.* (Respondent 12 Gauteng Province).

Ten managers were aware of the gaps in the existing psychosocial support to TOP providers, as well as the providers' reluctance to use the limited existing programmes. As the interviews progressed, some managers started to advocate for a support programme that would overcome the current weaknesses, and address TOP provider psychosocial needs. The dual managers-providers suggested mechanisms that they thought would be helpful for TOP providers. They recommended joint development of the support programme by TOP providers, facility management and sub – district management; and that type of programme should be varied and include organisational employee assistance and wellness, values clarification workshops, group sessions, peer support, symposia for TOP providers only, and individual debriefing sessions by clinical psychologists that should be available on and off site.

7.6 Discussion

This is one of the first studies that focused on the availability of psychosocial support programmes for TOP providers and the mechanisms that exist within health facilities to support TOP health providers with their work. In both provinces, psychosocial support programmes were only available at a minority of hospitals (3/26 or 11.5%) when combined. There were no reported support programmes at community health centres, despite TOP being provided at this level. Yet, the World Health Organization (WHO) has advocated for safe abortion care at the primary health care level in order to improve access (68). Outside the

health facility level, the support to health care providers of TOP services was limited to clinical meetings. The WHO has underscored the importance of strengthened health systems and a competent and responsive health workforce to ensure universal access to sexual and reproductive health-care services (274). The study findings suggest both lack of prioritisation of TOP services and of support to existing health care providers. The WHO has pointed out that such lack of prioritisation exacerbate staff shortages for TOP services, and it becomes a vicious cycle (68). In light of the global outcry on the refusal of the majority of health care providers to provide abortion services (259), the study findings highlight the need for urgent action by the two provincial health departments to ensure some kind of employee assistance programme to the few willing TOP providers.

The interviews with facility managers revealed a complex and contested picture. The majority of managers expressed ambivalent or indifferent opinions on the psychosocial support programme for TOP providers, influenced by their own negative and judgemental views of abortion. This lack of management support in turn exacerbates the lack of psychosocial support programmes at health facility level. The lack of management support also influenced access to resources at health facility level, whether of additional staff, equipment, time-off, and the willingness of other providers to provide TOP services. Other studies have also found that lack of management support, infrastructural constraints and lack of willingness by colleagues to support the few willing providers, undermine TOP providers and marginalise their psychosocial needs (175, 225, 240). These in turn influence the willingness of these TOP providers to continue with abortion provision, as they fear putting strain on their relationship with the manager and/or co- workers (92, 129).

Other studies have also found that supervisory support led to improvements in TOP providers' clinical skills and in improved quality of post-abortion care (275, 276). However, the vast majority of studies focus on the health care provider's role in ensuring access to sexual and reproductive health care (49), enabling reproductive rights and justice (277, 278), and ensuring access to safe abortion care (52, 68, 92, 279, 280). In many studies, the health care provider is often portrayed as a barrier to women accessing safe abortion care (70, 74, 281-283). We could not find studies that have demonstrated the links between increased

psychosocial support programmes for existing TOP providers, and increased access to TOP services. This is an area for future research. Nonetheless, we recommend that the psychosocial needs of existing TOP providers should be prioritised in tandem with addressing the negative attitudes of those health care providers that refuse to provide abortion services.

In this study, those managers who indicated support for abortion services or for TOP providers fulfilled a dual role of manager and TOP providers, or they were previous TOP providers. Unfortunately, they were in the minority. Nonetheless, there are important lessons that can be learned from these few managers. These lessons include recognition that support to providers is a management responsibility which includes supportive supervision, provision of the necessary resources and/or task-oriented support; an acknowledgement of the stress experienced by TOP providers and their need for psychosocial support; the willingness to ensure the availability of psychosocial programmes, within a resource constrained environment. At a minimum, these managers have demonstrated the value of improved supervisory support to TOP providers, even if just by asking about the well-being of TOP providers. The perceived effectiveness of supervision was found to enhance the psychosocial wellbeing of those being supervised (284).

The elements of job demand control support model could provide a useful approach in an abortion setting to develop appropriate psychosocial support programmes for TOP providers (120, 225, 285). This would necessitate specific strategies to take account of the South African context, and as a minimum should include: allowing TOP providers to participate in their work scheduling, within a conducive environment that allows privacy for both provider and client, that is well resourced to facilitate quality service provision, with adequate support from managers and co-workers to promote provider sense of control and responsibility for TOP service provision.

The inadequate psychosocial programmes at hospital level, the lack thereof at community health centres, and the management indifference and ambivalence to these TOP providers psychosocial programmes availability undermine the WHO emphasis on the need and

responsibility of health systems to provide quality abortion services (279). Our study findings suggest that policy makers should prioritise abortion services, and the development of TOP provider psychosocial support programmes. Value clarification workshops need to be introduced for both managers and health care providers, including training on their legal responsibilities in terms of CTOPA.

This study limitation is its cross-sectional nature, as it was conducted at a point in time. Nevertheless, the study has many strengths. To start with, the visits conducted at all designated facilities allowed the researcher to observe the intersection of numerous factors that influence provision of abortion services. The high response rate of 98% among the facility managers is encouraging. This study is one of the few studies that explored the opinions of facility managers opinion on the availability of psychosocial support programmes for TOP providers in the two provinces. This enabled a conversation, or at the very least, raising awareness of the need for provider psychosocial support programmes.

Some of these managers reported that the interviews made them think about their role in the provision of the psychosocial support for these providers, thus encouraging some kind of reflection on their management roles and responsibilities.

7.7 Conclusion

This study has generated new knowledge on the availability, reported utilisation, and management perspectives on psychosocial support programmes for TOP providers in two South African provinces. The scarcity of the TOP providers' support at the designated facilities, the reported ambivalence or indifference of the majority of managers towards the psychosocial programmes for abortion providers undermine the efforts of the few willing TOP providers. This study points to the importance of facility management's understanding, support and prioritisation of abortion and TOP providers, as an essential element of positive practice environments.

CHAPTER 8: DISCUSSION AND RECOMMENDATIONS

8.1 Introduction

The dominant discourse in abortion provision has been on health care providers as obstructionist gatekeepers with negative attitudes towards women (259). Undoubtedly, women's rights, access to SRH services, professional ethics and the obligations of health providers are of critical importance, especially in the context of UHC (54, 65, 259). At the same time, investment in HRH is crucial for the provision of safe abortion and post-abortion care (64, 65). Hence, the abortion discourse should also be about caring for the willing and competent health care providers that enable women's access to care (108, 165).

More than two decades after the promulgation of CTOPA in South Africa, my PhD study has generated new knowledge on compassion satisfaction and compassion fatigue among abortion providers in Gauteng and North West provinces, their coping strategies, and the availability of psychosocial support programmes, thus contributing to a positive discourse on HRH and abortion provision.

In this concluding chapter, I have integrated and discussed the key findings of this thesis (Chapters 4 to 7) and proposed recommendations for enhanced psychosocial support for TOP providers. In Section 8.2, I have summarised and discussed the key findings and recommendations of the PhD study. In Sections 8.3 and 8.4, I have highlighted the scholarly contribution and policy impact of the PhD respectively. Section 8.5 contains recommendations for further research.

8.2 Key findings and discussion

The key findings that emerged from this PhD study are shown in Table 8.1 and discussed further below in line with the study objectives (Chapter 1) and the conceptual framework (Chapter 3).

Table 8.1: Summary of key PhD findings

• TOP providers reported intense experiences of loneliness and courtesy stigma aggravated by health system deficiencies, with 77% of the 61 designated facilities providing TOP services (Gauteng =28/32; North West = 19/29). The providers were also affected by a lack of prioritisation of TOP services and insufficient or lack of management and collegial support

• The survey revealed a complex picture with regard to compassion satisfaction and compassion fatigue (burnout and secondary traumatic stress) among TOP providers
  • The survey among TOP providers obtained a 98% response rate
  • The majority of respondents were nurses (70.9%), female (82.0%), married (47.6%), with a mean age of 43.4 (SD=8.7).
  • Overall mean score for compassion satisfaction was high at 42 (SD 5.5). The predictors of compassion satisfaction were: finding work stimulating, the belief in making a difference, enjoying relationship with other nurses and years of TOP service ($p<0.05$).
  • Burnout mean scores were average at 33 (SD=4.0), with the belief in helping women to make informed choices a marginally significant predictor of burnout.
• Overall mean score for secondary traumatic stress was 23 (SD 6.8). Significant predictors of secondary traumatic stress scores were: finding work stimulating, the belief in women's rights, the belief in allowing women informed choices, age and gender

The 30 TOP providers interviewed reported both:
  • Positive coping strategies that included support seeking, self-control, and professionalism
  • Negative coping strategies that included silence and concealing emotions, work avoidance, judgemental and ill treatment of women seeking abortion

Psychosocial support programme for TOP providers were inadequate   • The interviews with managers revealed that only two out of 16 hospitals (12.5%) in Gauteng Province and one out of 10 (10.0%) in North West Province

had a psychosocial support programme for TOP providers, with no reported programmes at any of the community health centres

- The vast majority of managers interviewed reported ambivalence or indifference to abortion and to the psychosocial needs of TOP providers.

8.2.1 TOP providers' psychosocial issues

A key objective of this PhD was to examine the psychosocial issues experienced or faced by existing TOP providers, and to generate new knowledge on the demographic characteristics of these providers, their workloads, professional quality of life (PRoQOL), and organisational factors such as management and/or peer support within the context of the public health sector in the studied provinces of Gauteng and North West. I used the conceptual framework presented in Chapter 3 (81, 186, 286) and a combination of quantitative and qualitative methods to answer this research objective.

The PhD study found high mean scores of 42 for compassion satisfaction, and this is encouraging. Those TOP providers that found their work stimulating and were of the opinion that they made a difference had higher compassion satisfaction scores (240). My PhD was one of the first studies that had used the PRoQOL tool and that examined the relationship between compassion satisfaction scores and the philosophical reasons for working as TOP service providers. I could not find similar studies in South Africa or elsewhere, hence I do not have other studies to compare my study findings with. In the indepth interviews with a sub-set of TOP providers they reported intense experiences of loneliness and courtesy stigma, from other colleagues and managers (225). Studies in the USA and Denmark that also used PRoQOL among abortion providers found that these providers reported higher compassion satisfaction scores compared to other health care providers, but that abortion stigma was a significant predictor of lower compassion satisfaction (113, 234). I did not measure abortion stigma in my PhD, and I did not examine the relationship between perceived abortion stigma, and compassion satisfaction, hence these areas require further research in the South African context.

Those TOP providers who enjoyed collegial relationships with other nurses experienced higher compassion satisfaction. Although scholars have highlighted the importance of collegial support in abortion provision in qualitative studies (166, 170, 287, 288), I could not find other studies that have quantified this relationship. Nonetheless, the JCDS model, which I have used as a conceptual framework (Chapter 3), posits that collegial relationships are beneficial resources to employees as such relationships make it easier to do a difficult job or to draw on support when needed (186).

The finding in my PhD that those health care providers with less than one year TOP service experience had lower secondary traumatic stress (STS) could suggest that those providers with more years of service experience more negative effects of TOP provision. This is contrary to studies in Australia that found that abortion providers with a few years of service of TOP provision had higher anxiety levels compared to older nurses (235). However, these studies used qualitative methodology and did not measure these relationships empirically. This study finding could mean that the health system constraints in South Africa's public health sector, the pressure on the few willing providers and inadequate or lack of management support may influence the compassion satisfaction of TOP providers as time passes. A systematic review among health providers in Sub- Saharan Africa and South-East Asia on the reasons for non-provision of TOP services found that providers stopped abortion services due to stigma and lack of support from managers and co-workers (70). Although this systematic review did not focus on compassion satisfaction, my study finding makes intuitive sense that TOP providers with long service have lower compassion satisfaction (or derive less pleasure from doing abortion). Nonetheless, further studies with a larger number of TOP providers are needed to determine whether there is an inverse relationship between their compassion satisfaction and years of abortion service provision.

The TOP provider survey found that the burnout and secondary traumatic scores were average. However, a sub-set of these TOP providers reported a heavy burden of care

provision, and intense loneliness when they were interviewed. The discrepancy between the quantitative survey among TOP providers and the qualitative interviews with a sub-set of these providers, could be related to sampling (both method and number of study participants), the cross-sectional nature of the study, social desirability bias (199), and/or the PRoQOL tool. Nonetheless, together these two study components paint a complex picture of abortion provision in these two South African provinces. Martin *et al* have argued for recognition of this complexity, rather than simple categorisation (130).

The survey found that TOP provision in the urban, relatively well-resourced province of Gauteng, a belief in women's rights, and finding the work stimulating were protective factors (Chapter 5). This might be because of greater emphasis and/or awareness of women's rights in the urban province of Gauteng, and could explain why this is a protective factor. The finding that TOP providers' beliefs in the rights of women were a protective factor for secondary traumatic stress suggests the importance of a HRH narrative that celebrates those providers who fulfil their professional and ethical obligations, and who ensure women's access to SRH services, in line with global commitments (54).

The complex and overlapping psychosocial issues faced by TOP providers cannot be seen in isolation of the health system constraints that my study uncovered. Although more than three quarters (77%) of designated facilities were providing TOP services in the two provinces, a larger proportion of designated facilities were providing TOP services in the urban province of Gauteng (87%), compared to the mixed urban-rural province of North West (65.5%). In both provinces, TOP provision is reliant on an ageing, female workforce, working in isolation, with little support from managers or other colleagues. Combined, these are warning signs that should be addressed at both health policy and practice levels.

There are several recommendations that flow from my study findings, and which I have elaborated on below. These include greater prioritisation of abortion provision in line with

the enabling legislation in the country, addressing health system constraints, the creation of positive practice environments, and employee assistance programmes that enhance compassion satisfaction, and reduce burnout and secondary traumatic stress.

8.2.2 Coping strategies of TOP providers

Abortion provision is stressful, often described as difficult emotional labour (165). It remains contested, even with liberal abortion laws as is the case of CTOPA in South Africa (4). Given my work experience, my own ambivalence, and my positionality highlighted in the foreword, I was interested in how the TOP providers get up in the morning, go to work and perform abortions on a daily basis. Hence, another key objective of my PhD was to explore the coping strategies of these providers in the two studied provinces.

As was the case with the psychosocial issues experienced by TOP providers, the narratives of those interviewed revealed multifarious and seemingly contradictory coping strategies (Chapter 6). Some scholars have pointed out that individuals in stressful situations or occupations use different coping strategies simultaneously (289, 290), and these coping strategies are both context and culture-specific (252, 291, 292).

In my study, some TOP providers interviewed reported positive or adaptive coping strategies, which included self-control, professionalism and seeking support, whether from other colleagues, sympathetic managers and/or debriefing or counselling sessions. Other studies, one in 2008 in South Africa (175), and in other countries have also found that seeking social support was one of the most utilised coping strategies (153, 287, 288, 293, 294).

The TOP providers interviewed also reported so-called negative or maladaptive coping strategies that included work avoidance, and judgemental and ill-treatment of women seeking abortions. Another study in South Africa found that courtesy stigma contributed to provider disengagement from service provision (75). Researchers in the USA have also

found that abortion care providers used avoidance as a coping strategy in order to alter or resist negative attitudes about being a provider, thus avoiding courtesy stigma (169), while some recounted their difficulties of being non-judgemental all the time (130, 166).

In my study, providers also reported silence as a coping strategy. This could be related to their experiences of courtesy stigma (225), and/or their expressed ambivalence regarding TOP provision (Chapter 7). The use of silence as a coping strategy was also found in another 2006 study among nurses in South Africa (125), and in a study in Ghana to avoid judgement by colleagues, family and society (101). Studies among abortion providers in the USA (84, 113, 144, 172) and in Wales (295) have found that silence assists in dealing with abortion stigma and the fear of harassment and violence, and prevents them from making judgemental comments about women seeking abortion services (295).

