PREVALENCE OF CONSCIENTIOUS OBJECTION TO TERMINATION OF PREGNANCY AMONG HEALTH PROFESSIONALS IN THE CAPRICORN DISTRICT OF THE LIMPOPO PROVINCE

By

TSHEPO KABELO MOHALE

MINI-DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of

MASTER OF PUBLIC HEALTH

in the

FACULTY OF HEALTH SCIENCE

(School of Health Care Science)

at the

UNIVERSITY OF LIMPOPO

SUPERVISOR: Prof. E Maimela

2023

DEDICATION

This dissertation is dedicated to my mother, Matsatsi Jelous Mohale. I completed my master's of Public Health studies with your endless love and encouragement. I love you and appreciate everything that you have done for me.

DECLARATION

I declare that this dissertation titled PREVALENCE OF CONSCIENTIOUS OBJECTION TO TERMINATION OF PREGNANCY AMONG HEALTH PROFESSIONALS IN THE CAPRICORN DISTRICT OF THE LIMPOPO PROVINCE is my work. All the sources used or quoted have been acknowledged through complete references. This work has not been submitted for consideration for any other degree at any other institution.

Mohale Tshepo Kabelo — 23/01/2023

Full names — Date

_____

Signature

ACKNOWLEDGEMENTS

I want to acknowledge the following persons for their contributions to this dissertation:

- First and far most, my mother, Matsatsi Jelous Mohale, for your unconditional love, support, and encouragement. You are the best.
- Secondly, my siblings, Lefa Thapelo Ali Mohale and Lebogang Tshegofatso Hope Mohale, have provided tremendous support and understanding throughout this journey.
- A special thank you to my initial supervisor, Prof. TX Maluleke, for her guidance, support, and encouragement.
- Words cannot express how much it means to me for Prof E Maimela, who took over the supervision role after Prof Maluleke left the employ of the University of Limpopo. Your expertise and guidance played a considerable role in the completion of this.
- The Limpopo Province: Department of Health, permitting me to conduct the study.

DEFINITION OF CONCEPTS

Conscientious Objection

The term "conscientious objection" (CO) describes a health professional's unwillingness to carry out a certain action or take part in a particular circumstance because of conscience. Conscience is founded on three characteristics: an internal sense that separates right from wrong behaviors, the internalization of parental and social values, and a reflection of the integrity and wholeness of the person (Lachman, 2014). In this study, CO is the right of the healthcare professionals to refuse to participate or provide legal termination of pregnancy (TOP) or abortion services or assist during TOP procedures in the healthcare facilities designated for TOP services due to different reasons, including religious, educational, moral, or ethical beliefs.

Healthcare facility

Healthcare facility refers to places that provide healthcare services to community members (Ode, 2017). These include hospitals, community health centers (CHCs), mobile clinics, specialized care centers, and isolation camps (WHO, 2020). In this study, the healthcare facility will refer to hospitals, CHCs, and clinics in the Capricorn District that the Department of Health has designated to provide TOP services.

Healthcare Professionals

A healthcare professional is a trained individual such as a nurse, medical doctor, physiotherapist, or occupational therapist who studies, identifies, manages, and prevents human illness, injury, and other physical and mental disabilities (WHO, 2013). In this study, healthcare professionals will refer to nurses and doctors who are either trained or not trained to provide TOP services at the facilities designated to offer TOP services in the Capricorn District.

Maternal death

Regardless of the length and location of the pregnancy, the death of a woman while she is pregnant or within 42 days after delivery from any causes connected to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (Bomela, 2020). No matter the length or location of the pregnancy, maternal death will be defined in this study as the passing of a woman while pregnant or within 42 days of the pregnancy's termination.

Prevalence

Prevalence refers to the number of cases for a particular population at a given time (Ehrlich & Joubert, 2014). In this study, prevalence refers to the likelihood of having healthcare professionals refuse to participate or provide legal TOP services or assist during TOP procedures in healthcare facilities due to different reasons, due as religious, moral, cultural, or ethical beliefs.

Termination of pregnancy

Under the guidelines of the Choice on Termination of Pregnancy Act 92 of 1996, termination of pregnancy (TOP) or abortion occurs when a woman decides to end her pregnancy by using medical or surgical methods to remove the embryo, fetus, and placenta from the uterus before term (Government of South Africa, 2020). In this study, termination of pregnancy will mean the legal surgical or medical procedure used to terminate women’s pregnancies at designated healthcare facilities. Termination of pregnancy will be used interchangeably with abortion.

LIST OF ABBREVIATIONS

CEO:	Chief Executive Officer.
CHC'S:	Community health centres.
CO:	Conscientious Objection.
CTOP:	Choice on Termination of Pregnancy.
FHDC:	Faculty of Higher Degrees Committee.
ICCPR:	International Covenant on Civil and Political Rights.
ICPD:	International Conference on Population Development.
SDG'S:	Sustainable development Goals.
SREC:	School Research Ethics Committee.
TOP:	Termination of Pregnancy.
TREC:	Turfloop Research and Ethics Committee.
WHO:	World Health Organization.

ABSTRACT

Introduction: Women in South Africa have access to abortion services on demand thanks to the Choice on Termination of Pregnancy Act (CTOPA) 92 of 1996. The right to conscientious objection is one of the principal barriers to exercising this human right, which is protected by the constitution. In sub-Saharan African countries, there are little and questionable data on the prevalence of conscientious objection. Therefore, this study aimed to determine the prevalence of conscientious objections to the termination of pregnancy among healthcare professionals in the Capricorn District of Limpopo Province to ascertain the frequency of ethical objections to pregnancy termination among healthcare workers.

Methodology: A quantitative, descriptive cross-sectional research design was used to collect data from healthcare professionals at the healthcare facilities of the Capricorn District of Limpopo Province. The researcher used statistical software for Windows, such as Statistical Data Analysis version 15 (STATA, corporation, USA), and a p-value of less than 0.05 will be considered statistically significant.

Results: The overall prevalence of conscientious objection to termination of pregnancy was 55.4%. Conscientious objection to abortion was more common overall among both males and females as they aged. The healthcare professionals in the current study received were trained in a variety of methods to terminate a pregnancy, including manual vacuum aspiration, medical abortion, and dilatation and curettage. This study highlights the increasing rate of conscientious objection in the healthcare sector.

Discussion: The current study revealed that conscientious objection to termination of pregnancy is not unique to Capricorn District of Limpopo Province in South Africa. The current study found that conscientious objection to abortion was common. Contrary to other studies, religion was found not to be significantly associated with a conscientious objection to termination of pregnancy in the current study.

KEY CONCEPTS Prevalence; Conscientious objection; termination of pregnancy; healthcare facility; healthcare professional; maternal death

TABLE OF CONTENTS

1. CHAPTER ONE: OVERVIEW OF THE STUDY

1.1. Introduction and background

With the Choice on Termination of Pregnancy Act 92 of 1996 (CTOP), South Africa is one of the African nations with the most progressive abortion regulations. CTOP was implemented in 1997 to reduce the number of unsafe abortions (WHO, 2020a). The conscientious objection (CO) of healthcare providers was identified by the World Health Organization as one of the barriers to accessing safe abortion, among others such as restrictive laws, a lack of resources, high costs, stigma, and needless requirements including third-party authorization, required waiting periods, mandatory counseling, providing false information, and medically unnecessary tests (WHO, 2016). Similarly, Freeman and Coast (2019) argue that CO is also about rights, the right of healthcare providers to freedom of choice and religion. They also point out how the rights of healthcare providers contradict the right of women to access sexual and reproductive health services. To deal with these barriers, the WHO recommended that policies and regulations that legalize abortion services worldwide should enable women to access safe abortion services (WHO, 2020b).

The prevalence of denial of TOP services based on conscience claims is a growing trend and concern in healthcare worldwide because of its consequences for women, especially the most vulnerable groups (WHO, 2020b). According to the World Health Organization (WHO), in 2016, approximately 295 000 women died worldwide from preventable causes related to pregnancy and childbirth, with unsafe abortion accounting for about 70,000 deaths. About 99% of the 70 000 deaths were due to unsafe abortion, which occurred in sub-Saharan Africa, Central and Southeast Asia, Latin America, and the Caribbean (WHO, 2020a). These deaths could have been due to a lack of access to TOP services resulting from abortion restrictive laws, lack of trained staff, lack of facilities designated to provide TOP services, and the practice of CO to TOP services in TOP facilities in countries with liberal abortion laws (Magelssen, Le & Supphellen, 2019).

According to a study conducted in South Africa, barriers to obtaining abortion services include, among others, CO by trained professionals. The CO has reduced

the number of designated facilities that provide TOP services and limited the number of providers that are trained to provide service (Harries et al., 2014). It has also reduced the number of safe and legal abortion providers and has severe implications for women's access to TOP services (Freeman & Coast, 2019). Despite abortion being legally available in South Africa, barriers to accessing safe abortion services continue to exist, particularly in areas designated to offer this service due to conscientious objection (Harries *et al.*, 2014a).

The refusal to provide TOP services hurts the health and psycho-social well-being of the women who need the assistance. These refusals also contravene the international human rights policies that advocate access to the highest quality of reproductive healthcare, particularly for women seeking safe abortion services (Darzé & Barroso, 2018). Furthermore, CO could also interfere with efforts to achieve goal three of the Sustainable Development Goals (SDGs) of reducing maternal mortality because of lack of access to safe abortion services by women leading them to obtain abortion services from untrained, illegal providers who provide unsafe abortion (Keogh, Gillam, Bismark, McNamee, Webster, Bayly & Newton, 2019; Panchaud, Keogh, Stillman, Awusabo- Asare, Motta, Sidze & Monzon, 2019).

1.2. Research problem

Healthcare facilities are faced with the clash of two necessary rights, the rights of women to access abortion as a constitutional right under the CTOP law and the healthcare providers' rights to CO to abortion. This conflict of rights harms women seeking abortion services as they are often denied the services and not even referred to healthcare facilities that provide the needed service (Ngwena, 2003; Fiala & Arthur, 2017). According to WHO, conscientious objection to termination of pregnancy (TOP) is one of the significant barriers for women to access safe and legal TOP or abortion services worldwide, which often leads women to opt for unsafe and unregulated abortion services (WHO, 2016).

The researcher has observed that out of the 100 designated healthcare facilities in Capricorn district only 10 of them offer abortion services as required in the

Capricorn District. Also, healthcare providers that offer abortion services are only found within these settings that are offering the services and are often limited by their daily quota to provide the services. This is compounded by the fact that some trained providers often practice conscientious objection. According to the government news website for the republic of South Africa, between 52% and 58% of the estimated 260 000 abortions that occur in South Africa each year are illegal. Women in these situations frequently seek illegal or unsafe abortion services elsewhere or choose to carry out their undesired pregnancies as a result of the delays they face in getting a safe abortion.

These actions could be responsible for some women with incomplete and septic abortions in healthcare facilities because they were denied access to safe TOP services. In other words, some of these abortion complications could have been prevented if TOP services in healthcare facilities were available and accessible to women who need these services at all times. According to Mukwevho (2016), the number of patients admitted with incomplete abortions and complications related to the unprofessional performance of an abortion is increasing in Limpopo Province due to unavailable TOP services. These could be owing to the prevalence of CO to CTOP services. There is limited research done on the prevalence and impact of conscientious objection on CTOP in South Africa and Limpopo Province in particular. The current study could contribute valuable information that could be used to address access to abortion services when planning reproductive health services in the province. For this reason, the researcher wants to study the prevalence of conscientious objection and bring to the fore the implications that CO could have on the TOP provision.

1.3. Literature review

A literature review is a thorough summary of earlier studies on a subject (Paul & Criado, 2020). The literature reviewed was from books, surveys, scholarly articles, PubMed, Google Scholar, and the university of Limpopo online library. The reviewed literature guided the researcher to gain insights into the researched topic and be aware of what research has been done to enable the researcher to avoid

repeating the same studies. It also assisted the researcher in gaining awareness about the challenges other researchers have encountered when conducting similar studies (Brink, 2011). Chapter two will discuss a comprehensive literature review for this study.

1.4. Purpose of the study

1.4.1. Aim of the study

This study aimed to determine the prevalence of conscientious objections to the termination of pregnancy among healthcare professionals in the Capricorn District of Limpopo Province.

1.4.2. Objectives of the study

The objectives of the study were:

- To describe the demographics of healthcare workers providing termination of pregnancy at the healthcare facilities of the Capricorn District of Limpopo Province.
- To assess the prevalence of conscientious objection to termination of pregnancy services among healthcare professionals at the healthcare facilities of the Capricorn District of Limpopo Province.

- To determine causes of conscientious objection practices towards the termination of pregnancy services among healthcare professionals at the facilities of the Capricorn District of Limpopo Province.

- To determine the association between the causes of conscientious objection practices towards the provision of termination of pregnancy services and demographics of healthcare workers providing termination of pregnancy at the healthcare facilities of the Capricorn District of Limpopo Province

1.5. Research questions

The research question in the current study was “What is the prevalence of conscientious objection to termination of pregnancy among healthcare professionals at the facilities of the Capricorn District in the Limpopo Province?”

1.6. Research Methodology

A quantitative research approach was used to conduct the study, achieve the research aim, and answer the research questions. The research methodology covering the study design, study setting, study population, sampling, data collection and analysis, ethical considerations and validity, and the measures to minimise bias will be discussed in Chapter 3.

1.7. Significance of proposed research

The study could inform healthcare managers and policymakers about the prevalence of conscientious objection to termination of pregnancy which could highlight challenges related to the provision of safe, quality abortion services in healthcare facilities. It might highlight the motivation factors to CO to TOP services in healthcare facilities. The study findings could also be used to identify priorities in dealing with the clash of rights in the provision of TOP services.

1.8. Outline of the chapters

Chapter 1 covers an overview and introduction to the phenomenon of conscientious objection to abortion services which will be discussed. The background of the study will only appear in the introduction.

Chapter 2 covers an in-depth literature review of the conscientious objection to the termination of pregnancy was conducted. Articles from international high-income countries, developing countries in Africa, sub Saharan countries in Africa, including South African articles, were explored. Discussing topics of and also most recent articles were added within the literature review.

Chapter 3 covers a description of the research methodology and design following challenges that were encountered. The construction of the research instruments (questionnaire) used is justified. The pretesting of the instruments to establish their validity and reliability was discussed.

Chapter 4 covers the study findings and

Chapter 5 covers the discussions, summary, recommendations, strengths, and conclusion.

2. CHAPTER TWO LITERATURE REVIEW

2.1. Introduction

This literature review describes conscientious objection (CO) and termination of pregnancy (TOP), the laws governing the provision of TOP, the global perspective of termination of pregnancy and challenges, the prevalence of CO to abortion, the impact of CO on access to abortion, regulation of the CO clause, Access and related obstacles to CO and interventions to reduce CO. The literature was retrieved from multiple search engines, including Google Scholar, PubMed, and the online library of the University of Limpopo.

2.2. Conscientious objection

Conscientious objection to healthcare provision has become an increasingly major dilemma in healthcare systems worldwide (Magelssen, Le & Supphellen, 2019). Access to safe and legal abortion has been campaigned for by the international women's movement. By promoting abortion access as a fundamental right, more and more nations around the world are liberalizing their abortion laws (Truong & Wood, 2018). But in many cases, enduring obstacles make it impossible to fully put these laws and regulations into practice. The growing use of CO to provide abortion services on the basis of moral and religious convictions, the stigma attached to abortion, and the scarcity of providers willing to perform abortions are some aspects of this resistance to development (Harries et al, 2014).

2.3. Termination of pregnancy

Termination of pregnancy (TOP) is a safe and effective procedure. The pregnancy is ended either by taking pills or a surgical procedure. Vacuum aspiration, either by manual vacuum aspiration or electrical suction, is the method of surgical TOP, while medical abortion is another effective method that safely terminates the pregnancy (Li Lim Min, 2014). Contrarily, it is well known that all women who cannot access

safe abortion services and who are carrying an undesired pregnancy run the danger of having an unsafe, illegal abortion. When unsafe abortions are performed, there is a higher rate of maternal mortality and injury. The prevalence of unsafe abortion is higher in areas with little or no access to safe abortion providers (WHO, 2016).

2.4. The laws governing the provision of termination of pregnancy

The Human Rights Committee oversees state adherence to the International Covenant on Civil and Political Rights on a global scale (ICCPR). The Human Rights Committee has repeatedly urged national governments to take action to prevent providers from restricting women's access to abortion services by invoking their conscience or their religious beliefs (Ronald, Jr, Mishra, Lavelanet & Ganatra, 2017). From the 1960s onward, abortion laws were liberalized in several nations in Western Europe. Many of these legislation included provisions permitting healthcare professionals to refuse to conduct abortions on the basis of conscience out of political compromise or practical necessity.

The Maputo Protocol has been approved and adopted by 37 of the 54 African Union member states, with Sierra Leone being the most recent in 2015. Those with the fewest social or financial resources are likely to be disproportionately affected by widespread conscientious objection (Morrell & Chavkin, 2015). For every 100,000 unsafe abortions, roughly 30 women die in high-income nations. In underdeveloped nations, the figure jumps to 220 deaths per 100,000 unsafe abortions, and in Sub-Saharan Africa, it rises to 520 deaths per 100,000 unsafe abortions (WHO, 2016).

2.5. Global perspective and challenges of termination of pregnancy

Major international health organizations regard abortion as an essential part of reproductive health services that should not affect women's rights (Harris, Awoonor-Williams, Gerdts, Gil Arbano, Gonzeleze Velez & Halpern et al., 2016). Conscientious Objection to termination of pregnancy is a significant barrier to accessing safe abortion and impacts the women seeking to access safe abortion services (Fink, Stanhope, Rochat & Bernal, 2016; Keogh *et al.*, 2019).

Data show that globally, approximately 25 million abortions occur annually, with a third performed unsafely, which is about 8 million unsafe abortions lead to nearly 7 million maternal complications worldwide (WHO, 2016). CO has become increasingly politically contentious (Chavkin, Swerdlow & Fifield, 2017). Freedom of conscience is a core element of human rights respected among European countries, allowing abortion through the inclusion of a conscience clause.

However, the justifications for using conscientious objection are unclear (Fleming, Frith, Luyben & Ramsayar, 2018). In the context of providing healthcare, there is no international human rights criterion that specifies a right to "conscientious objection" (Truong & Wood, 2018; Amnesty International Report 2016/2017). The goals of their profession, which is to offer healthcare to those in need, are undermined when providers and institutions use personal or religious convictions to excuse their refusal to provide abortion services.

The prevalence of CO to abortion services internationally causes delays or barriers for women to access abortion services recognized internationally as a fundamental human right (Ronald *et al.*, 2017).

2.6. The African perspective and challenges of termination of pregnancy

The risk of sexual and reproductive health issues is increased for the 21 million girls in developing nations who are between the ages of 15 and 19 and the 2 million females who become pregnant each year. Even though they don't want to have kids, every year, teenagers between the ages of 15 and 19 give birth. They have several experiences that influence them to choose to either keep their children or terminate their pregnancies (TOP) (WHO, 2018a). 56 million (safe and unsafe) abortions were reportedly conducted annually over the world between 2010 and 2014, highlighting the application of human rights law and agreements regarding TOP (WHO, 2018b).

Problematic and lacking are statistics on the frequency of conscientious objection in sub-Saharan African nations (Freeman & Coast, 2019). However, even in countries where abortion has been made legal as required by the Maputo Protocol, the African

Charter on the Rights of Women in Africa, there are still implementation gaps because of stigmatization of abortion, a lack of abortion services and resources, and other obstacles, such as CO (Truong & Wood, 2018). Regulation of abortion is a sensitive issue for legislators; it frequently polarizes ideas and garners media attention (Autorino, Mattioli & Mencarini, 2020). To address the lack of services in many institutions in the study environment, the prevalence of this phenomenon needs to be investigated.

2.7. Challenges related to Abortion services in South Africa

The early, safe, and legal abortion of women is supported under the South African Choice on Termination Act (CTOP) No.92 of 1996. The CTOP Act of South Africa, which went into force in 1997, is the continent's most lenient abortion regulation. In cases where pregnancy is the result of rape, when the fetus is unlikely to survive, or when the woman's life, mental health, or physical well-being is in danger, it is permissible to have a voluntary abortion up to 12 weeks into pregnancy and without time restrictions. Less than 50% of licensed institutions with qualified midwives are offering abortion services to their communities, proving that the CTOP Act has not made abortion services consistently accessible (Truong & Wood, 2017).

The Constitutional Charter of Human Rights, which guarantees everyone's freedom of choice, including the choice not to procreate, is the foundation of South Africa's CTOP No. 92 of 1996. According to this, women have the freedom to choose their reproductive methods, as well as to request and consent to abortions. Since the CTOP Act, which allowed elective abortion, has been passed, there has been considerable public and private discussion of the ethical dilemma surrounding this issue (Pickles, 2012). Because of cultural considerations, nurses decided not to deliver these services to teenagers who requested CTOP but instead to refer them to other medical specialists (Landman, 2012).

In the South African study by Govender, the majority of nurses opposed legislation and the provision of abortion services to teens. However, the foundation of their work is care and compassion for their patients (Govender & Moodley, 2014). However, not all women who desire abortions within the specified time frame use TOP because

many TOP service providers have said that they personally disagree to abortion due to conscientious objection, stigmatization, and intimidation in medical institutions and communities (Sibuyi 2004). Due to these procedures, there is now a very high rate of serious morbidity from unsafe abortions (Hodes, 2016). Women who are turned away from healthcare facilities frequently have a painful experience since they have nowhere to report the wrongdoing and may not question the legality of the denial.