My PhD study found that religion or prayer reportedly enhanced providers' ability to cope with TOP provision, and could assist in dealing with their own ambivalence, the courtesy stigma experienced, and the lack of management support at health facilities. However, other studies in South Africa have produced contradictory findings on religious beliefs and the implementation of CTOPA (125) (75). More research is needed on strategies that encourage positive coping strategies among existing TOP providers. Importantly, the public sector cannot afford to lose the few committed and willing TOP providers. Hence a major endorsement is to implement recommendations on positive practice environments (PPEs) (177).

8.2.3 Availability of psychosocial support programme and managers' perspectives

The manager's role in creating PPEs has been highlighted as a key strategy in improving provider well being, health workforce retention, and improved work performance (64). PPEs are critical for health worker well being and patient safety, and can be achieved through professional recognition, supportive structures, management practices, education, and

occupational health and safety programmes (176, 177). Given my background as a public health professional, often working in a management capacity, I have had a special interest in the design of psychosocial support programme for TOP providers in the public health sector. In the absence of sufficient information on existing programmes, two of my PhD objectives were to determine the mechanisms that exist within the health sector to help TOP providers cope with their work, the availability of psychosocial support programmes, and the perspectives of public service managers on psychosocial support and/or programmes for TOP providers (Chapter 1).

There was a general lack of psychosocial support programme for TOP providers, with three hospitals reporting the availability of psychosocial support programmes (Gauteng=2/16; North West=1/10). There were no reported programmes at any of the community health centres, despite the proclaimed importance of PHC to the achievement of UHC in South Africa (78). With the exception of reports on the Providers Share Workshop for abortion (113, 172), there is dearth of studies on specific psychosocial support programmes for TOP or PPEs that focus on the needs of providers.

The vast majority of managers interviewed reported ambivalence or indifference to abortion and to the psychosocial needs of TOP providers, which is deeply concerning, as it adds to the occupational stress experienced by TOP providers. Other studies also found that the lack of management support added to the stress experienced by TOP providers (129), whereas management support made it easier to provide TOP services provision (92).

Drawing on the JDCS model, the lack of management support increases demands on TOP providers, reduces their sense of job control, with negative consequences for providers (186). However, I did not measure the association between management support and the compassion satisfaction and compassion fatigue of the providers. This is an area that requires further research. Nonetheless, my study results suggest that both health policy makers and

health facility managers should endeavour to create a respectful and supportive environment for abortion providers, which will enhance their retention in designated facilities, and enable them to promote safe abortion care (65).

8.3 Recommendations

South Africa has an obligation as a signatory of international human rights treaties and agreements to ensure that abortion services and information are available, acceptable accessible, and of good quality (296). Notwithstanding the noteworthy steps the South African government has taken on the promulgation of CTOPA, and its commitment to respecting, protecting and fulfilling women's sexual and reproductive rights, the Department of Health has not prioritised TOP services. The lack of prioritisation is evident in the virtual absence of TOP in strategic plans (297), failure to deal with the refusal of health professionals to provide abortion services (77), and the lack of an accurate database on designated facilities (63).

In this section, I have drawn on the study's conceptual framework presented in Chapter 1 and the study key findings to propose key recommendations. My recommendations are linked to the elements of a functioning health system: leadership, governance and stewardship; health financing; health informatics; health workforce; health services; and commodities (177, 286, 297), and are directed at three national and provincial government, as well as health facility and individual health professional levels.

8.3.1 National and provincial departments of health

a. Leadership, governance and stewardship

Health authorities have a statutory obligation to provide functional support systems and facility management support. The provision of support begins with clear guidelines and protocols to all health care professionals and health facility managers on TOP as an SRH programme, each cadre's role in the implementation and support of CTOPA, both for the

providers and the service. NDOH should also issue guidelines that distinguish clearly between resistance to abortion provision and conscientious objection for sustainable safe abortion provision (77). The health authorities should have mechanisms in place to monitor that the provision of TOP provider support is in the key performance areas of facility managers at designated facilities. TOP provision requires supportive and empathetic facility managers.

b. Health workforce

The NDoH should re-institute CTOPA training on the obligations of managers and health professionals, and this training should include values clarification (e.g personal values, moral perspectives, professional codes of conduct, etc.), ethics and the contribution of safe abortion services to the reduction of maternal mortality. These training workshops should include the rights and responsibilities of health care workers and of managers.

The role of managers in creating a PPE and in providing support to TOP providers should be emphasised, as well as strategies to relieve health professionals who may experience strain from TOP provision, or have ambivalence regarding the service. A health care worker with clarified values on TOP can have better understanding of the programme, and be more open to engage and support their co-workers.

c. Health information

Section 7 of CTOPA necessitates the notification and keeping of records of all TOPs conducted at facilities (4). Hence, the NDoH should mandate the provincial authorities to submit annual returns on the number of TOPs provided, the designated facilities in their respective provinces, the number of these facilities that are operational (providing TOP) at the time of the report, including the number of TOP providers on the database, and are providing abortion services. The NDOH should collate, manage and publish an up -to-date database of functional designated TOP facilities.

The provincial Departments of Health should ensure appropriate signage to TOP services, making information of these facilities available at the DOH office buildings, mobile apps, and website.

d. Health system strengthening

In line with the overall prioritisation of TOP, the NDoH, in consultation with provincial health departments, should develop minimum standards for all TOP services. Such minimum standards should include guidelines on infrastructure, equipment, dedicated staff, and funding.

8.3.2 Health facility managers

Although facility managers take their cue from national and provincial health authorities, much can be done by health facility managers who exercise leadership for improved service delivery. They should provide leadership on the development of sustainable employee wellness programmes that are context-specific and that are affordable. Those supportive facility managers who have experience of TOP provision should lobby the provincial health authorities for additional resources to strengthen health services in general, the creation of forums for the exchange of ideas and mutual learning on quality of care for all services, as these are likely to benefit SRH services as well.

A supportive supervisory environment promotes the health worker's sense of control, and enhances good performance. It is therefore important for the facility managers to include TOP and SRH services on the induction programme of all new staff, and as a standard agenda item for staff meetings and programme reviews. Orientation of new staff and inservice training of existing staff on TOP could serve as an entry point in making others understand what TOP is about, allowing the providers an opportunity to discuss with colleagues about their support needs, achievements and/or challenges.

8.3.4 TOP provider

The providers should speak out about factors that affect their psychosocial wellbeing, actively engage management for the support required, participate in the development of, and advocacy for an employee wellness programme, and maximise the collegial support (where available) as a beneficial resource that makes it easier to do their difficult job. The providers must hold the facility manager and the health authorities accountable for the implementation of PPEs, which in turn will improve access to abortion services.

The summary of recommendations is shown in Table 8.2.

Table 8.2 PhD study recommendations

Recommendation	Department of Health (national /provincial/district)	Facility manager	Individual TOP provider
1. Prioritise TOP as a part of integral sexual and reproductive health services and a prerequisite for the achievement of UHC in South Africa.	**X**	**X**	
2. Mandate provinces to submit annual returns on designated facilities on database and providing TOP.	**X**		
3. Collate, manage and publish an up -to-date database of functional designated TOP facilities.	**X**		
4. Include TOP provider support in the key performance area of facility managers, and monitor implementation.	**X**		
5. Issue clear guidelines and protocols, to all health care professionals, and health facility managers on TOP as an SRH programme, each cadre's role in the implementation and support of CTOPA.	**X**		
6. Ensure and monitor continued values clarification training of health workers and managers especially around psychosocial support programme for providers in TOP provision and service support.	**X**	**X**	

	Recommendation	Department of Health (national /provincial/district)	Facility manager	Individual TOP provider
7.	Advocate for additional resources for TOP provision at designated facilities (staffing, infrastructure, and psychosocial support staff/structures)	**X**	**X**	
8.	Provide leadership on the development of sustainable employee wellness programmes to support TOP providers psychosocial needs	**X**	**X**	
9.	Facilitate joint engagement of TOP providers and colleagues to develop strategies that promote ongoing collegial support in TOP provision	**X**	**X**	**X**
10.	Develop and implement strategies to enhance supervisory support that prioritises TOP provider support needs	**X**	**X**	
11.	Develop mechanisms and incentives that recognise excellence and/or commitment on the provision of TOP by few willing providers	**X**	**X**	
12.	Provide information on the available and functional support programmes for TOP providers	**X**	**X**	
13.	Engage with other facility managers and share good employee wellness practices that prioritise TOP providers		**X**	**X**
14.	Establish an environment that recognises negative emotions and consistently provide alternative outlet e.g timeout, colleagial support, referral (as necessary)	**X**	**X**	
15.	Include TOP in the induction programme of all new staff		**X**	
16.	Include TOP as a standard agenda item for staff meetings and programme reviews		**X**	**X**
17.	Advocate for the prioritisation of psychosocial support by maximising all opportunities (existing or new)		**X**	**X**

A multifaceted approach is needed in order to create PPEs that prevent burnout and secondary traumatic stress among the few willing providers of TOP services. The establishment of psychosocial support programmes for TOP providers, together with the implementation of other recommendations outlined in this section, could improve staff retention, and may attract new providers for sustainable and safe abortion service provision.

8.4 Scholarly contribution

The scholarly contribution of my PhD is evident throughout this thesis, but can be summarised as: the generation of new knowledge; methodological contribution; and relevance for health policy and practice.

8.4.1 Generation of new knowledge

My study has generated new knowledge on the psychosocial issues experienced or faced by existing TOP providers. I have measured compassion satisfaction, burnout and secondary traumatic stress, and have generated empirical information on the predictors of these professional quality of life aspects. The qualitative interviews have highlighted the experiences of loneliness among TOP providers, and their experiences of courtesy stigma, as well as their coping strategies. I have also generated new knowledge on the availability of the existing psychosocial support programmes at designated facilities, and the perspectives of the public service managers on psychosocial support and/or programmes for TOP providers.

Although I did not set out to verify the difference between designation of TOP facilities and actual provision, my study has generated empirical information on the proportion of designated facilities that are functional. I have also been able to document health system constraints within the context of abortion service provision.

The engagement of managers on TOP support programmes was original, and it yielded both information on the availability of, and managers perspectives on, TOP provider support; and afforded the managers an opportunity to reflect on, and appreciate, the need for some form of psychosocial support for TOP providers.

This study findings that providers experienced secondary traumatic stress, burnout, loneliness and courtesy stigma, within an environment that did not have adequate support programmes to address these providers psychosocial issues, contribute to the evidence required by government to re-focus the abortion discourse and develop programmes to support the few willing abortion service providers.

8.4.2 Methodological contribution

My PhD was one of the first studies that had used the PRoQOL tool in the TOP environment in South Africa, or an African context, and hence validated the tool. I adapted PRoQOL by adding questions that examined the philosophical reasons for working as TOP service providers. Hence, I was able to examine the relationship between compassion satisfaction, burnout and STS, and these reasons. My survey can be adapted by other researchers to confirm these relationships, measure other aspects, whether in South Africa or other LMICs.

I also used a facility checklist, and developed indepth interview schedules to elicit responses from providers and managers. These PhD study tools could be used and/or adapted by other researchers, wishing to answer complex TOP research questions, or explore other aspects of SRH services..

8.4.3 Health policy or practice impact

The PhD study findings could be used to inform the psychosocial support programme at designated TOP facilities in the two study provinces. The findings could also inform discussions on strategies to prioritise the psychosocial issues of TOP providers through supportive management, positive practice environments, and the development and implementation of effective and sustainable employee wellness programmes that enhance compassion satisfaction and reduce burnout and secondary traumatic stress among these providers.

The PhD also highlights the disjuncture between policy (in the form of the enabling CTOPA) and implementation on the ground, and the importance of ongoing efforts to ensure prioritisation of SRH services.

The recommendations are practical, and many of these could be implemented within existing resources (e.g. collegial support and maximising opportunities for individual engagement as a support mechanism).

8.5 Recommendations for further research

The PhD study found that health system deficiencies exacerbated the occupational stress (expressed as intense loneliness) of TOP providers psychosocial issues. More research is needed on the relationship between health system deficiencies and compassion satisfaction and compassion fatigue. There is a need to examine the relationships between the provision of TOP services at designated facilities, and the availability of human resources, including workloads. Building on my study findings that TOP providers with longer service may have lower compassion satisfaction (or derive less pleasure from doing abortion), I suggest that further studies with a larger number of TOP providers be conducted to determine whether there is an inverse relationship between their compassion satisfaction and years of abortion service.

Future research should look at using validated instruments like PRoQOL on a larger scale in South Africa and the region to:

- Explore the relationship between compassion satisfaction and compassion fatigue; and the heavy burden of TOP care, courtesy stigma and loneliness among TOP providers;
- The relationship between compassion satisfaction scores and the philosophical reasons for working as TOP service providers;
- Whether TOP providers' beliefs in the rights of women serve as a protective factor for secondary traumatic stress in TOP provision.

Furthermore, other possible research areas are:

- The effects of the negative coping strategies on the provider psychosocial wellbeing;
- The association between management support and the compassion satisfaction and compassion fatigue of the providers;
- The relationship between perceived abortion stigma, and compassion satisfaction;
- The costs and effectiveness of psychosocial support programmes;
- Models of psychosocial support and PPEs that optimise compassion satisfaction, and reduce burnout and STS among TOP providers;

- The quality of TOP service provision in the public sector, and the association between quality of care and reported coping strategies;
- The relationship between social and economic environments and the demand on TOP provision;
- Explore public violence experienced by TOP providers in low and middle - income countries;
- Explore TOP provider knowledge and practice on sonar as a prerequisite for the assessment of gestational age.

8.6 Conclusion

This PhD study has analysed the psychosocial issues and coping strategies of termination of pregnancy providers in two South African provinces. The PhD has underscored the importance of HRH in TOP service provision, and of shifting the discourse to a more positive one. The PhD has generated new knowledge on the overall levels and predictors of compassion satisfaction, burnout and secondary traumatic stress among these providers, coping strategies used by TOP providers, the availability of psychosocial support programmes, and the perspectives of public service managers on psychosocial support and/or programmes for TOP providers. Quality safe abortion care cannot be provided without addressing the psychosocial needs of the few willing providers.

The psychosocial issues of TOP providers need prioritisation through supportive management, and the development and implementation of effective and sustainable employee wellness programmes that enhance compassion satisfaction and reduce burnout and STS among these providers, within an enabling positive practice environment.

REFERENCES

1. Grimes D, Stuart G. *Abortion jabberwocky: the need for better terminology. Contraception*. 2010;81(2):93-6.
2. Poloska A, Gjonej R. *Evaluation of spontaneous and voluntary abortions in years in relation with abortions*. International Journal of Science and Research. 2015;4(2).
3. Rigterink E, Saftlas A, Atrash H. *Chapter 16 - Induced abortion. In: Goldman MB, Troisi R, Rexrode KM, editors*. Women and Health (second edition): Academic Press; 2013. p. 235-50.
4. Republic of South Africa. *Choice on Termination of Pregnancy Act (No.92 of 1996), as amended in 2008*. South Africa: Government Printer; 1996.
5. Mahopo Z. *Half of SA's 700-a-day abortions illegal.* Sowetan. 201812 July.
6. Siegel R. *Reasoning from the body: A historical perspective on abortion regulation and questions of equal protection*. Stanford Law Review. 1992;44(2):261-381.
7. Creanga A, Singh K, Li Q, Fruhauf T, Tsui A. *Changes in abortion service provision in Bihar and Jharkhand states, India between 2004 and 2013*. PLoS One. 2018;13(6):e0197300.
8. Braam T, Hessini L. *The power dynamics perpetuating unsafe abortion in Africa: A feminist perspective*. African Journal of Reproductive Health. 2004;8(1):43-51.
9. Peach L. *Feminist cautions about casuistry: The Supreme Court's abortion decisions as paradigms*. Policy Sciences. 1994;27(2-3):143-60.
10. Kohlberg L, Hersh R. *Moral development: A review of the theory*. Theory into practice. 1977;16(2):53-9.
11. Marquis D. *An argument that abortion is wrong. In: Shafer - Landau R, editor. Ethical theory: An anthology (second edition)*. Wiley -Blackwell; 2007. p. 439-50.
12. Clements B. *Religion and the sources of public opposition to abortion in Britain: The role of 'belonging', 'behaving' and 'believing'*. Sociology. 2014;48(2):369-86.
13. Prichard A. *A "grieviously sinful attempt to destroy the life which God has given": Abortion, Anglicanism, and Debates about community composition in twentieth - centruy Zanzibar. In: Stettner S, Ackerman K, Burnett K, Hay T (eds) Transcending Borders.* Palgrave Macmillan, Cham; 2017. p. 69-87.