2.8. The global prevalence of Conscientious objection

Monitoring state adherence to the International Covenant on Civil and Political Rights is done by the Human Rights Committee (ICCPR). The Human Rights Committee has repeatedly urged national governments to take action to prevent providers from restricting women's access to abortion services by invoking their conscience or their religious beliefs (Ronald, Jr, Mishra, Lavelanet & Ganatra, 2017). The goals of their profession, which is to offer healthcare to those in need, are undermined when providers and institutions use personal or religious convictions to excuse their refusal to provide abortion services. The prevalence of CO to abortion services internationally causes delays or barriers for women to access abortion services recognized internationally as fundamental.

2.9. The prevalence of Conscientious objection in Africa

In the African continent, the Maputo Protocol has been adopted and ratified by 37 of the African Union's 54 member states, with Sierra Leone becoming the newest in 2015. Those with the fewest social or financial resources are likely to be disproportionately affected by widespread conscientious objection (Morrell & Chavkin, 2015). For every 100,000 unsafe abortions, roughly 30 women die in high-income nations. In underdeveloped nations, the figure jumps to 220 deaths per 100,000 unsafe abortions, and in Sub-Saharan Africa, it rises to 520 deaths per 100,000 unsafe abortions (WHO, 2016). Problematic and lacking are statistics on the frequency of conscientious objection in sub-Saharan African nations (Freeman & Coast, 2019). However, even in places where abortion has been made legal as required by the Maputo Protocol, implementation gaps persist because of abortion stigma, a lack of abortion services and funding for health care, and other obstacles, such as CO (Truong & Wood, 2018).

2.10. The prevalence of Conscientious objection in South Africa

Despite TOP services being legally available for many years in South Africa, many women are unable to access safe abortion services in areas designated to offer this service due to CO (Harries, Cooper, Strebel & Colvin, 2014). In healthcare settings where CO to TOP services are highly prevalent, women cannot access abortion services because CO downplays the availability, accessibility, and equitable public healthcare. Many women, particularly young women, are often turned away from public hospitals because the facility has reached its weekly abortion quotas, the designated provider is unavailable, or the designated facility does not provide the service at all because of the moral and religious background of the healthcare professionals.

The World Health Organization (WHO) estimates that 295 000 women worldwide died in 2017 from avoidable conditions associated with pregnancy and delivery, with unsafe abortion contributing to nearly 70,000 of those fatalities. In sub-Saharan Africa, Central and Southeast Asia, Latin America, and the Caribbean, unsafe abortion caused approximately 99% of these fatalities (WHO, 2020a). These deaths may have been caused by a lack of access to TOP services as a result of restrictive laws on abortion, a lack of staff who are trained to provide TOP services, a lack of facilities designated to do so, or the practice of CO to TOP services in TOP facilities in nations with liberal abortion laws (Magelssen, Le & Supphellen, 2019).

2.11. Impact of Conscientious objection on access to termination of pregnancy services.

The prevalence of denial of TOP services based on conscience claims is a growing trend and concern in healthcare worldwide because of its consequences for women, especially the most vulnerable groups (WHO, 2020b). The refusal to provide TOP services hurts the health and psycho-social well-being of the women who need the assistance. These refusals also contravene the international human rights policies that advocate access to the highest quality of reproductive healthcare, particularly for women seeking safe abortion services (Darzé & Barroso, 2018).

The achievement of every woman's human rights requires access to safe and legal abortions, according to the International Conference on Population and Development Report (ICDP). Women have the right to make responsible and unrestricted decisions about the timing, number, and spacing of their children. They also have the right to the best possible sexual and reproductive health care, the ability to access information, and the means to always exercise their rights in a responsible manner. For every 100,000 unsafe abortions, roughly 30 women die in high-income nations. In underdeveloped nations, the figure jumps to 220 deaths per 100,000 unsafe abortions, and in Sub-Saharan Africa, it rises to 520 deaths per 100,000 unsafe abortions (WHO, 2016). In South Africa, the prevalence of severe morbidity due to unsafe abortions has remained high (Hodes, 2016).

Furthermore, CO could also interfere with efforts to achieve goal three of the Sustainable Development Goals (SDGs) of reducing maternal mortality because of limited access to safe abortion services by women leading them to seek abortion services from untrained illegal providers who provide unsafe abortion (Keogh, Gillam, Bismark, McNamee, Webster, Bayly & Newton, 2019; Panchaud, Keogh, Stillman, Awusabo- Asare, Motta, Sidze & Monzon, 2019).

The provision of reproductive health services must include abortion. However, abortion is a crucial component of services for reproductive health. However, healthcare professionals who have moral or religious objections may decline to offer abortion services. There are few statistics on the prevalence of CO in Sub-Saharan Africa (Freeman and Coast, 2019). Health professionals may decline to perform abortions.

2.12. Regulations of the CO clause

Although healthcare providers have the right to CO, as founded by the human rights to act according to individuals' religious and conscience beliefs, they cannot be discriminated against at work based on their beliefs. They are required, however, to equally respect the rights of others and patients that may seek healthcare services that they can provide. This means they cannot invoke their human rights to violate the human rights of others (Chavkin, Swerdlow & Fifield, 2017). In

practice, how CO is currently used is quite different from the initially proposed by liberalism. CO was meant to protect people's human rights and autonomy. However, the prevalence of CO in health care has been expanding since 1970, particularly regarding euthanasia and termination of pregnancy (Michel, Kung, Lopez-salam & Navarrette, 2020).

The misuse of conscientious objection (CO) is a significant barrier to accessing a termination of pregnancy services in many developing countries (Kung, Wilkus, Diaz de Lean, Huaraz, Pearson, 2021). Evidence reveals that CO is occasionally misused by public sector healthcare organizations and providers as an excuse to abdicate their duty to offer fundamental reproductive health treatments, such as pregnancy termination, as required by international and national laws, policies, and protocols. We need to investigate the causes of the refusal of termination of pregnancy services where there is a high incidence of CO usage in order to develop measures to reduce the misuse of CO (Kung, Wilkus, Diaz de Lean, Huaraz, Pearson, 2021).

The use of conscientious objection is subject to legal restrictions. Some healthcare organizations have laws that unethically violate religious conscience by giving patients excessive freedom to refuse treatment. Under normal circumstances, medical professionals have obligations to patients that can conflict with their right to refuse treatment out of conscience (Chavkin, Swerdlow & Fifield, 2017). Although the CTOP Act does not specifically state a right to CO for healthcare professionals, it is very clear about their professional duties. The ability to refuse only relates to the actual procedure, therefore people who are not directly participating are not allowed to do so.

2.13. Access and related challenges to abortion services in the Limpopo Province

The experience in Limpopo Province indicates the value of enlisting midlevel healthcare professionals in increasing the accessibility and availability of safe, legal abortion services. However, TOP providers and healthcare facility managers often refuse to provide TOP services because of CO to TOP services, stigmatisation,

victimisation and intimidation in their communities (Sibuyi, 2004). The minister has called for the closure of some of the healthcare facilities within the province which are providing unsafe abortion practices (Mukwevho, 2016).

However, Mothiba, Muthelo, and Mabaso (2020) found that various life experiences, including worries about being rejected by parents and other family members, fears of being teased by peers and the entire community, feelings of embarrassment and shame, and how the teen's parents are likely to react when they find out about the pregnancy, had an impact on the termination of unplanned pregnancies among teenagers in Limpopo Province. The aforementioned writers advise that support services be made consistently available for youngsters who choose to stop their pregnancies in this manner. More importantly, because they are better positioned to observe the changes or observe how the teenagers adapt before and after the abortion, the supportive environment produced by family members and close friends is of the utmost importance.

Most managers of healthcare facilities and service providers mention their own conscientious objections to abortion. The results of the Sustainable Abortion Ecosystem workshops held in Limpopo by Ipas show that the province faces difficulties in educating and retaining abortion providers, which is made worse by the dearth of health care facilities providing abortion services (Orner & De Bruyn, 2021). The prevalence of CO could be the reason for this. Thus, the researcher was interested in investigating the prevalence of CO because of the limited number of health institutions offering termination-of-pregnancy services and the difficulty in retaining termination-of-pregnancy providers.

2.14 Interventions to reduce CO

The best way to deal with CO is to focus on the policy framework, legality, and governance, policy formation that will address the conditions of CO to ensure that access to abortion services is not compromised (Ramón, Kung, López-Salm & Ariza, 2020). A study done in England, Norway and Portugal found that these countries have national laws that permit healthcare workers to exercise CO in abortion care. They do so by imposing constraints on objectors and assuring that

there will still be ready access to a functioning system. This demonstrates that it is possible to allow for abortion while yet guaranteeing that women can receive abortion care (Chavkin, Swerdlow & Fifield, 2017).

Ramón et al. (2020) suggested that the key areas that need intervention, deliberation, and clarity are the extent to which providers and corresponding duties can use this refusal, the limits associated with this refusal, how this refusal must be expressed in order to be considered valid, institutional responsibility to ensure access to abortion. To lessen the burden CO places on women seeking abortion services, they also indicated the acceptance of the rules and regulations governing its implementation (Awoonor- Williams, et al., 2016).

3. CHAPTER THREE: RESEARCH METHODOLOGY

3.1. Introduction

Research Methodology is defined as the study of how the research will be carried out (Ehrlich & Joubert, 2014). It is a guide for conducting research and describes and analyses methods of gaining knowledge. It details the variables used to measurehe

proposed constructs or models (Roller & Lavrakas, 2015). The current study used a quantitative research approach to achieve the research aim and answer the research questions.

3.1 Research design

The research design refers to the precise, deliberate, and comprehensive strategic plan to carry out a given research project in order to make the research findings valid and relevant. It is a framework of research procedures and methodologies that enables the researcher to focus on research methods that are successful for the study and appropriate for the research (Creswell & Poth, 2016). It details the variables used to measure proposed constructs or models (Roller & Lavrakas, 2015). A quantitative research strategy emphasizes the statistical analysis of data gathered through surveys and objective measurements. In order to explain a specific event, quantitative research relies on collecting numerical data and generalizing it across groups of people (Ehrlich & Joubert, 2014). A quantitative descriptive cross-sectional research design was used to achieve the objectives of this study. Ehrlich and Joubert (2014) explain descriptive cross-sectional design as a useful design to study the healthcare needs of a population at a given time. A descriptive study describes the distribution of one or more variables without regard to any causal or other hypotheses (Creswell & Poth, 2016). Therefore, the design was selected as the best way to determine the prevalence of CO among healthcare professionals at selected healthcare facilities of Capricorn District in the Limpopo Province.

Cross-sectional studies take place at a single point in time, do not involve manipulating variables, consider several characteristics at once, and analyze the prevailing factors in a given population. The investigator measures the outcome and the exposures in the study participants simultaneously and is used to estimate the prevalence of disease (Creswell & Poth, 2016). In this study, the researcher used a cross-sectional study to assess the prevalence of conscientious objection toward TOP.