14. Fromer M. *Abortion ethics*. Nursing Outlook. 1982;30(4):234.
15. Jarlenski M. *Arguments, evidence, and abortion policy*. New York: Public Health Post; 2017.
16. Lee P. *Abortion and unborn human life (second edition)*. Catholic University of America Press; 2010.
17. Siegel R. *The constitutionalization of abortion. Abortion law in transnational perspective: cases and controversies (first edition).* Philadelphia: University of Pennsylvania Press; 2014. p. 13-35.
18. Ekmekci PE. *Abortion in Islamic Ethics, and How it is Perceived in Turkey: A Secular, Muslim Country*. Journal of Religion and Health. 2017;56(3):884-95.
19. Dreifus C. *The Dalai Lama*. The New York Times Magazine. 1993 28 November.
20. Basinga P, Moore A, Singh S, Carlin E, Birungi F, Ngabo F. *Abortion incidence and postabortion care in Rwanda*. Studies in Family Planning. 2012;43(1):11-20.
21. Lecso P. *A Buddhist view of abortion*. Journal of Religion and Health. 1987;26(3):214-8.
22. Beckwith F. *Law, religion, and the metaphysics of abortion: A reply to Simmons*. Journal of Church and State. 2001;43(1):19 - 33.
23. Hessini L. *Abortion and Islam: policies and practice in the Middle East and North Africa.* Reproductive Health Matters. 2007;15(29):75-84.
24. Cook R, Erdman J, Dickens B. *Abortion law in transnational perspective: cases and controversies. Abortion Law in Transnational Perspective*. University of Pennsylvania Press; 2014. p. 1-10.
25. Shapiro G. *Abortion law in Muslim-majority countries: an overview of the Islamic discourse with policy implications*. Health Policy and Planning. 2013;29(4):483-94.
26. Brookman-Amissah E, Moyo J. *Abortion law reform in Sub-Saharan Africa: No turning back.* Reproductive Health Matters. 2004;12(sup24):227-34.
27. Al-Matary A, Ali J. *Controversies and considerations regarding the termination of pregnancy for foetal anomalies in Islam*. BioMed Medical Ethics. 2014;15(1):10.
28. Adamczyk A. *The effects of religious contextual norms, structural constraints, and personal religiosity on abortion decisions*. Social Science Research. 2008;37(2):657-72.

29. Levels M, Sluiter R, Need A. *A review of abortion laws in Western-European countries. A cross-national comparison of legal developments between 1960 and 2010*. Health Policy. 2014;118(1):95-104.
30. Mhlanga R. *Abortion: developments and impact in South Africa*. British Medical Bulletin. 2003;67(1):115-26.
31. Rahman A, Katzive L, Henshaw S. *A global review of laws on induced abortion, 1985-1997*. International Family Planning Perspectives. 1998;24(2):56-64.
32. Cook R, Dickens B, Bliss L. *International developments in abortion law from 1988 to 1998*. American Journal of Public Health. 1999;89(4):579-86.
33. United Nations Population Fund, editor. *Programme of Action of the International Conference on Population and Development*. UN Doc A/CONF171/13/Rev1 (1995) [hereinafter ICPD Programme of Action; 1994 Sept. 5-13 Cairo.
34. Hessini L. *Global progress in abortion advocacy and policy: An assessment of the decade since ICPD*. Reproductive Health Matters. 2005;13(25):88-100.
35. Burns C. *Controlling birth: Johannesburg, 1920–1960*. South African Historical Journal. 2004;50(1):170-98.
36. Lovenduski J, Outshoorn J. *The new politics of abortion.* Sage Publications. 1986;2(ix):175.
37. Boland R, Katzive L. *Developments in laws on induced abortion: 1998-2007.* International Family Planning Perspectives. 2008;34(3):110-20.
38. United Nations, editor. *International conference on population and development programme of action*. International Conference on Population and Development: 1994; 1994: UNDP Cairo:.
39. Center for Reproductive Rights, cartographer. *The world's abortion laws.* New York: Center for Reproductive Rights; 2019.
40. Smyth L,. *Abortion and nation: the politics of reproduction in contemporary Ireland (first edition).* Routledge; 2017.
41. Mohamed S, Izugbara C, Moore A, Mutua M, Kimani-Murage E, Ziraba A, et al. *The estimated incidence of induced abortion in Kenya: a cross-sectional study*. BioMed Central Pregnancy and Childbirth. 2015;15(1):185.

42. Nowicka W,. *The effects of the 1993 anti-abortion law in Poland.* Entre nous. 1996(34-35):13-5.
43. Finer L, Fine J. *Abortion law around the world: progress and pushback*. American Journal of Public Health. 2013;103(4):585-9.
44. Polis C, Mhango C, Philbin J, Chimwaza W, Chipeta E, Msusa A. I*ncidence of induced abortion in Malawi, 2015*. PLoS One. 2017;12(4):e0173639.
45. Center for Reproductive Rights. *A technical guide to understanding the legal and policy framework on termination of pregnancy in Mainland Tanzania*. New York: Center for Reproductive Rights 2012.
46. Albertyn C. *Claiming and defending abortion rights in South Africa*. Revista Direito GV. 2015;11(2):429-54.
47. Ross L, Solinger R. *Reproductive justice: An introduction*. United States of America: University of California Press; 2017.
48. Chrisler J,. *Reproductive justice: A global concern. Chrisler J, . editor*. Praeger; 2012.
49. United Nations Population Fund, editor. *Key actions for further implementation of the program of action of the International Conference on Population and Development*. UN GAOR 21st Special Sess; 1999 June 30-July 3, para. 63iii; A/S-21/5/ Add.1 (1999) [hereinafter ICPD + 5 Key Actions Document].
50. Shah I, Åhman E, Ortayli N. *Access to safe abortion: progress and challenges since the 1994 International Conference on Population and Development (ICPD).* Contraception. 2014;90(6, Supplement):S39-S48.
51. Gemzell-Danielsson K, Cleeve A. *Estimating abortion safety: advancements and challenges*. Lancet. 2017;390(10110):2333-4.
52. WHO. *Preventing unsafe abortion.* World Health Organization Fact sheet. 2018.
53. WHO. *Worldwide, an estimated 25 million unsafe abortions occur each year*. World Health Organization Newsletter. 2017.
54. United Nations. *Transforming our world: the 2030 Agenda for Sustainable Development*. New York 2015.

55. WHO. *Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008 (sixth edition)* Geneva: World Health Organization; 2011.
56. Faúndes A, Shah I. *Evidence supporting broader access to safe legal abortion*. International Journal of Gynecology and Obstetrics. 2015;131(S1):S56 - S9.
57. Brookman-Amissah E. *Woman-centred safe abortion care in Africa*. African Journal of Reproductive Health. 2004;8(1):37-42.
58. Republic of South Africa. *Abortion and Sterilization Act 2 of 1975.* In: Health do, editor. South Africa: Government printers; 1975.
59. Jogee F. *Is there room for religious ethics in South African abortion law?* South African Journal of Bioethics and Law. 2018;11(1):46-51.
60. Republic of South Africa. *Constitution of the Republic of South Africa 1996, Act 108 of 1996*. http://www.info.gov.za: 1996.
61. Bletcher M, Kollipara A, de Jager P, Zulu N. *Health Financing.* In: Padarath A, English R, editors. South African Health Review 2011. Durban: Health Systems Trust; 2011.
62. DOH. *Annual Report of the National Department of Health Strategic-2016/17*. South Africa: 2017.
63. Van Dyk J. *When there was no list of free abortion clinics, we made our own*. Mail and Guardian. 2017 17 November.
64. WHO. *Global strategy on human resources for health: Workforce 2030*. Geneva: World Health Organization; 2016.
65. United Nations. *Global strategy for women's, children's and adolescents' health, 2016-2030: Survive, Thrive, Transform*. United Nations, 2015.
66. Rispel L. *Analysing the progress and fault lines of health sector transformation in South Africa.* In: Padarath A, King J, Mackie E, Casciola J, editors. South African Health Review 2016. Durban: Health Systems Trust; 2016.
67. International Women's Health Coalition., Muyer Y Salud En Uruguay. *Unconscionable: When providers deny abortion care*. International Women's Health Coalition. 2018.

68. WHO. *Health worker role in providing safe abortion care and post abortion contraception*. Geneva: World Health Organization; 2015.
69. Berer M. *Provision of abortion by mid-level providers: international policy, practice and perspectives*. Bulletin World Health Organization. 2009;87:58-63.
70. Loi U, Gemzell-Danielsson K, Faxelid E, Klingberg-Allvin M. *Health care providers' perceptions of and attitudes towards induced abortions in sub-Saharan Africa and Southeast Asia: a systematic literature review of qualitative and quantitative data*. BioMed Central Public Health. 2015;15(1):139.
71. Dovlo D. *Using mid-level cadres as substitutes for internationally mobile health professionals in Africa. A desk review*. Human Resources for Health. 2004;2(1):7.
72. Billings D, Ankrah V, Baird T, Taylor J, Ababio K, Ntow S, et al. *Midwives and comprehensive postabortion care in Ghana. Postabortion care: Lessons learned from operations research*. Population Council. 1999:141 - 58.
73. Long C, Ren N, editors. *Abortion in Cambodia: country report. Expanding access: advancing the roles of midlevel providers in menstrual regulation and elective abortion care Ipas conference report*. South Africa; 2001 3 - 6 December; South Africa: Ipas/IHCAR Karolinska Institutet.
74. Wheeler S, Zullig L, Reeve B, Buga G, Morroni C. *Attitudes and intentions regarding abortion provision among medical school students in South Africa.* International Perspectives on Sexual and Reproductive Health. 2012;38(3):154-63.
75. Harries J, Stinson K, Orner P. *Health care providers' attitudes towards termination of pregnancy: a qualitative study in South Africa.* BioMed Central Public Health. 2009;9(1):296.
76. 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*. American Journal of Public Health. 2013;103(3):397-9. Epub 2013 Jan 17.
77. Harries J, Cooper D, Stebel A, Colvin CJ. *Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study*. BioMed Central Reproductive Health. 2014;11(1):16.

78. DOH. *National Health Insurance Policy: Towards universal health coverage*. In: Health Do, editor. South Africa: Department of Health; 2017.
79. WHO. *Safe abortion: technical and policy guidance for health systems*. Geneva: World Health Organization; 2012.
80. Schorge J, Schaffer J, Halvorson L, Hoffman B, Bradshaw K, Cunningham F. *Williams gynecology (second edition)*. Mc Graw Hill Medical; 2010.
81. Stamm B. *The concise manual for the professional quality of life scale. The PRoQOL (second edition)*. Pocatello; 2010.
82. Lazarus R, Folkman S. *Stress, appraisal, and coping*. Springer; 1984. p. 141-181
83. Goffman E. Stigma: *Notes on the management of spoiled identity*. Simon and Schuster; 2009. p. 1-40
84. Harris L, Martin L, Debbink M, Hassinger J. *Physicians, abortion provision and the legitimacy paradox*. Contraception. 2013;87(1):11-6.
85. Upadhyay U, Cockrill K, Freedman L. *Informing abortion counseling: An examination of evidence-based practices used in emotional care for other stigmatized and sensitive health issues*. Patient Education and Counseling. 2010;81(3):415-21.
86. Charles V, Polis C, Sridhara S, Blum R. *Abortion and long-term mental health outcomes: a systematic review of the evidence*. Contraception. 2008;78(6):436-50.
87. Keys J. *Running the gauntlet: Women's use of emotion management techniques in the abortion experience*. Symbolic Interaction. 2010;33(1):41-70.
88. Cameron S. *Induced abortion and psychological sequelae.* Best Practice and Research Clinical Obstetrics and Gynaecology. 2010;24(5):657-65.
89. Illsley R, Hall M. *Psychosocial aspects of abortion: A review of issues and needed research*. Bulletin of the World Health Organization. 1976;53(1):83.
90. Thorp JM, Hartmann KE, Shadigian E. *Long-term physical and psychological health consequences of induced abortion: review of the evidence*. Obstetric and Gynecology Survey. 2003;58.
91. Joffe C, Cosby K. T*he loneliness of the abortion patient*. Longview Institute 2009.

92. Aniteye P, Mayhew S. *Shaping legal abortion provision in Ghana: using policy theory to understand provider-related obstacles to policy implementation*. Health Research Policy and Systems. 2013;11(1):23.
93. Harries J, Lince N, Constant D, Hargey A, Grossman D. *The challenges of offering public second trimester abortion services in South Africa: health care providers' perspectives*. Journal of Biosocial Science. 2012;44(2):197-208.
94. Payne CM, Debbink MP, Steele EA, Buck CT, Martin LA, Hassinger JA. *Why women are dying from unsafe abortion: narratives of Ghanaian abortion providers*. African Journal of Reproductive Health. 2013;17(2):118 - 28.
95. Zampas C. *Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings.* International Journal of Gynecology and Obstetrics. 2013;123 Suppl 3(S3).
96. WHO. *Expanding health worker roles for safe abortion in the first trimester of pregnancy*. Geneva: World Health Organization, 2016 Contract No.: WHO/RHR/16.02
97. Faundes A, Duarte GA, Osis MJ. *Conscientious objection or fear of social stigma and unawareness of ethical obligations*. International Journal of Gynaecology and Obstetrics. 2013;123 (Suppl 3):S57-9. Epub 2013/12/18.
98. Johnson B, Kismodi E, Dragoman M, Temmerman M. *Conscientious objection to provision of legal abortion care*. International Journal of Gynecology and Obstetrics. 2013;123 Suppl 3(S60-2).
99. WHO. *Maternal mortality. World Health Organization Fact sheet*. Geneva, 2015.
100. WHO. *What health-care providers say on providing abortion care in Cape Town, South Africa: findings from a qualitative study.* Social Science Policy Brief. 2010.
101. Aniteye P, O'Brien B, Mayhew S. *Stigmatized by association: challenges for abortion service providers in Ghana*. BioMed Central Health Services Research. 2016;16(1):486.
102. Joffe C. *Dispatches from the abortion wars: the costs of fanaticism to doctors, patients, and the rest of us.* Beacon Press; 2010. 804-807

103. Glenton C, Sorhaindo A, Ganatra B, Lewin S. *Implementation considerations when expanding health worker roles to include safe abortion care: a five-country case study synthesis*. BioMed Central Public Health. 2017;17(1):730.
104. Johnson BR, Kismodi E, Dragoman MV, Temmerman M. *Conscientious objection to provision of legal abortion care*. International Journal of Gynaecology and Obstetrics. 2013;123 (Suppl 3):S60-2.
105. Fiala C, Arthur J. *There is no defence for 'Conscientious objection' in reproductive health care*. European Journal of Obstetrics & Gynecology and Reproductive Biology. 2017;216:254-8.
106. Fleming V, Frith L, Luyben A, Ramsayer B. *Conscientious objection to participation in abortion by midwives and nurses: a systematic review of reasons*. BioMed Central Medical Ethics. 2018;19(1):31.
107. Diniz D, Madeiro A, Rosas C. *Conscientious objection, barriers, and abortion in the case of rape: a study among physicians in Brazil*. Reproductive Health Matters. 2014;22(43):141-8.
108. Xaba M, Rispel L. *Ensuring women's right to choose: Exploring nurses' role in the Choice on Termination of Pregnancy Act*. Agenda. 2013;27(4):69-78.
109. Ray SL, Wong C, White D, Heaslip K. *Compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals*. Traumatology. 2013;19(4):255-67.
110. Hunsaker S, Chen H, Maughan D, Heaston S. *Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses*. Journal of Nursing Scholarship. 2015;47(2):186-94.
111. Wu S, Singh-Carlson S, Odell A, Reynolds G, Su Y, editors. *Compassion fatigue, burnout, and compassion satisfaction among oncology nurses in the United States and Canada*. Oncology Nursing Forum; 2016.
112. Sodeke-Gregson E, Holttum S, Billings J. *Compassion satisfaction, burnout, and secondary traumatic stress in UK therapists who work with adult trauma clients.* European Journal of Psychotraumatology. 2013;4(1):21869.
113. Martin L, Debbink M, Hassinger J, Youatt E, Harris L. *Abortion providers, stigma and professional quality of life*. Contraception. 2014;90(6):581-7.

114. Lynch S, Lobo M. *Compassion fatigue in family caregivers: a Wilsonian concept analysis*. Journal of Advanced Nursing. 2012;68(9):2125-34.
115. Sabo B. *Reflecting on the concept of compassion fatigue*. Online Journal of Issues in Nursing. 2011;16(1).
116. Sorenson C, Bolick B, Wright K, Hamilton R. *Understanding Compassion Fatigue in Healthcare Providers: A Review of Current Literature.* Journal of Nursing Scholarship. 2016;48(5):456-65.
117. Halbesleben J, Wakefield B, Wakefield D, Cooper L. *Nurse burnout and patient safety outcomes nurse safety perception versus reporting behavior*. Western Journal of Nursing Research. 2008;30(5):560-77.
118. Musa S, Hamid A. *Psychological problems among aid workers operating in Darfur. Social Behavior and Personality.* An International Journal. 2008;36(3):407-16.
119. Pietrantoni L, Prati G. *Resilience among first responders.* African Health Sciences 2008;8(Special edition):S14 -S20.
120. Mizuno M, Kinefuchi E, Kimura R, A. T. *Professional quality of life of Japanese nurses/midwives providing abortion/childbirth care*. Nursing Ethics. 2013;20(5):539-50.
121. Wolkomir M, Powers J. *Helping women and protecting the self: The challenge of emotional labor in an abortion clinic.* Qualitative Sociology. 2007;30(2):153-69.
122. Fiala C, Arthur JH. *'Dishonourable disobedience" – Why refusal to treat in reproductive healthcare is not conscientious objection*. Woman - Psychosomatic Gynaecology and Obstetrics. 2014;1(2):12 -23.
123. Sumner L. *Abortion and moral theory*. United States of America: Princeton University Press; 2014.
124. Varkey S. *Abortion services in South Africa: available yet not accessible to all*. International Family Planning Perspectives. 2000;26(2):87-8.
125. Mokgethi NE, Ehlers VJ, Merwe MM. *Professional nurses' attitudes towards providing termination of pregnancy services in a tertiary hospital in the North West province of South Africa*. Curationis. 2006;29(1).

126. Jewkes R, Gumede T, Westaway M, Dickson K, Brown H, Rees H. *Why are women still aborting outside designated facilities in metropolitan South Africa?* BJOG: An International Journal of Obstetrics & Gynaecology. 2005;112(9):1236-42.
127. Tavrow P. *Promote or discourage: how providers can influence service use. Social determinants of sexual and reproductive health: informing future research and programme implementation.* Geneva: World Health Organization. 2010:15-36.
128. Harris L. *Second trimester abortion provision: Breaking the silence and changing the discourse*. Reproductive Health Matters. 2008;16(31):74-81.
129. Freedman L, Landy U, Darney P, Steinauer J. *Obstacles to the integration of abortion into obstetrics and gynecology practice*. Perspectives on Sexual and Reproductive Health. 2010;42(3):146-51.
130. Martin L, Hassinger J, Debbink M, Harris L. *Dangertalk: Voices of abortion providers*. Social Science and Medicine. 2017;184:75-83.
131. Solinger R. " *A complete disaster": Abortion and the politics of hospital abortion committees, 1950-1970*. Feminist Studies. 1993;19(2):241.
132. Joffe C, Yanow S. *Advanced practice clinicians as abortion providers: Current developments in the United States*. Reproductive Health Matters. 2004;12(24):198-206.
133. Buchbinder M, Lassiter D, Mercier R, Bryant A, Lyerly A. *"Prefacing the script" as an ethical response to state-mandated abortion counseling*. AJOB Empirical Bioethics. 2016;7(1):48-55.
134. Faúndes A, Duarte G, Osis M. *Conscientious objection or fear of social stigma and unawareness of ethical obligations*. International Journal of Gynecology and Obstetrics. 2013;123(S3).
135. Mayers PM, Parkes B, Green B, Turner J. *Experiences of registered midwives assisting with termination of pregnancies at a tertiary level hospital*. Health South Africa Gesondheid. 2005;10(1):15 -25.
136. Botes A. *Critical thinking by nurses on ethical issues like the termination of pregnancies*. Curationis. 2000;23(3):26 -31.

137. Paul M, Gemzell-Danielsson K, Kiggundu C, Namugenyi R, Klingberg-Allvin M. *Barriers and facilitators in the provision of post-abortion care at district level in central Uganda - a qualitative study focusing on task sharing between physicians and midwives*. BioMed Central Health Services Research. 2014;14(1):28.
138. Doran F, Nancarrow S. *Barriers and facilitators of access to first-trimester abortion services for women in the developed world: a systematic review*. Journal of Family Planning and Reproductive Health Care. 2015;41(3):170-80.
139. Reeves M, Blumenthal P, Jones R, Nichols M, Shumaker H, Saporta V. *Innovative research at the 2016 national abortion federation annual meeting: continuously improving abortion care*. Contraception. 2016;93(5):375-7.
140. Ziegler M. T*he marginalization of providers, 1985 - 1992. In: Stettner S, Ackerman K, Burnett K, Hay T, editors. Transcending borders: abortion in the past and present.* Springer; 2017. p. 155 -70.
141. Freedman L. *Willing and unable: doctors' constraints in abortion care.* Vanderbilt University Press; 2010.
142. Norman W, Soon J, Maughn N, Dressler J. *Barriers to rural induced abortion services in Canada: findings of the British Columbia Abortion Providers Survey (BCAPS).* PLoS One. 2013;8(6):e67023.
143. Fetters T, Samandari G, Djemo P, Vwallika B, Mupeta S. *Moving from legality to reality: how medical abortion methods were introduced with implementation science in Zambia*. Reproductive Health. 2017;14(1):26.
144. Norris A, Bessett D, Steinberg JR, Kavanaugh ML, Zordo S, Becker D. *Abortion stigma: a reconceptualization of constituents, causes, and consequences.* Womens Health Issues. 2011;21 (S49 -54).
145. Pridemore W, Freilich J. *The impact of state laws protecting abortion clinics and reproductive rights on crimes against abortion providers: deterrence, backlash, or neither?* Law and Human Behavior. 2007;31(6):611-27.
146. Bazelon E. *The new abortion providers*. The New York Times. 2010;18.
147. Turk J, Steinauer J, Landy U, Kerns J. *Barriers to D&E practice among family planning subspecialists*. Contraception. 2013;88(4):561-7.

148. Mundigo A. *Determinants of unsafe induced abortion in developing countries.* International Programs. Center for Health and Social Policy. 2006;4:51 - 71.
149. Jones R, Jerman J. *Abortion incidence and service availability in the United States, 2011*. Perspectives on Sexual and Reproductive Health. 2014;46(1):3-14.
150. Harrison A, Montgomery E, Lurie M, Wilkinson D. *Barriers to implementing South Africa's Termination of Pregnancy Act in rural KwaZulu/Natal*. Health Policy and Planning. 2000;15(4):424-31.
151. Dickson-Tetteh K, Billings D. *Abortion care services provided by registered midwives in South Africa*. International Family Planning Perspectives. 2002;28(3):144-50.
152. Billings A, Moos R. C*oping, stress, and social resources among adults with unipolar depression*. Journal of Personality and Social Psychology. 1984;46(4):877.
153. McCann C, Beddoe E, McCormick K, Huggard P, Kedge S, Adamson C, et al. *Resilience in the health professions: A review of recent literature*. International Journal of Wellbeing. 2013;3(1):60 - 81.
154. Hart P, Brannan J, De Chesnay M. *Resilience in nurses: an integrative review*. Journal of Nursing Management. 2014;22(6):720-34.
155. Garcia-Dia M, DiNapoli J, Garcia-Ona L, Jakubowski R, O'Flaherty D. *Concept analysis: Resilience*. Archives of Psychiatric Nursing. 2013;27(6):264-70.
156. Joyce O, Oladotun A, Afolabi A, Blessing U. *Compassion fatigue and adopted coping strategies of mental health service providers working in a regional psychiatric hospital in Nigeria.* Journal of Behavior Therapy and Mental Health. 2016;1(2):38.
157. Collins S. *Statutory social workers: Stress, job satisfaction, coping, social support and individual differences*. British Journal of Social Work. 2007;38(6):1173-93.
158. Poncet M, Toullic P, Papazian L, Kentish-Barnes N, Timsit J, Pochard F, et al. *Burnout syndrome in critical care nursing staff.* American Journal of Respiratory and Critical Care Medicine. 2007;175(7):698-704.

159. Wilson M, Goettemoeller D, Bevan N, McCord J. *Moral distress: levels, coping and preferred interventions in critical care and transitional care nurses*. Journal of Clinical Nursing. 2013;22(9-10):1455-66.
160. Fassier T, Azoulay E. *Conflicts and communication gaps in the intensive care unit.* Current Opinion in Critical Care. 2010;16(6):654-65.
161. Naud'e J. *Occupational stress, coping, burnout and work engagement of emergency workers in Gauteng*. South African Journal of Economic and Management Sciences. 2003;5(1)35-62.
162. Cicognani E, Pietrantoni L, Palestini L, Prati G. *Emergency workers' quality of life: The protective role of sense of community, efficacy beliefs and coping strategies*. Social Indicators Research. 2009;94(3):449.
163. Prati G, Pietrantoni L. *An application of the social support deterioration deterrence model to rescue workers.* Journal of Community Psychology. 2010;38(7):901-17.
164. Lipp A, Fothergill A. *Nurses in abortion care: Identifying and managing stress*. Contemporary Nurse. 2009;31(2):108-20.
165. Purcell C, Cameron S, Lawton J, Glasier A, Harden J. T*he changing body work of abortion: a qualitative study of the experiences of health professionals*. Sociology of Health and Illness. 2017;39(1):78-94.
166. Nicholson J, Slade P, Fletcher J. *Termination of pregnancy services: experiences of gynaecological nurses*. Journal of Advanced Nursing. 2010;66(10):2245-56.
167. Lipp A. *Self-preservation in abortion care: a grounded theory study*. Journal of Clinical Nursing. 2011;20(5-6):892-900.
168. Hanna D. *The lived experience of moral distress: nurses who assisted with elective abortions*. Research and Theory for Nursing Practice. 2005;19(1):95.
169. O'Donnell J, Weitz T, Freedman L. *Resistance and vulnerability to stigmatization in abortion work.* Social Science and Medicine. 2011;73(9):1357-64.
170. Parker A, Swanson H, Frunchak V. *Needs of labor and delivery nurses caring for women undergoing pregnancy termination*. Journal of Obstetric, Gynecologic and Neonatal Nursing. 2014;43(4):478-87.
171. Ackerman K, Burnett K, Hay T, Stettner S. *"Every body has its own feminism": Introducing transcending borders*. Transcending Borders: Springer; 2017. p. 2.

172. Harris L, Debbink M, Martin L, Hassinger JA. *Dynamics of stigma in abortion work: Findings from a pilot study of the providers share workshop*. Social Science and Medicine. 2011;73(7):1062-70.
173. Dressler J, Maughn N, Soon J, Norman W. *The Perspective of rural physicians providing abortion in Canada: Qualitative findings of the British Columbia Abortion Providers Survey (BCAPS).* PLoS One. 2013;8(6):e67070.
174. Debbink M, Hassinger J, Martin L, Maniere E, Youatt E, LH. H. *Experiences with the providers share workshop method*. Qualitative Health Research. 2016;26(13):1823-37.
175. Alblas M. *A week in the life of an abortion doctor, Western Cape Province, South Africa.* Reproductive Health Matters. 2008;16(31 Suppl):69-73.
176. Baumann A. *International Council of Nurses. Positive practice environments : quality workplaces = quality patient care : information and action tool kit*. Geneva: ICN, International Council of Nurses; 2007.
177. ICN, editor. *Nurses: A voice to lead-Health is a human right: International Nurses Day Resources and Evidence*. International Nurses Day; 2018 May 12; Geneva: International Council of Nurses.
178. Ruotsalainen J, Verbeek J, Mariné A, Serra C. *Preventing occupational stress in healthcare workers*. Cochrane Database Systematic Review. 2015;4.
179. Salyers M, Hudson C, Morse G, Rollins A, Monroe-DeVita M, Wilson C, et al. *BREATHE: A pilot study of a one-day retreat to reduce burnout among mental health professionals*. Psychiatric Services. 2011;62(2):214-7.
180. Chiesa A, Serretti A. *Mindfulness-based stress reduction for stress management in healthy people: a review and meta-analysis*. The Journal of Alternative and Complementary Medicine. 2009;15(5):593-600.
181. Jain S, Shapiro S, Swanick S, Roesch S, Mills P, Bell I, et al. *A randomized controlled trial of mindfulness meditation versus relaxation training: effects on distress, positive states of mind, rumination, and distraction.* Annals of Behavioral Medicine. 2007;33(1):11-21.
182. Veage S, Ciarrochi J, Deane F, Andresen R, Oades L, Crowe T. *Value congruence, importance and success and in the workplace: Links with well-being and burnout*

amongst mental health practitioners. Journal of Contextual Behavioral Science. 2014;3(4):258-64.

183. Tariq S, Woodman J. *Using mixed methods in health research*. Journal of the Royal Society: Short Reports. 2013;4(6):2042533313479197.
184. Wisdom J, Cavaleri M, Onwuegbuzie A, Green C. *Methodological reporting in qualitative, quantitative, and mixed methods health services research articles*. Health Services Research. 2012;47(2):721-45.
185. WHO. *Everybody's business. Strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva: World Health Organization, 2007.
186. Luchman J, González-Morales M. *Demands, control, and support: A meta-analytic review of work characteristics interrelationships.* Journal of Occupational Health Psychology. 2013;18(1):37-52.
187. Karasek J, Robert A. J*ob demands, job decision latitude, and mental strain: Implications for job redesign*. Sage Publications. 1979;24(2):285-308.
188. Van der Doef M, Maes S. T*he job demand-control (-support) model and psychological well-being: a review of 20 years of empirical research*. Work and Stress. 1999;13(2):87-114.
189. Sanne B, Mykletun A, Dahl A, Moen B, Tell G. *Testing the Job Demand–Control–Support model with anxiety and depression as outcomes: The Hordaland health study*. Occupational Medicine. 2005;55(6):463-73.
190. Statistics South Africa. *Mid-year population estimates*. In: SA SSAS, editor. Pretoria 2018.
191. Johnson RB, Onwuegbuzie AJ, Turner LA. T*oward a definition of mixed methods research*. Journal of Mixed Methods Research. 2007;1(2):112-33.
192. Tavakol M, Dennick R. *Making sense of Cronbach's alpha*. International Journal of Medical Education. 2011;2:53.
193. Denzin N, Lincoln Y. T*he SAGE handbook of qualitative research*. Sage publications; 2011.
194. Tindall L. I*nterpretative Phenomenological Analysis: theory, method and research*. Qualitative Research in Psychology. 2009;6(4):346-7.