3.2 **Study setting**

The study was conducted in selected healthcare facilities of the Capricorn District in the Limpopo Province. Capricorn district is situated in the middle of Limpopo Province with mixed races and language groups such as Sepedi, Xitsonga, and Tshivenda. The district is dominated by Sepedi-speaking people. The Department of Health Limpopo Province website informs that the Capricorn District has 100 healthcare facilities which are hospitals, community health centers, and clinics that are distributed amongst five municipalities within the district as follows: Lepelle Nkumpi municipality has 23 health facilities, Blouberg municipality has 26 health facilities, Molemole municipality has nine facilities and Polokwane municipality has 42 of these facilities. Out of the 100 facilities in the Capricorn district, only 10 of these are providing Choice on Termination of pregnancy services. Of these ten facilities, only seven provide a Choice on termination of pregnancy daily. The study was conducted in the following healthcare facilities that offer Choice on Termination of pregnancy service daily in Capricorn district: Mankweng hospital, Seshego Hospital, Lebowakgomo Hospital, Helena Franz Hospital, W.F Knobel Hospital, Zebediela Hospital, and Rethabile Health Centre. The selected facilities have more than one healthcare provider offering the care and provision of choice on termination of pregnancy services.

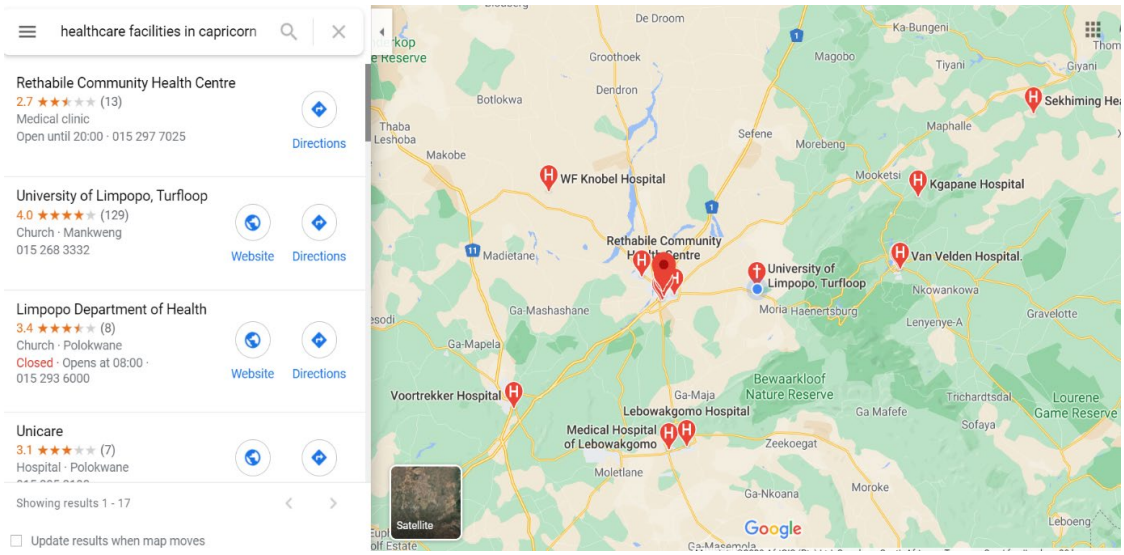


Figure 1: Healthcare facilities in Capricorn Districts

3.3 Study Population

The population refers to all individuals that meet the criteria for inclusion in the study (Grove, Gray, & Burns, 2015). The population for the current study was all healthcare

professionals that work within selected healthcare facilities that provide TOP services in Capricorn Districts. The selected healthcare facilities include Mankweng Hospital, Lebowakgomo Hospital, Seshego Hospital, WF Knobel, Helena Franz Hospital, Zebediela Hospital, and Rethabile Health Center. The population comprised all healthcare professionals (registered nurses and medical doctors) working in the Gynaecological (Gynae) ward and Clinic at selected facilities of Capricorn Districts. The healthcare professionals included both trained and non-trained nurses and medical doctors in the facilities that provide termination of pregnancy services.

3.4 Sampling

Sampling is the practice of choosing subjects who are representative of the entire population being investigated (Grove, Gray & Burns, 2015). A stratified sampling method was used where the healthcare professionals were divided into two groups: strata for the doctors and a strata for the nurses. Each element of the population belongs to one stratum. According to Grove, et al. (2015), a stratified sample can provide greater precision than a simple random sample of the same size. Then within each stratum, a random sampling method was used to select the healthcare professionals for participation in the study using the simple random technique. To achieve fair or equal participation, the researcher used a computer-based simple random sampling technique to select the respondents.

Grove, et al. (2015) define simple random sampling as a sample method that provides a firm representative of a target population by increasing the sample size. Simple random sampling further gives respondents an equal chance to be selected for the study. The current study will be conducted at selected healthcare facilities, including Mankweng Hospital, Lebowakgomo Hospital, Seshego Hospital, WF Knobel, Helena Franz Hospital, Zebediela Hospital, and Rethabile Health Centre in Capricorn District. The table below presents how many health professionals we have in each health establishment. The selected facilities are the only facilities that provide Termination of Pregnancy services on a daily basis. As such, the facilities are found to be suitable areas for conducting the study. The hospitals and clinics are located in different areas that are 30-45km away from Polokwane City. Therefore, all the healthcare professionals from the selected facilities had an equal chance to participate.

Participants were selected from the strata randomly, and whoever picked a number less than the total sample size was included in the study.

3.5 Sample size

The sample size in this research was estimated using a formula with known prevalence as the population size was unknown.

$$n = \frac{Z^2pq}{d^2}$$

Where n is the sample size

Z is the 95% confidence interval

p is the prevalence of the same phenomenon

d is the sampling error (5%)

q is 1-p

A prevalence of 44.1% has been reported in a study done by Awoonor-Williams, Baffoe, Ayivor, Fofie, et al. (2017) in Ghana on the Prevalence of conscientious objection to legal abortion services among clinicians in northern Ghana.

Therefore:

$$n = \frac{(1.96)^2(0.441)(1-0.441)}{(0.05)^2}$$

= (1.96) X (1.96) X (0.441) X (0.559)/ 0.0025

= 0,947/0.0025

= 378.81

According to this formula, the sample size for the study will be 379 healthcare professionals.

3.5.1 **Inclusion criteria**

For the current study, the criteria for inclusion of the population in the study refers to those professionals who work at sections that provide TOP services. Only the healthcare professionals working in the Gynaecological ward or clinics and those who have consented to participate in the study were included in the study because they are exposed to and involved in the provision of Termination of Pregnancy. The inclusion further included both trained and non-trained healthcare professionals for the provision of TOP services who were affected more than once in the provision of TOP services.

3.5.2 **Exclusion criteria**

Healthcare professionals who were unavailable during the data collection and those who have never been involved in the provision of TOP services were excluded from the study because of less or lack of involvement in the provision of TOP services.

3.6 DATA COLLECTION

Data collection involves obtaining information about the study topic (Grove et al., 2015). For this study, a questionnaire was used to collect data from nurses and doctors working within the reproductive unit or gynae unit at the selected healthcare facilities of Capricorn District.

3.6.1 Data collection instrument

An adapted and validated questionnaire used by Awoonor-Williams, Baffoe, Ayivor, Fofie, et al. (2017) was used in the current study to achieve the research aim. The adapted questionnaire was self-administered by the researcher who also provided clarity and guidance to the respondents regarding how to complete the questionnaire. The questionnaire was divided into four sections: Section A: Demographic information; Section B: Information about personal TOP practices; Section C: information about TOP services in the facility; Section D: training in TOP procedures and provision practices; Section E: TOP conscientious objection practices. The questionnaire consisted of closed-ended questions with a single-answer selection, comparative rating, and Likert scale type of questions to help simplify and quantify the respondents' attitudes or behaviors (see Appendix D).

3.6.2 Data collection procedure

The researchers contacted the manager of the health institutions to build rapport and discussed the involvement of the participants in the study, and planned dates for data collection. The purpose of the study was given to managers with the approval letter from Turfloop Research and Ethics Committee (TREC) and the permission letter to collect data from the Limpopo Provincial Department of Health office. Participants were recruited directly from the health establishment after Random selection from the strata groups obtained from the population. The researcher issued the questionnaire to all healthcare professionals at the selected healthcare facilities of Capricorn District.

The Questionnaires were completed in a private room, with each participant completing it individually guided by the researcher on how to complete the questionnaire. The completed questionnaire was kept in a locked room until data capturing commenced. The researcher captured the data from the questionnaire into the SPSS program for analysis purposes. The data remained on the computer device with password access encryption.

3.7 DATA ANALYSIS

A table with numbers and percentages describing respondents and non-respondents was used to report information about the number of members of the sample who did and did not return the questionnaire. Data analysis was conducted using software for Windows, such as Statistical Data Analysis version 15 (STATA, corporation, USA) and SPSS software version 26. The distribution of facility, sociodemographic characteristics, and measures of clinical practice (e.g., level of abortion training) were calculated for the whole sample and provider type (doctor and nurses). The prevalence of CO was calculated as the proportion of objectors among all respondents, and the results were stratified by provider type and facility. $\chi 2$ tests were used to identify significant differences in the prevalence of CO between provider types and health institutions. $P<0.05$ was taken to be statistically significant.

Pre-testing of the research instrument

Pretesting of a questionnaire in quantitative research refers to the stage when a questionnaire is tested on members of the target population/study population to evaluate its reliability and validity before their final distribution (Creswell & Poth, 2016). The data collection instrument – the questionnaire, was pre-tested at one of the four healthcare facilities that provide TOP services in Capricorn District that will not participate in the study. This assisted the researcher in determining if respondents understood the questions as well as if they had the information that the questions required. Pre-testing of the questionnaire was conducted with five healthcare professionals that provide TOP to ensure the reliability of the data collection instrument. The data collected from the pre-test was analyzed but will not form part of the study.

3.8 RELIABILITY, VALIDITY

The extent to which the research findings accurately depict what is occurring in the circumstance is known as validity (Grove et al., 2015). The degree to which a test is seen as covering the idea it is intended to measure is known as face validity (Grove et al., 2015). By submitting the questionnaire to my supervisor for review before to administration, face validity was verified. Additionally, the study collected data using a validated questionnaire. Grove et al. (2015) defined content validity as how thoroughly a measurement tool examines numerous facets of the particular construct in question. Content validity of the questionnaire was ensured by doing an extensive review of the literature to check if the instrument's content aims at achieving the study's objective. The questionnaires were given to the supervisor and biostatistician to evaluate if the content was valid before being administered.

When an instrument is reliable, it can be relied on to produce consistent results when used frequently throughout time on the same subject (Brink, Van der Walt, & amp; Van Rensburg, 2012). Pre-testing the research instrument implicates determining the feasibility of using an instrument in a formal study. The researcher did a pre-test to check for glitches in the wording of questions and lack of clarity of questions that may impede the instrument’s ability to collect data, to evaluate if research questions answer the research questions, and the results will assist in restructuring and validating the questionnaire.

Bias

The quality of the study's evidence may be impacted by bias, which is an effect that results in an error or distortion (Brink et al., 2012). Bias was minimized by not asking leading questions. Bias is minimized by using simple random sampling.

- Recall bias is a type of systematic inaccuracy that happens when people don't precisely recall or omit details from past experiences or events. There is a chance that later experiences and events will affect how accurate memories are (Brink et al., 2012). Recall bias was minimized by formulating high-quality

questions and allowing respondents sufficient time to complete the questionnaire and recall long-term memory.

- When respondents provide answers they think would make them liked and popular by others, they are exhibiting social desirability bias. Regardless of the research method, some people will fabricate information on sensitive or private matters in order to present themselves in the best possible light.Social desirability bias was minimized by ensuring anonymity.
- Response bias was examined using a respondent/non-respondent study. The researcher also investigated response bias by calling a small number of non-responders to see if their comments varied significantly from those of respondents. This served as a respondent-no-respondent test for bias in responses.

3.9 ETHICAL CONSIDERATIONS

The World Medical Association published principles to protect human participants in human research (Bošnjak, 2001). These are known as the declaration of Helsinki. The following ethical standards and regulations derived from the declaration of Helsinki were adhered to in the study to protect the rights of the participants.

3.10 ETHICAL CLEARANCE

The proposal was presented to the Department of Public Health at the University of Limpopo for the purpose of approval. The Department of Public Health approved the proposal to be submitted to the School Research Ethics Committee (SREC), which then granted the researcher the permission to submit the proposal to the Faculty of Higher Degrees Committee of the Faculty of Health Sciences (FHDC) at the university. The FHDC, by issuing a letter, granted the researcher permission to request ethical clearance. Ethical clearance for the study was requested from the Turfloop Research and Ethics Committee (TREC) of the University of Limpopo.

3.11 PERMISSION TO CONDUCT THE STUDY

Permission to conduct the study was obtained from the Department of Health Limpopo Province after obtaining ethics clearance from TREC. The letter requesting permission is attached as Appendix C, which was sent to the Department of Health. After receiving permission to conduct the study from the Department of Health Limpopo Province, the researcher then requested permission to conduct the study at selected healthcare facilities from the hospital's Chief Executive Officer of healthcare chosen facilities (see Appendix F for the letter to the CEO of the hospitals) after obtaining permission letter from the Limpopo Department of Health.

3.12 INFORMED CONSENT

The ethical standard of informed consent was achieved by giving accurate, relevant, and correct information about the study to the participants (Mulaudzi, Mokeana & Troskie, 2019). Signed informed consent was obtained from all participants participating in the study. The informed consent form is attached as Annexure D. The researcher has shown respect to the right to self-determination and autonomy in the study. This implies that the researcher did not coerce participants to participate in the study and has therefore respected the decision taken by them either to participate or not participate in the study.

The participants were informed in detail of the purpose and significance of the study and that their participation was voluntary. They have the right to participate willingly and to withdraw anytime during the study and data collection. The researcher has respected the right of self-determination and autonomy. This implies that the researcher has not coerced participants to participate in the research and will therefore respect the decision taken by them either to participate or not participate in the study.

3.13 PRINCIPLE OF CONFIDENTIALITY, ANONYMITY, AND PRIVACY

Mulaudzi, Mokoena, and Troskie (2019) describe the principle of confidentiality, anonymity, and privacy as the principle that entails protecting the information given by participants regarding the study. Furthermore, the authors outline that the researcher

has to build a good trusting relationship with participants to achieve the principle. The researcher has ensured that all collected information is not divulged to any unauthorized personnel but only to supervisors and that the information was kept in a safe, locked room. Lastly, the researcher assigned unique numbers to the questionnaires to protect the participants' identities. The researcher has communicated to the participants that under no circumstances will their real names be used during the study or indicated in the questionnaire or part of the questionnaire. The questionnaires were kept separate from the consent forms in a locked cabinet and safe office. Under no circumstances were they accessed by other people who were not part of the study without the participants' consent.

3.14 PRINCIPLE OF BENEFICENCE AND MALEFICENCE

The principle of beneficence and Maleficence implies that the researcher should refrain from doing anything that can harm the participants either psychologically, socially, or physically (Mulaudzi, et al., 2019). The researcher explained to the participants the purpose of the study and how it would help in clarifying and protecting the rights of the practitioners as well as clients in regard to conscientious objection to TOP services. This was done to ensure that the participants were fully informed that the study does not aim at belittling their moral beliefs but to frame policy formation to protect their moral beliefs and rights. The researcher ensured that no physical or emotional harm would be imposed on participants and participants would be able to withdraw at any time should the research topic be sensitive to their emotions or against their religious beliefs. In case of unavoidable harm that had occurred, such as participants that may get emotional or physically harmed during data collection researcher assisted them with immediate stabilization of the client by referring them to the appropriate practitioner to help them. Psychological debriefing of participants was offered post data collection.

3.15 PRINCIPLE OF JUSTICE

The principle of justice refers to being fair to all participants participating in the study (Mulaudzi, et al., 2019). The researcher ensured fairness in the study by treating all

the participants in the same manner and using the same sampling method across the population of healthcare providers.

4 CHAPTER 4: INTERPRETATION AND PRESENTATION OF FINDINGS

4.1. Introduction

In this chapter, a summary of the findings from the collected data is a cross-sectional study with population healthcare professionals working within selected healthcare

facilities that provide TOP services in Capricorn Districts. The data was collected using an adapted and validated questionnaire used by Awoonor-Williams, Baffoe, Ayivor, Fofie, et al. (2017) to achieve the research aim and the objectives which are outlined below:

- To describe the demographics of healthcare workers providing termination of pregnancy at the healthcare facilities of the Capricorn District of Limpopo Province.
- To describe the training and understanding of health professionals providing termination of pregnancy services about the rights of women at the healthcare facilities of the Capricorn District of Limpopo Province.

- To assess the prevalence of conscientious objection to termination of pregnancy services among healthcare professionals at the healthcare facilities of the Capricorn District of Limpopo Province.

- To determine the association between the demographics of health care workers providing termination of pregnancy and conscientious objection to termination of pregnancy services at the healthcare facilities of the Capricorn District of Limpopo Province

4.2. The demographics of healthcare workers providing termination of pregnancy

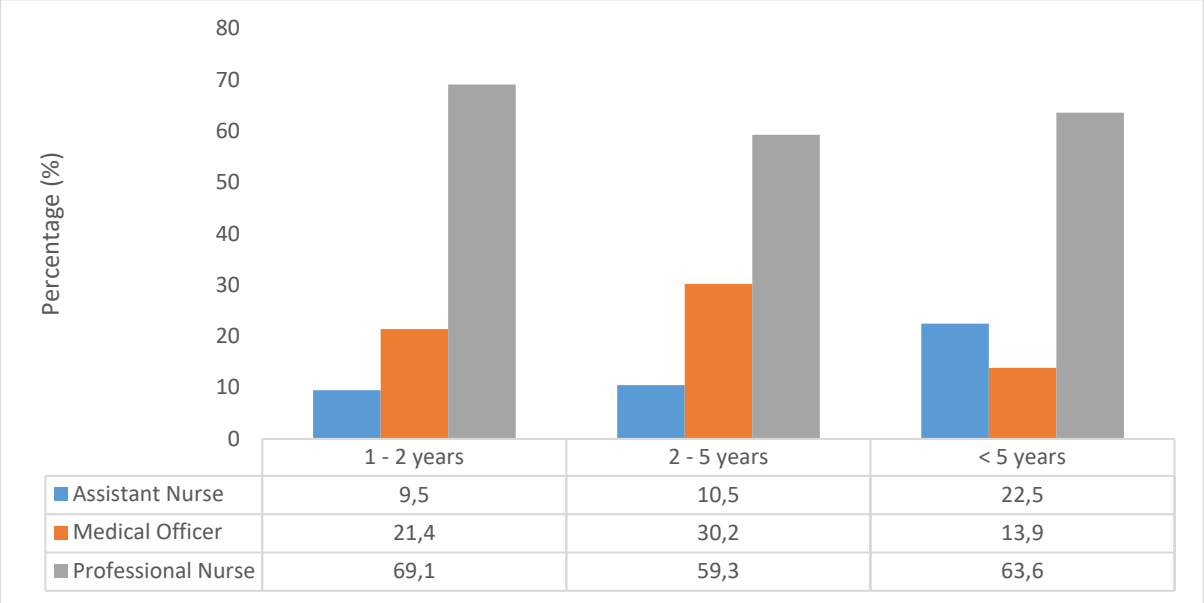
Table 4.1 Characteristics of the study population

	Both sexes (n=379) n(%)	**Female (n=270) n(%)**	**Male (n=109) n(%)**	**p-value for trend**

Age in years					
	< 30	53 (13.9)	39 (14.4)	14 (12.8)	0.040
	30 – 39	148 (39.1)	95 (35.2)	53 (48.6)	
	40 –49	93 (24.5)	77 (28.5)	16 (14.7)	
	59 – 59	70 (18.5)	49 (18.2)	21 (19.3)	
	≥60	15 (3.9)	10 (3.7)	5 (4.6)	
Marital status					
	Single	208 (54.9)	146 (54.1)	62 (56.9)	0.424
	Married	144 (38.0)	102 (37.8)	42 (38.5)	
	Divorced	21 (5.5)	16 (5.9)	5 (4.6)	
	Widowed	6 (1.6)	6 (2.2)	0 (0.0)	
Educational level					
	Diploma in Nursing (Enrolled Nurse)	57 (15.0)	46 (17.0)	11 (10.1)	<0.001
	Diploma in Nursing (Registered Nurse)	92 (28.5)	77 (28.5)	15 (13.8)	
	Bachelor of science in Nursing (Registered Nurse)	85 (22.4)	61 (22.6)	24 (22.0)	
	Medical degree (MBCHB)	73 (19.3)	30 (11.1)	43 (39.5)	
	Senior Certificate in Nursing Assistance	72 (19.0)	56 (20.7)	16 (14.7)	
Years of experience					
	1 – 2 years	84 (22.2)	65 (24.9)	19 (17.4)	0.001
	2 – 4 years	86 (22.7)	48 (17.8)	38 (34.9)	
	≥ 5 years	209 (55.2)	157 (58.2)	52 (47.7)	
Religion					
	Christians	354 (93.4)	257 (95.2)	97 (89.0)	0.101
	Atheist	9 (2.4)	4 (1.5)	5 (4.6)	
	Muslim	1 (0.3)	1 (0.4)	0 (0.0)	
	Traditionalist	15 (4.0)	8 (3.0)	7 (6.4)	

The mean age of the study population was 40.52 ±10.27 years, and the majority of participants were in the age group 30 – 39 years at 39.1%, followed by age group 40 – 49 years, 50 – 59 years, and less than 30 years at 24.5%, 18.5% and 13.9% respectively. Seventy one percent of the participants were females while most of the participants were never single at 54.9% followed by those who were married, divorced and widowed at 38%, 5.5% and 1.6%, respectively. There was a statistical significance difference between educational level (*p<0.001*) as majority of the participants were registered nurses at 50.9% (those with diploma in nursing were at 28.5% and those with a bachelor of science in nursing were at 22.4%) followed by those with MBCHB, a senior certificate in

nursing assistance and diploma in nursing for enrolled nurse at 19.3%, 19% and 15% respectively. There was a statistical significance difference between educational level (*p=0.001*) as the majority of participants had working experience of 5 years or more at 55.2% followed by those with 2 – 4 years and 1 – 2 years experience at 22.7% and 22.2%, respectively. The majority of the participants were Christians at 93.4% followed by traditionalists and atheists at 4% and 2.4%, respectively while Muslims were only 0.3% as presented in Table 4.1 above.