195. Charlick S, Pincombe J, McKellar L, Fielder A. *Making sense of participant experiences: Interpretative phenomenological analysis in midwifery research*. International Journal of Doctoral Studies. 2016;11(unknown):205-16.
196. Leung L. *Validity, reliability, and generalizability in qualitative research*. Journal of Family Medicine and Primary Care. 2015;4(3):324-7.
197. Wilson V. *Research methods: triangulation*. Evidence -based Library and Information Practice. 2014;9(1):74-5.
198. Sackett D. *Bias in analytic research. The case-control study consensus and controversy*. Journals of Chronic Diseases; 1979. p. 51-63.
199. Randall D, Fernandes M. *The social desirability response bias in ethics research.* Journal of Business Ethics. 1991;10(11):805-17.
200. Levin K. *Study design III: Cross-sectional studies*. Evidence-Based Dentistry. 2006;7(1):24.
201. United Nations. *The Millennium Development Goals Report 2011*. New York: United Nations, Inter-Agency and Expert Group on MDG Indicators, 2011.
202. Bride B. S*econdary traumatic stress scale*. Retrieved on March. 1999;4:2003.
203. Sedgh G, Singh S, Shah IH, Åhman E, Henshaw SK, Bankole A. I*nduced abortion: incidence and trends worldwide from 1995 to 2008*. Lancet. 2012;379 625–32.
204. DOH. *An evaluation of the implementation of the Choice on Termination of Pregnancy Act*. South Africa: Department of Health, 2000.
205. DOH. S*aving Mothers 2011-2013: sixth report on the confidential enquiries into maternal deaths in South Africa*. South Africa: Department of Health, 2013.
206. Silal SP, Penn-Kekana L, Harris B, Birch S, McIntyre D. *Exploring inequalities in access to and use of maternal health services in South Africa*. BioMed Central Health Services Resesearch. 2012;12:120. Epub 2012/05/23.
207. Aimakhu C, Adepoju O, Nwinee H, Oghide O, Shittu A, Oladunjoye O. *Attitudes towards abortion law reforms in Nigeria and factors influencing its social acceptance among female undergraduates in a Nigerian university*. African Journal of Medicine and Medical Sciences. 2014;43(4):327-32.
208. Faúndes A. *Strategies for the prevention of unsafe abortion*. International Journal of Gynecology and Obstetrics. 2012;119:S68-S71.

209. Aniteye P, O'Brien B, Mayhew SH. *Stigmatized by association: Challenges for abortion service providers in Ghana*. BioMed Central Health Services Research. 2016;16(1):1-10.
210. Adams KB, Matto H, Harrington D. *The Traumatic Stress Institute Belief Scale as a Measure of Vicarious Trauma in a National Sample of Clinical Social Workers. Families in Society*. The Journal of Contemporary Social Services. 2001;82(4):363-71.
211. HEARD. *Unsafe abortion in South Africa: country factsheet.* Durban: Health Economics and HIV/AIDS Research Division/ University of KwaZulu-Natal, 2016.
212. Shenton A. *Strategies for ensuring trustworthiness in qualitative research projects*. Education for Information. 2004;22(2):63-75.
213. Biggerstaff D, Thompson A. *Interpretative Phenomenological Analysis (IPA): A qualitative methodology of choice in healthcare research*. Qualitative Research in Psychology. 2008;5(3):214-24.
214. Smith J, Flowers P, Larkin M. *Interpretative Phenomenological Analysis:Theory, Method and Research*. Sage Publications; 2009.
215. Day C, Gray A. *Health and Related Indicators*. In: Padarath A, King J, Mackie E, Casciola J, editors. South African Health Review 2016. Durban: Health Systems Trust; 2016.
216. National Treasury. *Inter-governmental Fiscal Reviews-Provincial Budgets and Expenditure Review : 2010/11 - 2016/17*. Pretoria: National Treasury, Republic of South Africa, 2015.
217. Hord C, Wolf M. *Breaking the Cycle of Unsafe Abortion in Africa*. African Journal of Reproductive Health 2004;8(1):29-36.
218. Benson J, Andersen K, Samandari G. *Reductions in abortion-related mortality following policy reform: evidence from Romania, South Africa and Bangladesh*. Reproductive Health. 2011;8(1):39.
219. Hu D, Grossman D, Levin C, Blanchard K, Goldie SJ. *Cost-effectiveness analysis of alternative first-trimester pregnancy termination strategies in Mexico City.* BJOG: An International Journal of Obstetrics and Gynaecology. 2009;116(6):768-79.

220. Samandari G, Wolf M, Basnett I, Hyman A, Andersen K. *Implementation of legal abortion in Nepal: a model for rapid scale-up of high-quality care*. Reproductive Health. 2012;9(1):1-11.
221. WHO. *Health worker roles in providing safe abortion care and post-abortion contraception.* Geneva: World Health Organization, 2015.
222. Lie M, Robson SC, May CR. *Experiences of abortion: A narrative review of qualitative studies.* BioMed Central Health Services Research. 2008;8(1):150.
223. Pickles C. *Lived experiences of the Choice on Termination of Pregnancy Act 92 of 1996: bridging the gap for women in need*. South African Journal on Human Rights. 2013;29(3):515-35.
224. Rispel LC, Cloete A, Metcalf CA. *'We keep her status to ourselves': Experiences of stigma and discrimination among HIV-discordant couples in South Africa, Tanzania and Ukraine*. Sahara Journal. 2015;12(1):10-7.
225. Teffo M, Rispel L. *'I am all alone': Factors influencing the provision of termination of pregnancy services in two South African provinces*. Global Health Action. 2017;10(1).
226. Lombardo B, Eyre C. *Compassion fatigue: A nurse's primer*. The Online Journal of Issues in Nursing. 2011;16(1):3.
227. Potter P, Deshields T, Divanbeigi J, Berger J, Cipriano D, Norris L, et al. *Compassion fatigue and burnout*. Clinical Journal of Oncology Nursing. 2010;14(5).
228. Yoder E. *Compassion fatigue in nurses*. Applied Nursing Research. 2010;23(4):191-7.
229. Sprang G, Clark J, Whitt-Woosley A. *Compassion Fatigue, Compassion Satisfaction, and Burnout: Factors Impacting a Professional's Quality of Life*. Journal of Loss and Trauma. 2007;12(3):259-80.
230. Statistics South Africa. *Mid -year Population Estimates.* South Africa 2015.
231. Royston P, Ambler G, Sauerbrei W. *The use of fractional polynomials to model continuous risk variables in epidemiology*. International Journal of Epidemiology. 1999;28(5):964-74.

232. WHO. S*afe abortion: technical and policy guidance for health systems*. Geneva: World Health Organization; 2012.
233. DOH. *Strategic Plan for Nursing Education, Training and Practice 2012/13–2016/17*. South Africa: Department of Health; 2013.
234. Vinggaard C, Christiansen A, Petersson B. *Faced with a dilemma: Danish midwives' experiences with and attitudes towards late termination of pregnancy*. Scandinavian Journal of Caring Sciences. 2013;27(4):913-20.
235. Hegney D, Craigie M, Hemsworth D, Osseiran-Moisson R, Aoun S, Francis K, et al. *Compassion satisfaction, compassion fatigue, anxiety, depression and stress in registered nurses in Australi*a:Phase 2 results.2013.
236. WHO. *Global strategy on human resources for health: workforce 2030.* World Health Organization Library Cataloguing-in-Publication Data. 2016.
237. Godwin A, Alex L, Selorm F. *Occupational stress and its management among nurses at St. Dominic Hospital, Akwatia, Ghana*. Health Science Journal. 2016;10(6):1.
238. Opollo J, Gray J, Spies L. *Work-related quality of life of Ugandan healthcare workers*. International Nursing Review. 2014;61(1):116-23.
239. Gray R. *Workplace Stress: A review of the literature*. Kumpania Consulting, 1998.
240. Teffo M, Levin J, Rispel L. *Compassion satisfaction, burnout and secondary traumatic stress among termination of pregnancy providers in two South African provinces* Journal of Obstetrics, Gynaecology Research. 2018;44(7).
241. Johnson S, Cooper C, Cartwright S, Donald I, Taylor P, Millet C. *The experience of work-related stress across occupations.* Journal of Managerial Psychology. 2005;20(2):178-87.
242. Campbell J, Quincy C, Osserman J, Pedersen O. C*oding in-depth semistructured interviews: Problems of unitization and intercoder reliability and agreement.* Sociological Methods & Research. 2013;42(3):294-320.
243. MacPhail C, Khoza N, Abler L, Ranganathan M. *Process guidelines for establishing Intercoder Reliability in qualitative studies*. Qualitative Research. 2016;16(2):198-212.

244. Mbindyo P, Gilson L, Blaauw D, English M. *Contextual influences on health worker motivation in district hospitals in Kenya*. Implementation Science. 2009;4(1):43.
245. Okeke B. *Social support seeking and self-efficacy-building strategies in enhancing the emotional well-being of informal HIV/AIDS caregivers in Ibadan, Oyo state, Nigeria*. SAHARA J: Journal of Social Aspects of HIV/AIDS Research Alliance. 2016;13(1):35-40.
246. Selamu M, Thornicroft G, Fekadu A, Hanlon C. *Conceptualisation of job-related wellbeing, stress and burnout among healthcare workers in rural Ethiopia: a qualitative study*. BioMed Central Health Services Research. 2017;17(1):412-.
247. Bankole A, Ahiadeke C, Juarez F, Blades N, Sundaram A. *The impact of Ghana's R3M programme on the provision of safe abortions and postabortion care*. Health Policy and Planning. 2014;30(8):1017-31.
248. Ting L, Jacobson J, Sanders S. *Available supports and coping behaviors of mental health social workers following fatal and nonfatal client suicidal behavior*. Social Work. 2008;53(3):211-21.
249. Bardi A, Guerra V. *Cultural values predict coping using culture as an individual difference variable in multicultural samples*. Journal of Cross-Cultural Psychology. 2011;42(6):908-27.
250. Tankink M, Richters A. *Silence as a coping strategy: The case of refugee women in the Netherlands from South-Sudan who experienced sexual violence in the context of war.* Voices of Trauma: Springer.; 2007. p. 191-210.
251. Sunday Tribune. *Women wanting abortions sleep on pavement at Addington*. Sunday Tribune. 2018 1 July.
252. Tankink M. *The silence of South-Sudanese women: social risks in talking about experiences of sexual violence*. Culture, Health and Sexuality. 2013;15(4):391-403.
253. Klingberg-Allvin M, Nga N, Ransjö-Arvidson A, Johansson A. *Perspectives of midwives and doctors on adolescent sexuality and abortion care in Vietnam*. Scandinavian Journal of Public Health. 2006;34(4):414-21.

254. Mngadi PT, Faxelid E, Zwane IT, Hojer B, Ransjo-Arrvidson AB. *Health providers' perceptions of adolescent sexual and reproductive health care in Swaziland*. International Nursing Review. 2008;55.

255. Pargament K, Ano G, Wachholtz A. T*he religious dimension of coping. Handbook of the psychology of religion and spirituality*. New York: Guilford Press; 2005. p. 479-95.

256. Stolley J, Buckwalter K, Koenig H. *Prayer and religious coping for caregivers of persons with Alzheimer's disease and related disorders*. American Journal of Alzheimer's Disease. 1999;14(3):181-91.

257. Heo G. *Religious coping, positive aspects of caregiving, and social support among Alzheimer's disease caregivers*. Clinical Gerontologist. 2014;37(4):368-85.

258. WHO. *Global strategy on human resources for health: Workforce 2030.* Geneva: World Health Organization, 2016.

259. International Women's Health Coalition., Muyer Y Salud En Uruguay. *Unconscionable: When Providers Deny Abortion Care*. New York: International Women's Health Coalition. 2018.

260. Lassi ZS, Musavi NB, Maliqi B, Mansoor N, de Francisco A, Toure K, et al. S*ystematic review on human resources for health interventions to improve maternal health outcomes: evidence from low- and middle-income countries*. Human Resources for Health. 2016;14(1):10.

261. Teffo M, Rispel L. *Resilience or detachment? Coping strategies of termination of pregnancy health care providers in two South African provinces*. Culture, Health and Sexuality. [In press].

262. Röhrs S. *The influence of norms and values on the provision of termination of pregnancy services in South Africa*. International Journal of Africa Nursing Sciences. 2017;6:39-44.

263. Wolkomir M, Powers J. H*elping Women and Protecting the Self: The Challenge of Emotional Labor in an Abortion Clinic*. Qualitative Sociology. 2007;30:153–69 DOI 10.1007/s11133-006-9056-3.

264. Sibuyi M. *Provision of abortion services by midwives in Limpopo Province of South Africa.* African Journal of Reproductive Health. 2004;8(1):75-8.

265. Ibrahim R. *Application of Karasek's model on job satisfaction of Malaysian workers.* International Journal of Art and Commerce. 2013;2(1):149-62.
266. Harris J, Winskowski A, Engdahl B. *Types of workplace social support in the prediction of job satisfaction.* The Career Development Quarterly. 2007;56(2):150-6.
267. Chigudu S, Jasseh M, d'Alessandro U, Corrah T, Demba A, Balen J. *The role of leadership in people-centred health systems: a sub-national study in The Gambia*. Health Policy and Planning. 2018;33(1):e14-e25.
268. Cogin JA, Ng JL, Lee I. *Controlling healthcare professionals: how human resource management influences job attitudes and operational efficiency*. Human Resources for Health. 2016;14:55.
269. Harris C, Cortvriend P, Hyde P. *Human resource management and performance in healthcare organisations.* Journal of Health Organization and Management. 2007;21(4/5):448-59, https://doi.org/10.1108/14777260710778961.
270. Munyewende PO, Rispel LC, Chirwa T. *Positive practice environments influence job satisfaction of primary health care clinic nursing managers in two South African provinces.* Human Resources for Health. 2014;12(1):27.
271. Patterson M, Rick J, Wood SJ, Carroll C, Balain S, Booth *A. Systematic review of the links between human resource management practices and performance*. Health Technology Assessment. 2010;14(51):1 - 334,iv.
272. Mitchell EM, Trueman K, Gabriel M, Bock LB. *Building alliances from ambivalence: evaluation of abortion values clarification workshops with stakeholders in South Africa*. African Journal of Reproductive Health. 2005;9.
273. Statistics South Africa. *Mid-year Population Estimates-Statistical release P0302*. Pretoria: Statistics South Africa, 2018.
274. WHO. S*urvive, Thrive, Transform: Global Strategy for Women's, Children's and adolescents' health (2016–2030), 2018 monitoring report: current status and strategic priorities*. Geneva: World Health Organization. 2018.
275. Htay T, Sauvarin J, Khan S. I*ntegration of Post-Abortion Care: The Role of Township Medical Officers and Midwives in Myanmar*. Reproductive Health Matters. 2003;11(21):27-36.