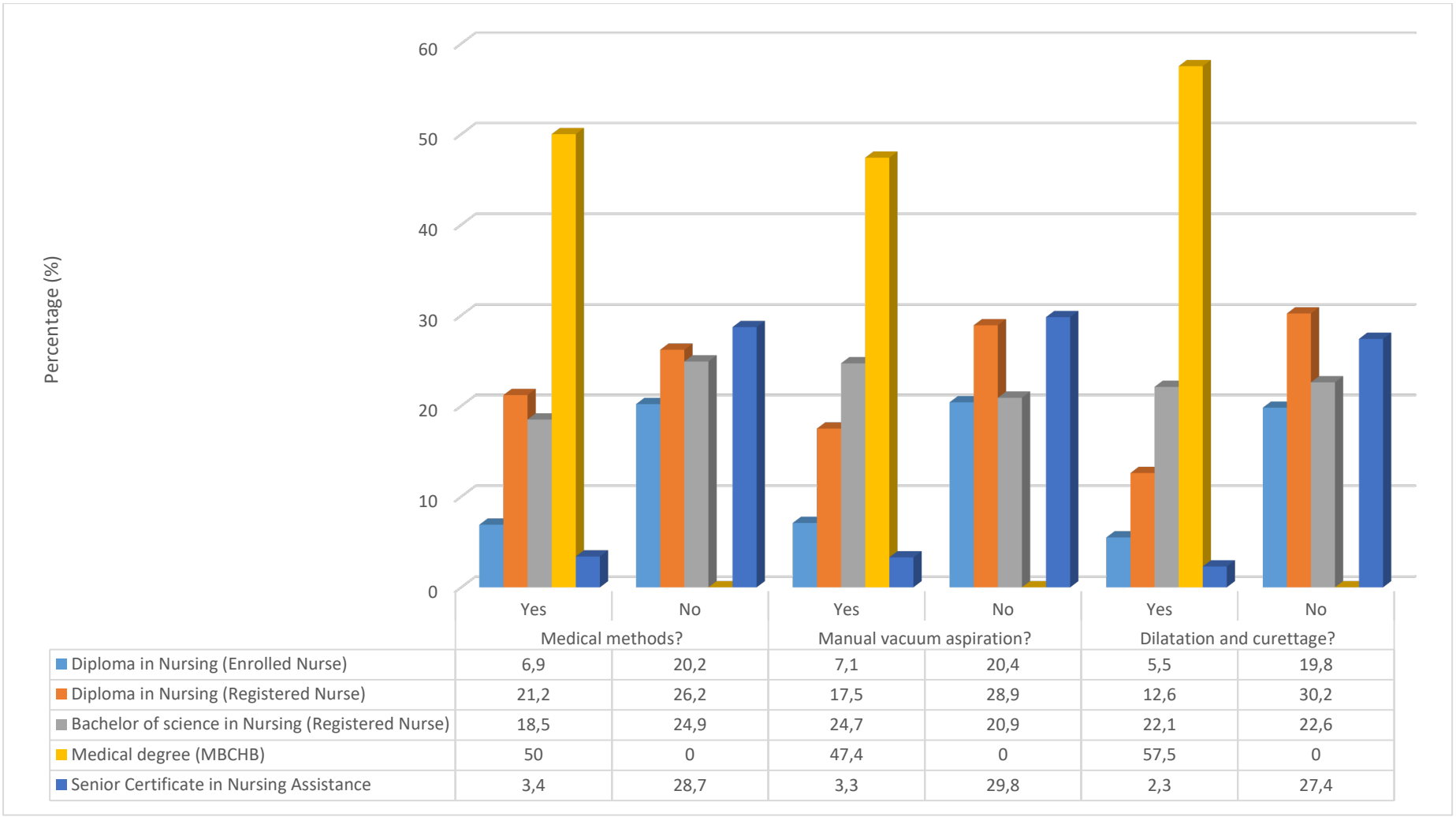
	1 - 2 years	2 - 5 years	< 5 years
Assistant Nurse	9,5	10,5	22,5
Medical Officer	21,4	30,2	13,9
Professional Nurse	69,1	59,3	63,6

Figure 4.1 The years of experience stratified by profession

As presented in Figure 4.1 above, considering the profession and work experience, professional nurses dominated with working experience of 1 – 2 years at 69.1% followed by 5 years or more and 2 – 5 years at 63.6% and 59.3%, respectively. Medical officers were dominated with working experience of 2 – 5 years at 30.2%, while assistant nurses were dominated with working experience of 5 years or more at 22.5%.

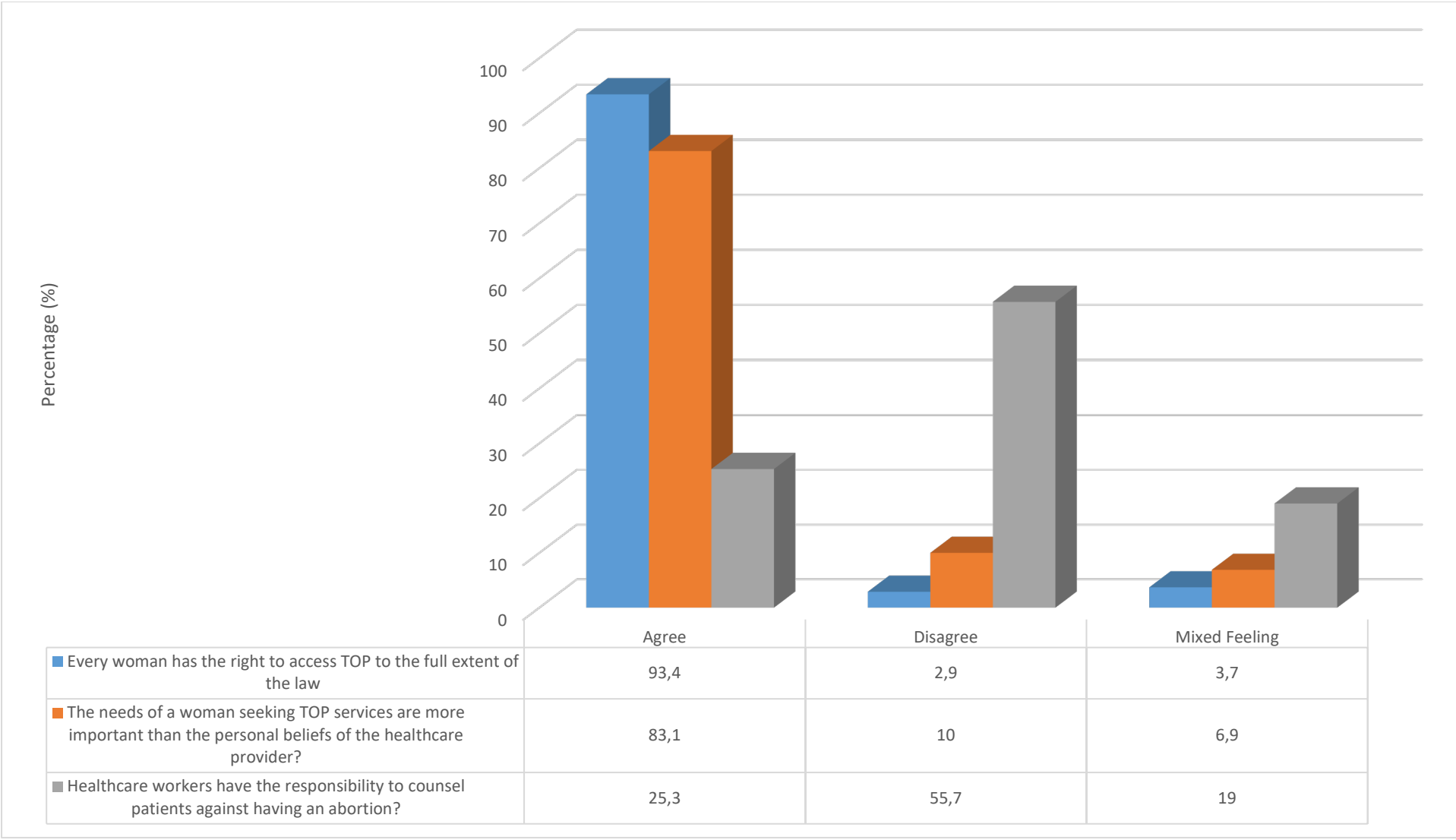
4.3 The training and understanding of health professionals providing termination of pregnancy services in relation to the rights of women

The analysis of the training of health professionals providing termination of pregnancy services stratified by level of education revealed that health professional with medical degree (MBCHB) are the mostly trained in the provision of abortion using dilatation and curettage at 57.5% followed by those who were trained in the provision of abortion using medical methods and trained in the provision of abortion using manual vacuum aspiration at 50% and 47.4% respectively.



	Medical methods?		Manual vacuum aspiration?		Dilatation and curettage?	
	Yes	No	Yes	No	Yes	No
Diploma in Nursing (Enrolled Nurse)	6,9	20,2	7,1	20,4	5,5	19,8
Diploma in Nursing (Registered Nurse)	21,2	26,2	17,5	28,9	12,6	30,2
Bachelor of science in Nursing (Registered Nurse)	18,5	24,9	24,7	20,9	22,1	22,6
Medical degree (MBCHB)	50	0	47,4	0	57,5	0
Senior Certificate in Nursing Assistance	3,4	28,7	3,3	29,8	2,3	27,4

Figure 4.2 The training of health professionals providing termination of pregnancy services by level of education



	Agree	Disagree	Mixed Feeling
Every woman has the right to access TOP to the full extent of the law	93,4	2,9	3,7
The needs of a woman seeking TOP services are more important than the personal beliefs of the healthcare provider?	83,1	10	6,9
Healthcare workers have the responsibility to counsel patients against having an abortion?	25,3	55,7	19

Figure 4.3 The understanding of health professionals providing termination of pregnancy services in relation to the rights of women

4.4 The prevalence of conscientious objection to termination of pregnancy

The overall prevalence of conscientious objection to termination of pregnancy was 55.4% as presented in Figure 4.4 below.

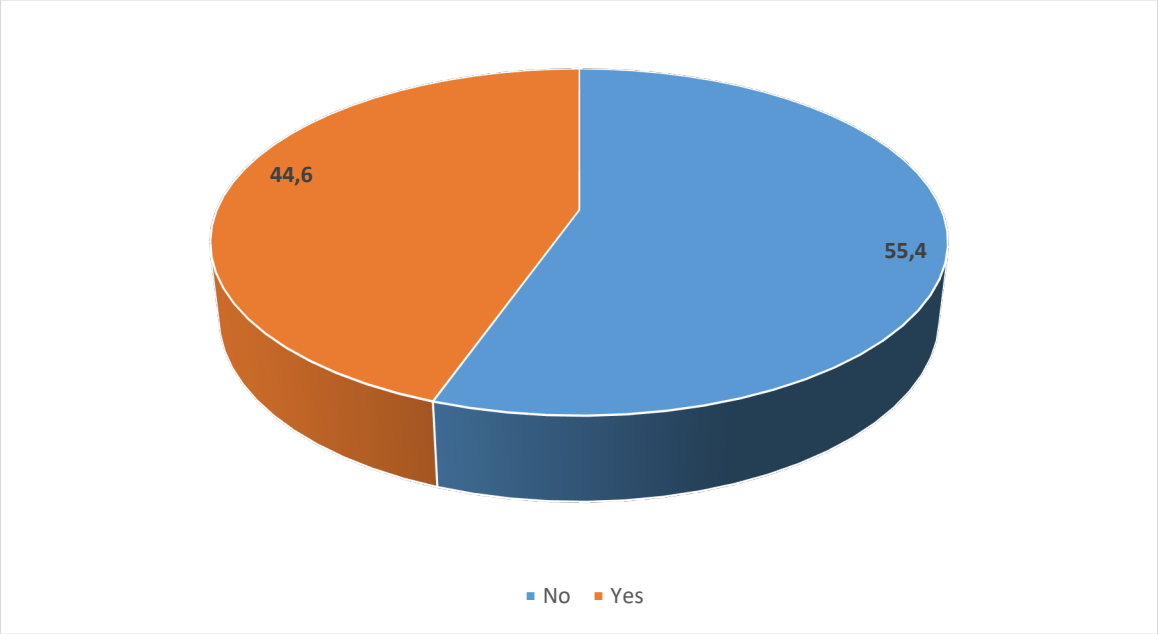


Figure 4.4 Overall prevalence of conscientious objection to performing termination of pregnancy

Table 4.2 below presents the prevalence of conscientious objection to performing termination of pregnancy by gender stratified by age group. The overall prevalence of conscientious objection to termination of pregnancy in females increased with increasing age from 42.3% in age group 23 – 34 to 53.3% in age group 35 – 44 years then dropped to 41.7% in age group 45 – 54 years and lastly increased to 44.7% in age group 55 years and above. The prevalence of conscientious objection to termination of pregnancy in females due to tiredness and being overworked increased with increasing age from 21.6% in age group 23 – 34 to 26.7% in age group 45 – 54 years. The prevalence of conscientious objection to termination of pregnancy in females due to the thought that women are using termination of pregnancy as a mode of contraceptive increased with increasing age from 36.1% in age group 23 – 34 to 40% in age group 35 – 44 years then dropped to 35% and 31.6% in age group 45 – 54 years and 55 years and above respectively. The prevalence of conscientious objection to termination of pregnancy in females due to the provider wanting to stop

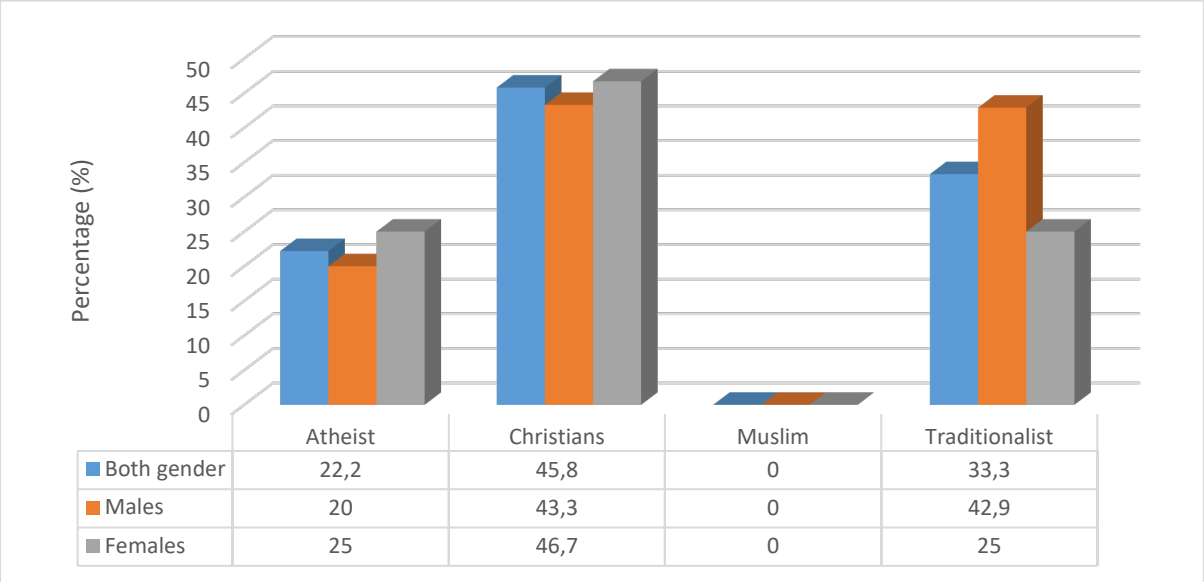
performing termination of pregnancy increased with increasing age from 3.1% in age group 23 – 34 to 10.5% in age group 55 years and above. Lastly, the prevalence of conscientious objection to termination of pregnancy in females due to the provider being threated of called names by someone increased with increasing age from 11.3% in age group 23 – 34 to 18.3% in age group 45 – 54 years then dropped to 15.8% in age group 55 years and above.

The overall prevalence of conscientious objection to termination of pregnancy in males had a similar trend like in females as it increased with increasing age from 45.9% in age group 23 – 34 to 51.3% in age group 35 – 44 years then dropped to 35.7% and 21.1% in age group 45 – 54 years and age group 55 years and above respectively. The prevalence of conscientious objection to termination of pregnancy in males due to tiredness and being overworked also increased with increasing age from 21.6% in age group 23 – 34 to 33.3% in age group 35 – 44 years then dropped from 7.1% in age group 45 – 54 years to 5.3% in age group 55 years and above. A similar trend was noted in the prevalence of conscientious objection to termination of pregnancy in females due to the thought that women are using termination of pregnancy as a mode of contraceptive as it increased with increasing age from 35.1% in age group 23 – 34 to 43.6% in age group 35 – 44 years then dropped from 35.7% in age group 45 – 54 years to 15.8% in age group 55 years and above. On contrary to females, in males the prevalence of conscientious objection to termination of pregnancy in females due to the provider wanting to stop performing termination of pregnancy decreased with increasing age 8.1% in age group 23 – 34 to 5% in age group 55 and above. Lastly, the prevalence of conscientious objection to termination of pregnancy in males due to the provider being threated of called names by someone decreased with increasing age from 16.2% in age group 23 – 34 to 7.1% in age group 45 – 54 years then increased to 10.5% in age group 55 years and above.

Table 4.2: Prevalence of conscientious objection to performing termination of pregnancy by gender stratified by age group

	Age in years			
	23 – 34 % (95% CI)	35 – 44 % (95% CI)	45 – 55 % (95%CI)	> 54 % (95% CI)
	Females (n=270)			
Prevalence				
Overall CO	42.3 (32.8 – 52.3)	53.3 (42.0 – 64.3)	41.7 (29.9 – 54.5)	44.7 (29.9 – 60.1)
CO due to tiredness and overworked	21.6 (14.5 – 30.9)	24.0 (15.6 – 34.9)	26.7 (16.9 – 39.2)	21.1 (10.9 – 36.9)
CO contraceptive method	36.1 (27.1 – 46.1)	40.0 (29.5 – 51.5)	35.0 (24.0 – 47.8)	31.6 (18.8 – 47.8)
CO because wanted to stop performing TOP	3.1 (0.9 – 9.2)	4.0 (1.3 – 11.7)	5.0 (1.6 – 14.5)	10.5 (4.0 – 24.9)
CO threatened or called names by someone	11.3 (0.6 – 19.4)	13.3 (7.3 – 23.1)	18.3 (10.4 – 30.2)	15.8 (7.2 – 31.0)
	Males (n=109)			
Prevalence				
Overall CO	45.9 (30.7 – 62.0)	51.3 (35.8 – 66.5)	35.7 (15.5 – 62.7)	21.1 (8.0 – 44.9)
CO due to tiredness and overworked	21.6 (11.1 – 37.8)	33.3 (20.3 – 49.5)	7.1 (0.9 – 37.6)	5.3 (0.7 – 29.9)
CO contraceptive method	35.1 (21.5 – 51.7)	43.6 (28.9 – 59.4)	35.7 (15.5 – 62.7)	15.8 (5.1 – 39.5)
CO because wanted to stop performing TOP	8.1 (2.6 – 22.5)	5.1 (1.2 – 18.6)	–	5.0 (0.7 – 29.9)
CO threatened or called names by someone	16.2 (7.4 – 31.9)	15.4 (7.0 – 30.5)	7.1 (0.9 – 37.6)	10.5 (2.6 – 34.1)

The prevalence of conscientious objection to termination of pregnancy by religion is presented in Figure 4.5 below. In overall, Christians had a prevalence of 45.8% followed by traditionalists and atheists at 33.3% and 22.2% respectively. A similar trend has been noted in both males and females.



	Atheist	Christians	Muslim	Traditionalist
Both gender	22,2	45,8	0	33,3
Males	20	43,3	0	42,9
Females	25	46,7	0	25

Figure 4.5 Prevalence of conscientious objection to performing termination of pregnancy by religion of participants

4.4 The association between the causes of conscientious objection practices and demographics of health care workers providing termination of pregnancy

The older healthcare workers were 1.1 times more likely to have conscientious objections than the younger ones, but not statistically significant. Males were found to be 0.9 times less likely to have conscientious objection as compared to females but also not statistically significant. Religion was found not significantly associated with a conscientious objection to the termination of pregnancy. Professional nurses were found to be 1.4 times more likely to have conscientious objections as compared to medical officers, but not statistically significant. In contrast, assistant nurses were 2.5 times more likely to have conscientious objections than medical officers, which was statistically significant at *p=0.010*. Single healthcare workers were 0.9 times less likely to have conscientious objection (p=0.670) and those who were divorced were 0.4 times less likely to have conscientious objection (*p=0.047)* as compared to married healthcare workers. Widowed healthcare workers were 5.7 times more likely to have conscientious objections than married healthcare workers, but not statistically significant. Considering years of experience of health workers, those with 2 – 4 years of working experience were found to be 0.9 times less likely to have conscientious objection (*p=0.657*), while those with 1 – 2 years of working experience were found to be 1.1 times more likely to have conscientious objection (*p=0.973*) as compared to health care workers with 5 years or more of working experience. The healthcare workers who were trained on manual vacuum aspiration to conduct termination of pregnancy were found to be 0.5 times less likely to have conscientious objection, while those who were trained on dilatation and curettage were found to be 0.6 times less likely to have conscientious objection as compared to those who were trained on medical methods both statistically significant at *p=0.002* and *p=0.020* respectively as presented in Table 4.3 below.