276. Kishen M, Stedman Y. *The role of Advanced Nurse Practitioners in the availability of abortion services*. Best Practice & Research Clinical Obstetrics and Gynaecology. 2010;24(5):569-78.
277. Ross L, R. S. *Radical Reproductive Justice*. Feminist Press: New York. NY; 2017.
278. Luna Z. *Marching toward reproductive justice: Coalitional (re) framing of the March for Women's Lives*. Sociological inquiry. 2010;80(4):554-78.
279. WHO. *Safe abortion: technical and policy guidance for health systems: legal and policy considerations*. World Health Organization, 2015.
280. Harrison B. O*ur right to choose: Toward a new ethic of abortion*. Wipf and Stock Publishers; 2011.
281. Pace L, Sandahl Y, Backus L, Silveira M, Steinauer J. *Medical Students for Choice's Reproductive Health Externships: impact on medical students' knowledge, attitudes and intention to provide abortions*. Contraception. 2008;78(1):31-5.
282. Schwandt H, Creanga A, Adanu R, Danso K, Agbenyega T, Hindin M. *Pathways to unsafe abortion in Ghana: the role of male partners, women and health care providers*. Contraception. 2013;88(4):509-17.
283. Onah H, Ogbuokiri C, Obi S, Oguanuo T. *Knowledge, attitude and practice of private medical practitioners towards abortion and post abortion care in Enugu, south-eastern Nigeri*a. Journal of Obstetrics and Gynaecology. 2009;29(5):415-8.
284. Livni D, Crowe T, Gonsalvez C. *Effects of supervision modality and intensity on alliance and outcomes for the supervisee*. Rehabilitation Psychology. 2012;57(2):178.
285. Duarte J, Pinto-Gouveia J, Cruz B. *Relationships between nurses' empathy, self-compassion and dimensions of professional quality of life: A cross-sectional study*. International Journal of Nursing Studies. 2016;60(Supplement C):1-11.
286. WHO. *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for a*ction. Geneva: WHO; 2007. Geneva, Switzerland: World Health Organization; 2014.
287. Gallagher K, Porock D, Edgley A. The concept of 'nursing' in the abortion services. Journal of Advanced Nursing. 2010;66(4):849-57.

288. Greenberg M, Herbitter C, Gawinski B, Fletcher J, Gold M. *Barriers and Enablers to Becoming Abortion Providers*. Family Medicine. 2012;44(7):493.
289. Folkman S. *The case for positive emotions in the stress process*. Anxiety, Stress, and Coping. 2008;21(1):3-14.
290. Morimoto H, Shimada H, Tanaka H. *Coping orientation and psychological distress in healthcare professionals: The utility of appraising coping acceptability*. Japanese Psychological Research. 2015;57(4):300-12.
291. Cai ZX, Li K, Zhang XC. *Workplace stressors and coping strategies among Chinese psychiatric nurses*. Perspective of Psychiatric Care. 2008;44.
292. Teo S, Pick D, Newton C, Yeung M, Chang E. *Organisational change stressors and nursing job satisfaction: the mediating effect of coping strategies*. Journal of Nursing Management. 2013;21(6):878-87.
293. Killian K. *Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors*. Traumatology. 2008;14(2):32.
294. Lambert V, Lambert C, Itano J, Inouye J, Kim S, Kuniviktikul W, et al. *Cross-cultural comparison of workplace stressors, ways of coping and demographic characteristics as predictors of physical and mental health among hospital nurses in Japan, Thailand, South Korea and the USA (Hawaii)*. International Journal of Nursing Studies. 2004;41(6):671-84.
295. Lipp A. *Conceding and concealing judgement in termination of pregnancy; a grounded theory study*. Journal of Research in Nursing. 2010;15(4):365-78.
296. *United Nations Committee on Economic; Social and Cultural Rights*. E/C.12/GC/22, 2016.
297. *National Planning Commission. National Development Plan 2030: Our future–make it work*. Pretoria: Presidency of South Africa. 2012.

LIST OF TABLES

LIST OF FIGURES

APPENDICES

Appendix 1: PhD ethics approval

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HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M140543

NAME: (Principal Investigator) Ms Mantshi T effo

DEPARTMENT: School of Public Health
Medical School

PROJECT TITLE: Exploring Psychosocial Issues and Coping Strategies of Healthcare Providers at Termination of Pregancy Services in Two South African Provinces

DATE CONSIDERED: *30/05/2014*

DECISION:

CONDITIONS:

SUPERVISOR: Prof Laetitia Rispel

APPROVED BY:

Professor PE Cleaton-Jones, Ch Medical)

DATE OF APPROVAL:

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS
To be completed in duplicate and ONE COpy returned to the Secretary in Room 10004, 10th floor. Senate House. University
I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and Ilwe undertake to ensure compliance with these conditions. Should any departure be contemplated. from the research protocol as approved. *t/we* undertake to resubmit the application to the Committee. I agree to submit a yearly progress report

Principal Investigator Signature

'd-l TiA '- ':/ 2..014-
M140543Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix 1.1 Change of Title _ Spell Correction M1405443

Ms ME Teffo-Menziwa
POBox 92334
Boordfontein
0201
South Africa

Faculty of Health Sciences
Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172040

Dear Ms Teffo-Menziwa

Reference: Ms Thokozile Nhlapo
E-mail: thokozile.nhlapo@wits.ac.za

Doctor of Philosophy: Change of title of research

17 June 2014
Person No: 587763
TAA

I am pleased to inform you that the following change in the title of your Thesis for the degree of Doctor of Philosophy has been approved:

From:	Exploring psycho-social issues and coping strategies of health care providers at temination of pregnancy services in two South African Provinces
To:	Exploring psycho-social issues and coping strategies of health care providers at termination of pregnancy services in two South African Provinces

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

Appendix 2: Gauteng Provincial Ethics Approval

GAUTENG PROVINCE

HEALTH
REPUBLIC OF SOUTH
AFRICA

OUTCOME OF PROVINCIAL PROTOCOL REVIEW COMMITTEE (PPRC)

Researcher's Name (Principal investigator)	Mantsi Teffo
Organization / Institution	University of Witwatersrand
Research Title	Exploring psycho-social issue and coping strategies of health care providers at Termination of pregnancy services in two South Africa Provinces.
Protocol number	P070714
Date submitted	17/06/2014
Date reviewed	16/07/2014
Outcome	APPROVED
Date resubmitted	N/A
Date of second review	N/A
Final outcome	N/A

It is a pleasure to inform that the Gauteng Health Department has approved your research on Exploring psycho-social issue and coping strategies of health care providers at Termination of pregnancy services in two South Africa Provinces."

The Provincial Protocol Review Committee kindly requests that you to submit a report after completion of your study and present your findings to the Gauteng Health Department.

Data should be collected at the following facilities

- Primary Health Care
- Community Health Care
- Tertiary Hospitals
- Academic Hospital

Approves/~

Dr N Mazamisa
Chief Director: Hospital Services
Date 25/07/14

Appendix 3: Ekurhuleni District (Gauteng) Ethics Approval

Ekurhuleni
METROPOLITAN MUNICIPALITY

EKURHULENI RESEARCH CLEARANCE CERTIFICATE

Research Project Title: Exploring Psycho-Social Issues And Coping Strategies Of Health Care Providers At Termination Of Pregnancy Services In Two South African Provinces.

Research Project Number: *20102/2015-8*

Name of Researcher(s): Ms. Mantshi Teffo

Division/Institution/Company: School of Public Health, University of Witwatersrand

DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT RESEARCH COMMITTEE (EHDRC)

- *THIS DOCUMENT CERTIFIES THAT THE ABOVE RESEARCH PROJECT* HAS *BEEN FULLY APPROVED BY THE EHDRG. THE RESEARCHER(S) MA Y THEREFORE COMMENCE WITH THE INTENDED RESEARCH PROJECT.*
- *NOTE THA T THE RESEARCHER WILL BE EXPECTED TO PRESENT THE RESEARCH FINDINGS OF THE PROPOSED RESEARCH PROJECT A T THE ANNUAL EKURHULENI RESEARCH CONFERENCE.*
- *THE RESEARCH COMMITTEE WISHES THE RESEARCHER(S) THE BEST* OF *SUCCESS.*

DEPUTY CHAIRPERSON: EKURHULENI METROPOLITAN U
Dated: 25/02/2015

MUNICIPALITY

CHAIRPERSON: GAUTENG DEPARTMENT OF HEALTH (EKURHULENI REGION)
Dated: 25/02/2015

Appendix 4: Sedibeng District (Gauteng) Ethics Approval

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

En: Dr. Victor Figueroa
(016) 9506116
(016) 950 6034

To: Sedibeng District Health Services
D.D PHC services Mrs E. Monamodi

From: Dr. Victor Figueroa
Sedibeng District Research Co-ordinator

Re: Permission to conducting research to PhD researcher Mr Mantsi Teffo

This is to certify that Mr Mantsi Teffo currently a PhD candidate has successfully obtain ethical clearance received by the University of Witwatersrand (Protocol P070714) on 16 June 2014.

The Title of the study is: Exploring psycho-social issue and coping strategies of health care providers at Termination of Pregnancy services in two South African provinces.

The above mentioned candidate is requesting permission to utilize data from TOP services and interview personnel.

I, Dr. Victor Figueroa in my capacity as Sedibeng District Research Co-ordinator recommend and support for permission to be granted to the above researcher.

Regards,

Dr. Victor Figueroa
2014/11/25

2015/03/16
Permission granted.

1

Appendix 5: North West Provincial Ethics Approval

health
Department Of Health
North West Province
REPUBLIC OF sourn AFRicA

3801 First Street
New Office Park
MAHIKENG, 2735

Enq: Keitumelse Shogwe
kshogwe@nVfPQ.gov.za
www.nwhealth.gov.za

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

To : Ms Mantsbi Teffo

From : Policy, Planning, Research, Monitoring & Evaluation

Subject : Approval Letter- Exploring psychosocial issues and coping strategies of Healthcare Providers at termination of pregnancy services in two South African Provinces.

Purpose

To inform the researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to arrange in advance with the chosen districts or facilities, and issue this letter as prove that permission has been granted by the provincial office.

Upon completion, the department expects to receive a final research report from the researcher.

Kindest regards

Acting Director: PPRM&E
Mr. L Moaisi

/2. / () &/2-
o14~
Date

DEPARTMENT OF HEALTH
PRIVATE BAG x2068
2014 -06- 12
SUPERINTENDENT GENERAL

X

Healthy Living for All

Appendix 6: Tembisa Hospital Ethics Approval

Permission to do Research and access Records / Files / Data base at the Tembisa Hospital

To: Chief Executive Officer/Information Officer
Tembisa Hospital

From: The Investigator

Dr Rebeiro

Re: Permission to do the following research at Tembisa Hospital

I am a PhD student at the University of Witwatersrand at the School of Public Health. I am requesting permission on my behalf to conduct a study on the Tembisa Hospital grounds that involves access to 2013 data on termination of pregnancy performed.

The title of the study is: Exploring psycho-social issues and coping strategies of termination of pregnancy providers at two South African provinces.

I intend to publish the findings of the study in a professional journal and/ or at professional meeting like symposia, congresses, or other meetings of such a nature.

I furthermore request in terms of the requirements of the Promotion of Access to Information Act. No.2 of 2000 that we be granted access to clinical records, files and databases.

I undertake not to proceed with the study until we have received approval from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

Yours sincerely

Signature of the Principle Investigator

Permission to do the research study at this hospital and to access the information as requested, is hereby approved.

Chief Executive Officer _____ Hospital
Dr _____

Signature of the CEO

Hospital Official Stamp

Appendix 7: Dr George Mukhari Academic Hospital Ethics Approval

Dr. George Mukhari Academic Hospital

GAUTENG PROVINCE

HEALTH REPUBLIC OF SOUTH AFRICA

Office of the Director Clinical Services
Enquiries: Dr. PMT. Mabusela
Tel: (012) 529 3880
Fax: (012) 5600099
Philly.mabusela@gauteng.gov.za
Kedibone.matsimela@gauteng.gov.za

To : Ms. Mantshi Teffo
: Department of School of Public Health
: University of Witwatersrand
: Johannesburg
: 2000

Date : 30 April 2015

PERMISSION TO CONDUCT RESEARCH

The Dr. George Mukhar; Hospital hereby grants you permission to conduct research on "Eploring Psychosocial issues and coping strategies of providers at termination of pregnancy services in two South African Provinces at Dr. George Mukhari Academic Hospital."

The hospital is aware that you have already obtained Clearance from the University of Witwatersrand

This permission is granted subject to the following conditions:

That the Hospital incurs no cost in the course of your research

That access to the staff and patients at the Dr George Mukhari Hospital will not interrupt the daily provision of services.

That prior to conducting the research you will liaise with the supervisors of the relevant sections to introduce yourself (with this letter) and to make arrangements with them in a manner that is convenient to the sections.

Yours sincerely

DR. PMT MABUSELA
DIRECTOR: CLINICAL SERVICES

Appendix 8: Kgabo Community Health Centre Ethics Approval

Annexure 1

Declaration of intent from the clinic manager or hospital CEO

I give preliminary permission to *Mantshi Teffo (*name of researcher) to do his or her research on CTOP (research topic) in

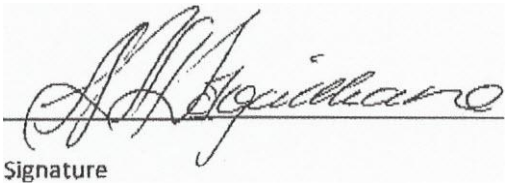
_____ _____(name of clinic) or

KGABO _____(name ofCHC) or

(name of hospital).

I know that the final approval will be from the Tshwane/Metsweding Regional Research Ethics Committee and that this is only to indicate that the clinic/hospital is willing to assist.

Other comments or conditions prescribed by the clinic or CHC manager or hospital CEO:



Clinic Manager/CHC Manager/CEO

April 2015

Date

Appendix 9: Phedisong Community Health Centre Ethics Approval

Annexure 1

Declaration of intent from the clinic manager or hospital CEO

I give preliminary permission to Mautsi Teffo (name of researcher) to do his or her research on Exploring psychosocial issues and coping strategies of health care providers at termination of pregnancy in services in two South African provinces (research topic)

Phedisong Clinic 4 (name of clinic) or

{name of CHC) or

(name of hospital).

I know that the final approval will be from the Tshwane/Metsweding Regional Research Ethics Committee and that this is only to indicate that the clinic/hospital is willing to assist.

Other comments or conditions prescribed by the clinic or CHC manager or hospital CEO:

D.E. RAMETSI

Signature

Clinic Manager/CHC Manager/CEO

Date 30/4/2015

Appendix 10: Soshanguve Community Health Centre Ethics Approval

Annexure 1

Declaration of intent from the clinic manager or hospital CEO

I give preliminary permission to Mantshi Teffo researcher} to do his or her research on _____ {research topic} / (name of

In

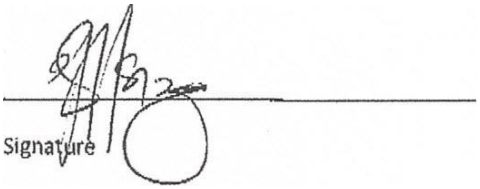
_____ _____ (name of clinic) or

Soshanguve CHC _____ (name of CHC) or

_____ .....- _____~ _____ (name of hospital).

I know that the final approval will be from the Tshwane/Metsweding Regional Research Ethics Committee and that this is only to indicate that the clinic/hospital Is willing to assist.

other comments or conditions prescribed by the clinic or CHe manager or hospital CEO:



Clinic Manager/CHC Manager/CEO

10 | 04 | 2015

Date

Appendix 11: Charlotte Maxeke Hospital Ethics Approval

GAUTENG PROVINCE

HEALfH
REPUBLIC OF SOUTH AFRICA

CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITAL

Enquiries:
Mr. J. Maepa
Office of the Clinical Director
Tell: (011): 488-3365
Fax: (011): 488-3753
08 June 2015

Dear Ms. Mantshi Tefo

STUDY TITLE: Exploring psycho-social issues and coping strategies of Health care providers at termination of pregnancy of pregnancy services in two South African Provinces,

Permission to collect the relevant data needed to complete the research indented under the Tittle: Exploring psychosocial issues and coping strategies of Health care providers at termination of pregnancy of pregnancy services in two South African Provinces, at CMJAH.

Dr. M.I. foke

Approved/not approved

ng

Dr.M.I Mofokeng
Clinical Director
DATE: 8/6/2015

Appendix 12: Approval to reproduce journal article: "I am all alone": Factors influencing the provision of termination of pregnancy services in two South African provinces

Re: Permission to publish for doctoral studies

From Academic Journals ZGHA Peer Review <ZGHA-peerreview@tandf.co.uk

to me

Thank you for your email. In terms of permission, you do not need to seek permission to publish this work as it is Open Access.

This is an Open Access article distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/4.0/), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

We wish you well in your PhD and look forward to any future publications that you may wish to submit to Global Health Action.

Kind Regards,

Nicola Parsons

Appendix 13: Declaration by student and co-authors' agreement for write-up with published articles

Declaration: Student's contribution to article(s) and agreement of co-author(s)

I, [Mantshi Elizabeth Teffo], student number [587763], declare that this Thesis/Dissertation/Research Report is my own work and that I contributed adequately towards research findings published in the article(s) stated below which are included in my Thesis/Dissertation/Research Report.

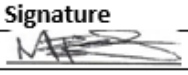
Signature of Student:  **Date:** 01 April 2019

Name of Primary Supervisor: Professor Laetitia Charmaine Rispel

Signature of Primary Supervisor .....**Date**.....

Agreement by co-authors: By signing this declaration, the co-authors listed below agree to the use of the article(s) by the student as part of his/her Thesis/Dissertation/Research Report. In cases where the student is not the 1st author of a published article, the primary supervisor must explain (under comments) why the student is entitled to use the paper for his/her degree purposes.

Article 1: Title: 'I am all alone': factors influencing the provision of termination of pregnancy services in two South African provinces. Global Health Action. 2017, 10:1, 1347369.

Authors	Name	Signature	Date
1st author	Mantshi Elizabeth Teffo		01 April 2019
2nd author	Laetitia Charmaine Rispel		
3rd author			

Comments by primary supervisor:

Article 2: Title: Compassion satisfaction, burnout and secondary traumatic stress among termination of pregnancy providers in two South African provinces. Journal of Obstetrics and Gynaecology Research. 2018, volume 44 Pages: 1202 – 1210.

Authors	Name	Signature	Date
1st author	Mantshi Elizabeth Teffo		01 April 2019
2nd author	Professor Jonathan Levin		
3rd author	Professor Laetitia Charmaine Rispel		
4th author			

Comments by primary supervisor:

.....

Article 3: Title: Resilience or detachment? Coping strategies of termination of pregnancy health care providers in two South African provinces. Culture, Health and Sexuality.
Manuscript ID TCHS -2018-0151, under review.

Authors	Name	Signature	Date
1st author	Mantshi Elizabeth Teffo		01 April 2019
2nd author	Professor Laetitia Charmaine Rispel		
3rd author			

Comments by primary supervisor:

.....

Appendix 14: Self-administered PRoQOL questionnaire for TOP provider survey

EXPLORING PSYCHO-SOCIAL ISSUES AND COPINGSTRATEGIES OF HEALTH CARE PROVIDERS AT TERMINATION OF PREGNANCY SERVICES

TOP PROVIDER SURVEY

For official use only

Hospital/ Clinic Name			
	Questionnaire number		☐☐☐☐
2	**Province ID**		☐☐
	Health Facility ID		☐☐☐
12	**Was the questionnaire completed?**	☐ **No 0** ☐ **Yes 1**	☐
15	**Date of survey:**	**DD/MM/YY**	☐☐☐☐☐☐

STATEMENT OF CONSENT

I have been given an information sheet and I understand the objectives of the study. I further understand that my responses will be kept confidential and that it is up to me whether or not to complete this questionnaire. My refusal to participate will in no way prejudice me**.**

I agree voluntarily to complete the questionnaire **(please tick).** ☐ **Yes**

☐ **No**

Initials or Signature:..... Date:.....

IF YOU AGREE TO PARTICIPATE, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. TICK/ MARK OR CIRCLE THE BOX NEXT TO THE APPROPRIATE ANSWER.

SECTION 1: BACKGROUND CHARACTERISTICS

For official use only

☐☐	**101**	**How old are you?** *(in completed years)*	_____ years
☐	**102**	**What is your sex?**	☐ Male…1 ☐ Female…2
☐	**103**	**What is your current marital status?**	☐ Married.....1 ☐ Living together.....2 ☐ Single.....3 ☐ Divorced/Separated...4 ☐ Widowed.....5
☐	**104**	**Do you have children?**	☐ No...0 **GO TO 106** ☐ Yes...1

	105	**How many children do you have?**	_____
	106	**Professional category**	☐ Professional nurse… 1 ☐ Doctor…….. 2 ☐ Manager……3 ☐ Other…..……9 Specify……
	107	**How long have you been a TOP provider?**	_____ years *(Answer 0 if less than 1 year)*
	108	**Have you received training in TOP?**	☐ No....0 ☐ Yes...1
	109	**Do you consider yourself to be religious?**	☐ No...0 **GO TO SECTION 2** ☐ Yes...1
	110	**Which religion do you most closely associate with (select one only)?**	☐ Christian.....1 ☐ Islamic.....2 ☐ Judaism.....3 ☐ Hindu……....4

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☐ African indigenous-based.....5

☐ Other ……....9

Please specify----------

SECTION 2: PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE

(PROQOL) VERSION 5 (2009)

When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a helper.

Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

	Question	1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
1	I am happy.					
2	I am preoccupied with more than one person I *[help]* .					
3	I get satisfaction from being able to *[help]* people.					
4	I feel connected to others.					
5	I jump or am startled by unexpected sounds.					
6	I feel invigorated after working with those I *[help]* .					
7	I find it difficult to separate my personal life from my life as a *[helper]* .					
8	I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]* .					
9	I think that I might have been affected by the traumatic stress of those I *[help]* .					
10	I feel trapped by my job as a *[helper].*					
11	Because of my *[helping]* , I have felt "on edge" about various things.					
12	I like my work as a *[helper].*					
13	I feel depressed because of the traumatic experiences of the people I *[help].*					
14	I feel as though I am experiencing the trauma of someone I have *[helped].*					
15	I have beliefs that sustain me.					
16	I am pleased with how I am able to keep up with [helping] techniques and protocols					
17	I am the person I always wanted to be.					
18	My work makes me feel satisfied.					
19	I feel worn out because of my work as a *[helper].*					
20	I have happy thoughts and feelings about those I *[help]* and how I could help them					
21	I feel overwhelmed because my case [work] load seems endless.					
22	I believe I can make a difference through my work.					
23	I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help].*					
24	I am proud of what I can do to *[help]* .					
25	As a result of my *[helping]* , I have intrusive, frightening thoughts.					
26	I feel "bogged down" by the system.					
27	I have thoughts that I am a "success" as a [helper].					
28	I can't recall important parts of my work with trauma victims.					
29	I am a very caring person.					
30	I am happy that I chose to do this work.					

SECTION 3

Listed below are possible reasons for working as a TOP health care provider. Thinking about the past 12 months and your own reasons, please indicate how strongly you would agree or disagree with each statement by circling the corresponding number. PLEASE INDICATE A RESPONSE FOR EACH STATEMENT – DO NOT LEAVE ANY OUT.

	Statement (look at issues/strategies in literature)	**Strongly Disagree**	**Disagree**	**Disagree slightly**	**Neither disagree nor agree**	**Agree slightly**	**Agree**	**Strongly agree**
1	I like to help clients make informed choices	1	2	3	4	5	6	7
2	I feel strongly about women's health	1	2	3	4	5	6	7
3	I feel strongly about women's rights	1	2	3	4	5	6	7
4	I receive feedback on the quality of my work	1	2	3	4	5	6	7
5	I find my work stimulating	1	2	3	4	5	6	7
6	I like the quality of supervision	1	2	3	4	5	6	7
7	I like the programme available for employee wellness	1	2	3	4	5	6	7
8	I enjoy the relationship with other nurses	1	2	3	4	5	6	7
9	I am making a difference	1	2	3	4	5	6	7
10	I enjoy the relationship with doctors	1	2	3	4	5	6	7
	Other, please specify	**……**						

SECTION 4: STAYING IN CURRENT JOB

For official use only			
☐	**401**	In the PAST 12 months, have you considered leaving your current job?	☐ No...0 ☐ Yes...1
☐	**402**	In the NEXT 12 months, do you plan to leave your current job?	☐ No...0 → **GO TO 501** ☐ Yes...1
☐	**403**	If you plan to leave your primary job, where do you intend moving to?	☐ Different public sector job...1 ☐ Different private sector job...2 ☐ NGO... 3 ☐ Overseas... 4 ☐ Other...9 Please specify:_____

SECTION 5: PSYCHO-SOCIAL SUPPORT SERVICES

For official use only			
☐	**501**	Would you be interested in a psychosocial programme at your workplace to help you to cope with TOP service provision?	☐ No...0 ☐ Yes...1
☐	**502**	What type of programme would you prefer (*Choose only one answer?)*	☐ One-on-one counselling...1 ☐ Group session……..2 ☐ Workshop or seminar…. 3 ☐ Other…….9 Please specify:_____

6. Do you have any further comments you wish to make?

.....
.....

.....
.....

.....
.....

.....

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

Appendix 15 : Approval to reproduce journal article : Compassion satisfaction, burnout and secondary traumatic stress among termination of pregnancy providers in two South African provinces

Re: Permission to publish my manuscript D is JOGR-2017-1255.R1

From: JOGR Editorial Office

to me

Dear Dr Teffo,

Thank you for your patience.

If you reproduce your Wiley-published article within the scope of the standard copyright transfer agreement (CTA), you do not have to ask for a permission under the condition that the article concerned is properly cited.

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We hope this helps.

Kind regards,
Editorial Office
The Journal of Obstetrics and Gynaecology Research

Appendix 16 : Study Background Information Sheet for TOP Providers

EXPLORING PSYCHO-SOCIAL ISSUES AND COPING STRATEGIES OF HEALTH CARE PROVIDERS AT TERMINATION OF PREGNANCY SERVICES

INFORMATION SHEET

Introduction and background

My name is Mantshi Teffo and I am a doctoral student in the School of Public Health at the University of the Witwatersrand, conducting a study on the psychosocial issues and coping strategies of health care providers in termination of pregnancy services (TOP services) in South Africa.

I am requesting your participation as a TOP provider because of your knowledge and expertise.

The interview will last for approximately 45 minutes. If you agree to take part, I will ask you questions about your current work at the clinic or hospital, some of the issues that you face in providing TOP services and mechanisms in the workplace to provide support to you. The questions are not a test, so there are no right or wrong answers. It is your opinions, perceptions and experiences that are important. My role as an interviewer is to listen and to understand your point of view, and not to pass judgment. You may refuse to answer any questions that you don't feel comfortable answering. You may also say that you don't know the answer to a question.

Confidentiality

The information that you give in the interview will be kept confidential. Only persons directly involved with the research will know who has been interviewed. All interviewees will be assigned a unique code and these codes will be used on the transcribed interviews. Participants will not be identified from the code and these codes will only be known to the researcher. I undertake that all information provided by you will be used only for the purpose of the study. Everything that you say when answering the questions will be treated as private and confidential. This means that apart from the person who asks you the questions, no one will know how you answered. Your name will not be revealed in any written data or report resulting from the study.

The answers given by participants will be combined and analysed to look for common themes and experiences. The combined information will be written up in the form of journal articles.

Consent

Permission to carry out this project was obtained from the University of the Witwatersrand Research Ethics Committee (Medical). I will ask you to sign an informed consent form, both to participate in the study and to record the interview/discussions. If you are willing to give your consent and take part, I will appreciate your participation and the information that you are willing to provide.

Benefits and risks of participation

Please note that participation in this study is voluntary and there will be no direct benefits to anyone who participates in the interviews/discussions. Similarly there will be no negative consequences for individuals who do not want to be interviewed. You will not be compensated for taking part in the study. During the interview, you have the right to decline

to answer any question that makes you feel uncomfortable, or to stop the interview at any time.

Recording the interview

I would like to request your permission to audiotape the interview because I cannot write down all your answers quickly enough and might miss some important things that you will say. The tapes and notes will remain confidential and your identity will not be disclosed. The only thing we are interested in is your honest responses. Tapes of interviews will be transcribed and transcripts of interviews will bear the unique code and not the name of the interviewee. The information will then be analysed and organized into a report. The tapes will be kept in a locked cupboard. As per national requirements, the tapes will be destroyed five years after the publication of the research findings.

Contact details

I will be happy to answer any question you have about this study. This research has been approved by the University of the Witwatersrand Research Ethics Committee (Medical). If you have any questions about your rights as a study participant, or questions or concerns about any aspect of the study, you may contact the ethics office on (011) 717 1234. If you have questions about the research, you may contact the principal researcher or the study supervisor:

PRINCIPAL RESEARCHER

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Fax : +27 86 501 1928
Email: mantshim@gmail.com

Or

RESEARCH SUPERVISOR

Professor Laetitia Rispel
School of Public Health
University of the Witwatersrand, Johannesburg
Phone: +27 11-717 2543
Email: laetitia.rispel@wits.ac.za

Appendix 17: Professional Quality of Life Scale (ProQOL) 5_English

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue
(ProQOL) Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last* 30 *days*.

I=Never 2=Rarely 3=Sometimes 4=Often 5=Very Ofter

1. I am happy.
2. I am preoccupied with more than one person I *[help]*.
3. I get satisfaction from being able to *[help]* people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I *[help]*.
7. I find it difficult to separate my personal life from my life as a *[helper]*.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
9. I think that I might have been affected by the traumatic stress of those I *[help]*.
10. I feel trapped by my job as a *[helper]*.
11. Because of my *[helping]*, I have felt "on edge" about various things.
12. I like my work as a *[helper]*.
13. I feel depressed because of the traumatic experiences of the people I *[help]*.
14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a *[helper]*.
20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
24. I am proud of what I can do to *[help]*.
25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a *[helper]*.
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

Appendix 18 : Information Sheet for TOP Provider Interview

EXPLORING PSYCHO-SOCIAL ISSUES AND COPING STRATEGIES OF HEALTH CARE PROVIDERS AT TERMINATION OF PREGNANCY SERVICES

INFORMATION SHEET

Introduction and background

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Confidentiality

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The answers given by participants will be combined and analysed to look for common themes and experiences. The combined information will be written up in the form of journal articles.

Consent

Permission to carry out this project was obtained from the University of the Witwatersrand Research Ethics Committee (Medical). I will ask you to sign an informed consent form, both to participate in the study and to record the interview/discussions. If you are willing to give your consent and take part, I will appreciate your participation and the information that you are willing to provide.

Benefits and risks of participation

Please note that participation in this study is voluntary and there will be no direct benefits to anyone who participates in the interviews/discussions. Similarly there will be no negative consequences for individuals who do not want to be interviewed. You will not be compensated for taking part in the study. During the interview, you have the right to decline to answer any question that makes you feel uncomfortable, or to stop the interview at any time.

Recording the interview

I would like to request your permission to audiotape the interview because I cannot write down all your answers quickly enough and might miss some important things that you will say. The tapes and notes will remain confidential and your identity will not be disclosed. The only thing we are interested in is your honest responses. Tapes of interviews will be transcribed and transcripts of interviews will bear the unique code and not the name of the interviewee. The information will then be analysed and organized into a report. The tapes will be kept in a locked cupboard. As per national requirements, the tapes will be destroyed five years after the publication of the research findings.

Contact details

I will be happy to answer any question you have about this study. This research has been approved by the University of the Witwatersrand Research Ethics Committee (Medical). If you have any questions about your rights as a study participant, or questions or concerns about any aspect of the study, you may contact the ethics office on (011) 717 1234. If you have questions about the research, you may contact the principal researcher or the study supervisor:

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Or

RESEARCH SUPERVISOR

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School of Public Health
University of the Witwatersrand, Johannesburg
Phone: +27 11-717 2543
Email: laetitia.rispel@wits.ac.za

Appendix 19 : Consent for TOP Provider Interview

EXPLORING PSYCHO-SOCIAL ISSUES AND COPING STRATEGIES OF HEALTH CARE PROVIDERS AT TERMINATION OF PREGNANCY SERVICES

CONSENT FORM FOR TOP PROVIDER INTERVIEW

I have been given the information sheet on the project entitled: *Exploring psycho-social issues and coping strategies of health care providers at termination of pregnancy services.* I have read and understood the Information Sheet and all my questions have been answered satisfactorily.

I understand that it is up to me whether or not I would like to participate in the interview and that there will be no negative consequences if I decide not to participate. I also understand that I do not have to answer any questions that I am uncomfortable with and that I can stop the interview at any time.

I understand that the researcher involved in this project will make every effort to ensure confidentiality and that my name will not be used in the study reports, and that comments that I make will not be reported back to anybody else. I consent voluntarily to participate in the interview for this study. I have been given telephone numbers that I may call if we have any questions or concerns about the research.

Participant's signature: _____ Date: _____

Interviewer's signature: _____ Date: _____

INFORMED CONSENT FOR AUDIOTAPE-RECORDING OF INTERVIEW

I have been given the information sheet on the project entitled: *Exploring psycho-social issues and coping strategies of health care providers at termination of pregnancy services.* I have read and understood the Information Sheet and all my questions have been answered satisfactorily.

I understand that I can decide whether or not the interview should be tape-recorded and that there will be no consequences for me if I do not want the interview to be recorded.

I understand that information from the tapes will be transcribed and transcripts will be given a code and my name will not be mentioned. I understand that if the interview is tape-recorded, the tape will be destroyed two years after publication of the findings.

I understand that I can ask the person interviewing me to stop tape recording, and to stop the interview altogether, at any time.

I consent voluntarily for the researcher to record the interview.

Participant's signature: _____ Date: _____

Interviewer's signature: _____ Date: _____

Appendix 20: TOP Provider Interview Schedule

EXPLORING PSYCHO-SOCIAL ISSUES AND COPING STRATEGIES OF HEALTH CARE PROVIDERS AT TERMINATION OF PREGNANCY SERVICES IN TWO SOUTH AFRICAN PROVINCES

PROVIDER INTERVIEW SCHEDULE

Could you tell me about your job as a TOP provider?

(Probe: when appointed, educational background, training in TOP, mentor (s), etc)

What are the things that you like about being a TOP health care provider?

Probes:

Decision to provide TOP services?

When did you start?

Number of patients seen every day?

Appreciation from clients

Appreciation from other colleagues or supervisor?

Could you share with me what is the most rewarding aspect of your job?

What are the aspects that are not so good about being a TOP health care provider?

Harassment or fear thereof, victimization, threats?

Client complications?

Family or relatives of clients?

Relationship with doctor?

Reaction from other colleagues?

Other issues?

What would you say is the most frustrating aspect of your job? *(Probe- If you could change anything in your job, what would you change and why)?*

In your opinion, how do you think other health professionals view you as a TOP service provider?

(Probes: appreciated, adding value, seen as an important player in health service provision feel judged, undermined, rejected)?

Outside the health facility, who else knows what your job entails?

Probe: family members, friends, community members, congregation? How do they view your job? What is the reason why no one else knows?

Do you consider yourself to be religious?

Probe: religious affiliation/denomination, barriers experienced in relation to religion and work?

How do you cope when managing TOP clients at your facility?

Probe: clients in pain, crying, verbalising guilt, conflict between partners/families on the decision to do TOP.

Which aspects of TOP procedure affect you most?

Probe: first trimester, second trimester, surgical procedure, medical procedure, incomplete TOP emergencies from complications?

How do you deal with your emotions related to these aspects that affect you?

Probe: relax away from work, never talk or does work at home, numbness, suppress emotions, ignore emotions, guilt, blames self or clients; debrief (with peers/alone/family), talk about them, never talk about them?

Have you ever had a personal TOP experience?

Probe: relative or friend had TOP, personally had a miscarriage?

Is there a support programme or mechanism available to TOP providers in this facility?

If yes

What does the programme entail?

Do you use the programme

What do you think about it (strengths, areas that could be improved)

What is the role of your manager in the provision of psychosocial support in the organisation/unit?

If no

What are your thoughts about the psychosocial support for TOP HCP?

How do you think the system/program can benefit you as the TOP HCP?

What kind of programme should be implemented?

Will you use the programme

If you could design the programme, what will it look like?

What recommendations would you make to improve TOP HCP psychosocial support?

To you

In your organisation?

Do you have any other comments that you wish to make about TOP providers or about psychosocial support?

THANK YOU FOR YOUR PARTICIPATION

Appendix 21: Facility Manager Interview Schedule

EXPLORING PSYCHO-SOCIAL ISSUES AND COPING STRATEGIES OF HEALTH CARE

PROVIDERS AT TERMINATION OF PREGNANCY SERVICES IN TWO SOUTH AFRICAN PROVINCES

MANAGEMENT INTERVIEW

Note: To be completed by all managers at 61 facilities

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Participant number	☐☐☐☐
Province ID	☐☐
Facility ID:	☐☐☐
Date of interview DD/MM/YY	☐☐☐☐☐☐

SECTION 1: TOP FACILITY STAFFING AND CLIENT LOAD		
☐	How many TOP providers are there in this facility?	----------
☐	How many of these providers are trained in TOP provision?	----------

☐	On average how many TOP patients are seen per day in the TOP facility?	----------
	Please give us a copy of your TOP statistics for 2013?	Not received …0 ☐ Received ☐
☐	What type of TOP procedure is provided?	Medical TOP….1 ☐ Surgical TOP …2 ☐ Both…….. 3 ☐
☐	What gestational age is TOP provided at your facility?	1st trimester TOP….1 ☐ 2nd Trimester TOP …2 ☐ Both…….. …..3 ☐

SECTION 2: TOP FACILITY SUPPORT SERVICES

For official use only ☐	201	Does the facility have a support programme or support mechanism available to TOP providers?	☐ No...0 → GO TO 207 ☐ Yes...1

Please give more information

202 ----------

☐ No...0 → GO TO 207

☐ Yes...1

Do TOP providers use the programme?

203 How often is the programme available to the TOP providers?

☐ Daily...1

☐ Weekly...2

☐ Monthly... 4

☐ Other...9

Specify:_____

204	Who provides the TOP programme?	☐ Social worker…1 ☐ Psychologist...2 ☐ Manager... 3 ☐ Peers... 4 ☐ Other...9 Please specify:_____

205. In your opinion, what are the strengths of the programme?

206. In your opinion, what are the weaknesses/ areas that need improvement?

207. What are your thoughts about a psychosocial programme for TOP providers?

Probe: Is it necessary? If yes why? If not, why not? When must it be provided? Who must develop it? Who must provide it? How must it be provided? Who must benefit from it?

208. What should it entail?

Probe: ask about the type, frequency, format, and issues to be included, how long?

209. Who should provide it?

Probe: organisation, peer-to-peer, external provider, included in employee wellness?

210. Could you tell us about your role in the provision of psychosocial support to TOP providers?

Probe: What do you look out for to determine TOP provider psychosocial needs? What measures do you put in place to address these?

211. In your opinion, what elements must be included in the development of guidelines for psychosocial support of TOP providers?

Probe: Relevance to the TOP provider? Adaptability to the context?

212. Do you have additional comments about psychosocial social support to providers?

THANK YOU FOR YOUR PARTICIPATION

Appendix 22: Consent for Facility Manager Interview

EXPLORING PSYCHO-SOCIAL ISSUES AND COPING STRATEGIES OF HEALTH CARE PROVIDERS AT TERMINATION OF PREGNANCY SERVICES

CONSENT FORM FOR MANAGER INTERVIEW

I have been given the information sheet on the project entitled: *Exploring psycho-social issues and coping strategies of health care providers at termination of pregnancy services.* I have read and understood the Information Sheet and all my questions have been answered satisfactorily.

I understand that it is up to me whether or not I would like to participate in the interview and that there will be no negative consequences if I decide not to participate. I also understand that I do not have to answer any questions that I am uncomfortable with and that I can stop the interview at any time.

I understand that the researcher involved in this project will make every effort to ensure confidentiality and that my name will not be used in the study reports, and that comments that I make will not be reported back to anybody else. I consent voluntarily to participate in the interview for this study. I have been given telephone numbers that I may call if we have any questions or concerns about the research.

INFORMED CONSENT FOR AUDIOTAPE-RECORDING OF INTERVIEW

I have been given the information sheet on the project entitled: *Exploring psycho-social issues and coping strategies of health care providers at termination of pregnancy services.* I have read and understood the Information Sheet and all my questions have been answered satisfactorily.

I understand that I can decide whether or not the interview should be tape-recorded and that there will be no consequences for me if I do not want the interview to be recorded.

I understand that information from the tapes will be transcribed and transcripts will be given a code and my name will not be mentioned. I understand that if the interview is tape-recorded, the tape will be destroyed two years after publication of the findings.

I understand that I can ask the person interviewing me to stop tape recording, and to stop the interview altogether, at any time.

I consent voluntarily for the researcher to record the interview.

Participant's signature: _____ Date: _____

Interviewer's signature: _____ Date: _____

Appendix 23: Information Sheet for Managers Interview

EXPLORING PSYCHO-SOCIAL ISSUES AND COPING STRATEGIES OF HEALTH CARE PROVIDERS AT TERMINATION OF PREGNANCY SERVICES IN TWO SOUTH AFRICAN PROVINCES

INFORMATION SHEET FOR MANAGERS

Introduction and background

Good day. My name is Mantshi Teffo and I am a doctoral student in the School of Public Health at the University of the Witwatersrand, conducting a study on the psychosocial issues and coping strategies of health care providers in termination of pregnancy services (TOP services) in South Africa.

I am requesting your participation as a manager because of your knowledge and expertise. The interview will last for around 45 minutes. If you agree to take part, I will ask you questions about organisational and managerial support, systems and access thereof available to health providers of TOP services, possible interventions directed at providers or the health system. The questions are not a test, so there is no right or wrong answer. It is your opinions, perceptions and experiences that are important. My role as an interviewer is to listen and to understand your point of view, and not to pass judgment. You may refuse to answer any questions that you don't feel comfortable answering. You may also say that you don't know the answer to a question.

Confidentiality

The information that you give in the interview will be kept confidential. Only persons directly involved with the research will know who has been interviewed. All interviewees will be assigned a unique code and these codes will be used on the transcribed interviews.

Participants will not be identified from the code and these codes will only be known to the researcher. I undertake that all information provided by you will be used only for the purpose of the study. Everything that you say when answering the questions will be treated as private and confidential. This means that apart from the person who asks you the questions, no one will know how you answered. Your name will not be revealed in any written data or report resulting from the study.

The answers given by participants will be combined and analysed to look for common themes and experiences. The combined information will be written up in the form of journal articles.

Consent

Permission to carry out this project was obtained from the University of the Witwatersrand Research Ethics Committee (Medical). I will ask you to sign an informed consent form, both to participate in the study and to record the interview/discussions. If you are willing to give your consent and take part, I will appreciate your participation and the information that you are willing to provide.

Benefits and risks of participation

Please note that participation in this study is voluntary and there will be no direct benefits to anyone who participates in the interviews/discussions. Similarly there will be no negative consequences for individuals who do not want to be interviewed. You will not be compensated for taking part in the study. During the interview, you have the right to decline to answer any question that makes you feel uncomfortable, or to stop the interview at any time.

Recording the interview

I would like to request your permission to audiotape the interview because I cannot write down all your answers quickly enough and might miss some important things that you will say. The tapes and notes will remain confidential and your identity will not be disclosed. Tapes of interviews will be transcribed and transcripts of interviews will bear the unique code and not the name of the interviewee. The information will then be analysed and organized into a report. The tapes will be kept in a locked cupboard. As per national requirements, the tapes will be destroyed five years after the publication of the research findings.

Contact details

I will be happy to answer any question you have about this study. This research has been approved by the University of the Witwatersrand Research Ethics Committee (Medical). If you have any questions about your rights as a study participant, or enquiries and/ or complaints about any aspect of the study, you may contact the Human Research Ethics Committee chair Professor Peter Cleaton- Jones on (011) 717 1234. If you have questions about the research, you may contact the principal researcher or the study supervisor:

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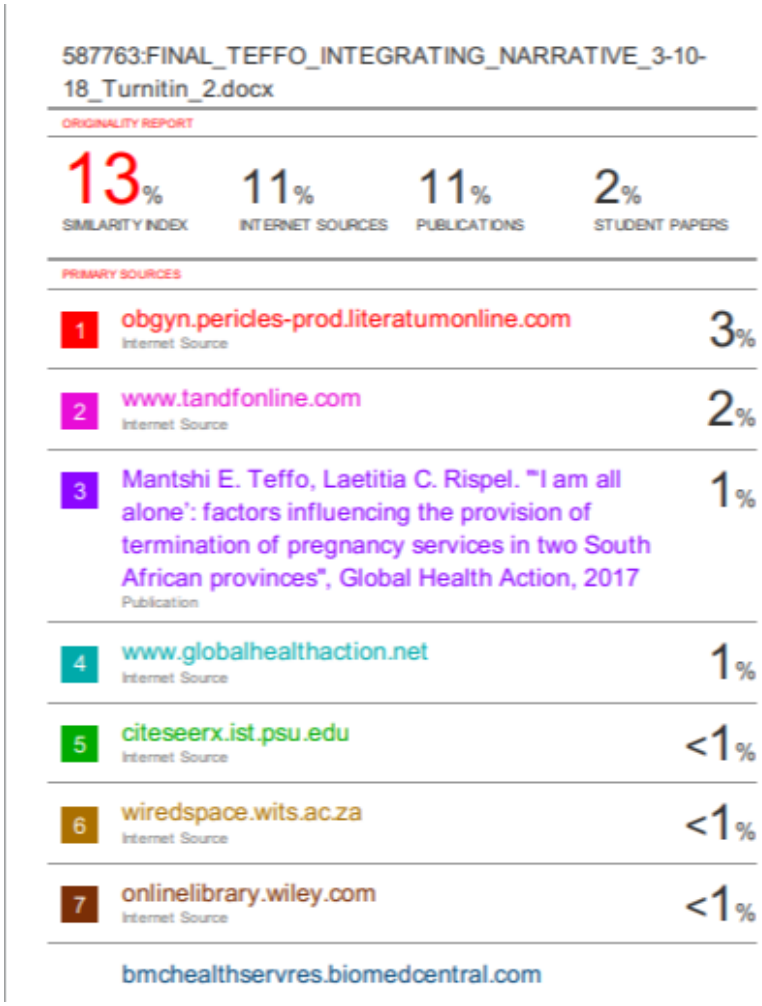
Appendix 24: TOP setting in Gauteng and North West Provinces

Indicator	Gauteng	North West	Total
Facilities providing TOP services	28 (55%)	23 (45%)	51 (100%)
Type of facility providing TOP services			
- Hospital	16 (57%)	10 (43%)	26 (100%)
- Community health centre	12 (43%)	13 (57%)	25 (100%)
Number of hospitals with TOP provided at:			**Waiting area**
- Antenatal clinic	4 (100%)	0 (0%)	shared
- Stand alone	3 (100%)	0(0%)	separate
- Mother and Child outpatient	2 (40%)	3(60%)	shared
- Gynaecology and obstetrics outpatient	7 (50%)	7 (50%)	shared
Number of CHC with TOP provided at:			**Waiting area**
- Antenatal clinic	3 (100%)	0 (0%)	shared
- Stand alone	6 (43%)	8 (57%)	separate
- Mother and Child outpatient	3 (37.5%)	5 (62.5%)	shared

Appendix 25: Turnitin Report



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