Table 4.3**:** Logistic regression to determine predictors of conscientious objection

Variables	OR(95%CI)	p-value
Age		
23 – 34 years	Reference (1)	Reference (1)
≥45 years	1.1 (0.7 – 1.7)[a]	0.705
Gender		
Female	Reference (1)	Reference (1)
Male	0.9 (0.5 – 1.4)[a]	0.552
Religion		
Christians	Reference (1)	Reference (1)
Atheist	0.3 (0.07 – 1.7)	0.181
Muslim	–	–
Traditionalist	0.6 (0.2 – 1.8)	0.348
Profession		
Medical Officers	Reference (1)	Reference (1)
Professional Nurses	1.4 (0.8 – 2.4)[a]	0.215
Assistant Nurses	2.5 (1.2 – 4.9)*	0.010
Marital status		
Married	Reference (1)	Reference (1)
Single	0.9 (0.6 – 1.4)[a]	0.670
Divorced	0.4 (0.1 – 1.0)*	0.047
Widowed	5.7 (0.7 – 50.4)[a]	0.115
Years of experience		
≥ 5 years	Reference (1)	Reference (1)
2 – 4 years	0.9 (0.5 – 1.6)[a]	0.657
1 – 2 years	1.1 (0.6 – 1.7)[a]	0.973
Training		
Medical methods	Reference (1)	Reference (1)
Manual vacuum aspiration	0.5 (0.3 – 0.8)**	0.002
Dilatation and curettage	0.6 (0.4 – 0.9)*	0.020

Values are reported as odds ratios (95%CI); *significant *at p<0.05;* **significant *at p<0.005;* ***significant *at p<0.001*, [a]Not significant

5 CHAPTER FIVE: INTERPRETATION AND PRESENTATION OF FINDINGS

5.1 Introduction

The study aimed to determine the prevalence of conscientious objections to the termination of pregnancy among healthcare professionals in the Capricorn District of Limpopo Province. This chapter summarises the findings and discussions made and provides conclusions about the conscientious objections by healthcare workers. Finally, the strength and weaknesses, including the limitations of the study, are discussed, and the implications for further research and clinical and public health practice are described

5.2 Demographics of the patients

In the current study, most participants were in the age group 30 – 39 years which concurs with findings from a study conducted in the Republic of Ireland (O'Shaughnessy, O'Donoghue & Leitao, 2021). The current study revealed that there was a statistical significance difference between educational level ($p<0.001$) as the majority of the participants were registered nurses, followed by those with MBCHB, which concurs with the study by O'Shaughnessy et al. (2021). Due to nurse allocation to other health programs or sending them for training to support other programs (such as primary health care), as well as provider resignation or retirement and lack of replacement by other personnel, there are human resource issues in the provision of TOP services (Teffo & Rispel, 2017). This could be supported by the fact that in the current study, the number of doctors providing TOP is very limited, which was 19% as compared to 81% of the nurses.

5.3 Training and understanding of health professionals providing termination of pregnancy services in relation to the rights of women

The TOP Act requires abortion services to be provided by trained, certified doctors in registered facilities (Cameron, Glasier, Chen, Johnstone, Dunlop & Heller, 2012; Singh, Shekhar, Acharya, Moore, Stillman & Pradhan et al., 2018). The current study

revealed that the training of health professionals providing TOP services were health professionals with a medical degree (MBCHB) who were mostly trained in the provision of abortion using dilatation and curettage, followed by those who were trained in the provision of abortion using medical methods and trained in the provision of abortion using manual vacuum aspiration respectively.

The current study concurs with findings from a study by Warriner et al. (2011), as there were lower level heath care professionals who were trained in the provision of TOP services. The mid-level provider group in the current study included midwives, nurses, auxiliary nurse midwives, and physician assistants trained in termination of pregnancy services which concurs with study findings by Renner et al., 2013. Expanding access to safe abortion services and adhering to the global trend toward task-shifting in regions where doctors are expensive and in short supply would be achieved by training midlevel healthcare professionals in medical abortion with suitable referral systems (Warriner et al., 2011). In support of the current study findings, the National Abortion Care Programme (NACP), established by the South African government, increased access to high-quality abortion care services in public clinics and health centers by educating healthcare professionals about low-cost methods for safe abortion, educating midwives about managing incomplete abortions and performing first trimester abortions with MVA, and educating midwives about post-abortion contraceptive counseling (Benson, Andersen & Samandari, 2011).

As securely as doctors can, midlevel clinicians can do vacuum aspiration first-trimester abortions. However, concerns persist over the quality of care and security of medical abortions given by midlevel healthcare professionals (Warriner et al., 2011). TOPs of pregnancies of 12 weeks gestation or less can be performed by registered medical practitioners and a registered nurse or midwife who has completed the prescribed abortion training course. TOPs in the second trimester (13–20 weeks) can only be performed by a registered medical doctor (Harries, Cooper, Strebel & Colvin, 2014). This is supported by the findings of this study, as there are different categories of healthcare workers who have been trained to perform TOP.

5.4 The prevalence of conscientious objection to termination of pregnancy

The refusal to perform an abortion on the grounds of one's moral, ethical, or religious convictions is known as conscientious objection to abortion. Additionally, it is basically about rights: the right to health; the right to reproductive freedom; the right to freedom of thought, conscience, and religion (Harris, Halpern, Prata, Chavkin & Gerdts, 2018; Freeman & Coast, 2019). Conscientious objection is complex, understudied, and seems to be a barrier to care, particularly for some minorities. However, it is uncertain to what extent teenagers' access to sexual and reproductive healthcare has been hampered by conscientious objection (Morrell & Chavkin, 2015). There aren't many statistics on the prevalence of conscientious objection or research efforts to pinpoint the causes of these objections (Darzé & Barroso Jnior, 2018). But The prevalence of conscientious objection varies significantly across countries (Autorino, Mattioli & Mencarini, 2020).

In the current study, the overall prevalence of conscientious objection to termination of pregnancy was high at approximately 55%, which is higher than the prevalence of self-identified conscientious objection among physicians, midwives, nurses, and physician assistants in hospital facilities in northern Ghana (Freeman & Coast, 2019). Data on the prevalence of conscientious objection In Sub-Saharan Africa are scarce and problematic (Freeman & Coast, 2019)

Despite South Africa's legalization of abortion following a change in the law in 1996, there are still obstacles to obtaining safe abortion services. These obstacles include provider resistance to abortion, frequently based on moral or religious convictions, and the unregulated practice of conscientious objection (Harries et al., 2017). In the current study, the prevalence of conscientious objection to termination of pregnancy by religion revealed that Christians had a high prevalence of conscientious objection as compared to other religions, which is supported by a study conducted in Italy, because Catholics make up the majority of the Italian population. Doctors' opinions may be influenced by the Catholic Church's opposition to abortion (Autorino et al., 2020).

The South African Choice on Termination of Pregnancy Act (CTOP) No.92 of 1996 promotes a woman's reproductive right to have an early, safe, and legal abortion. With this legislation, abortion-related morbidity and mortality decreased by 91.1% (Harries et al., 2017). However, despite this legislation, there are still healthcare providers who have a conscientious objection to termination of pregnancy mainly because they do not want to perform termination of pregnancy which is reported in the current study to be increasing with increasing age. This may be due to moral or religious convictions, the stigma attached to abortion, a shortage of medical professionals skilled and willing to perform abortions, and a lack of facilities specifically designed to provide abortion services, especially in rural areas (Harries et al., 2017).

The proportion of objectors to abortion among physicians in Italy (Bo, Zotti & Charrier, 2015; Minerva, 2015), Poland, Slovakia, Portugal, and Austria is already high, and it is increasing in the UK (Bo et al., 2015) which concurs with findings from the current study. Italy has reported a gradual increase in conscientious objection, with more than 80% of gynecologists against participating in elective abortion in some regions of the country (Bo et al., 2015). In South Africa, Conscientious objection is not regulated in the Choice on Termination of Pregnancy Act (CTOPA), however, it does stipulate rules for providers that state that only a direct service provider may raise conscientious objection; that a service provider cannot deny a woman medical care unrelated to abortion services; and that all clinical staff is required to treat patients with abortion complications and to perform abortion services in an emergency. Any objections from the service provider must be made in writing to their employer (Favier, Greenberg & Stevens, 2018; Nabaneh, 2020).

The International Federation of Gynecology and Obstetrics (FIGO) provides the most comprehensive ethical guidelines on the subject matter. These guidelines state that 'conscientious objection to treating a patient is secondary to the primary duty, which is to treat, provide benefit and do not harm' (Zampas, 2013, p.65). Therefore, conscientious objection triggered a debate on how religious and moral beliefs can have an impact on women's right to access free and safe abortion (Bertolè, 2021).
In Ethiopia, conscientious objection (CO) to abortion provision is not allowed due to government regulations, but it is practiced despite the regulations forbidding it

(Magelssen & Ewnetu, 2021). However, in settings where conscientious objection is highly prevalent, and abortion services are limited, conscientious objection is also about public health and equity.

Effective contraceptive use is pivotal in preventing unwanted pregnancy (Loeber & Muntinga, 2017). However, the prevalence of conscientious objection to termination of pregnancy in both males and females due to the thought that women are using termination of pregnancy as a mode of contraceptive increased with increasing age in the current study. This is supported by the research on family planning (FP) in sub-Saharan Africa (SSA) suggests that many women use abortion as their primary method of FP, sometimes instead of other contraceptive methods (Morris & Prata, 2018). Another study from Kenya supports the idea that most women who had induced abortions did not use contraception or used less effective methods in the month they became pregnant. As a result, healthcare professionals believe that women who did not use contraception were more likely to seek another abortion than those who did (Maina, Mutua & Sidze, 2015).

5.5 The association between the causes of conscientious objection practices and demographics of health care workers providing termination of pregnancy

When medical personnel who directly provide abortion care are disallowed from doing so or refrain from doing so themselves for moral, ethical, or philosophical reasons, this is known as conscientious objection (Fink, Stanhope, Rochat & Bernal, 2016). The conscientious clause in nursing is a type of unique ethical and legal regulation that grants nurses the freedom to refuse to actively perform particular medical procedures that go against their own personal system of values (typically, but not always, these values are connected to nurses' religious beliefs) (Dobrowolska, Kane, Pilewska-Kozak & Linsley, 2013). In the current study, religion was found not to be significantly associated with a conscientious objection to pregnancy termination, contrary to the findings from Italy, as the prevalence of conscientious objection was often related to religious beliefs. This is mainly because in Italy the majority of the Italian population is Catholic, and the critical stance of the Catholic Church against abortion may influence

physicians' attitudes (Autorino et al., 2020). Again in another study conducted in Australia, there was some correlation at the regional level between the percentage of objectors and how religious the population is (Keogh, Gillam, Bismark, McNamee, Webster & Bayly et al., 2019). Conscientious objection appears to be treated like a holy cow, an unquestionable religious belief, by those who want to keep it a legal right in reproductive healthcare. However, there are drawbacks and failures when evidence-based treatment and religion are combined (Fiala & Arthur, 2017). Lastly, religion has been associated with a conscientious objection to abortion procedures mainly because some Christian denominations regard it as a mortal sin, meaning a sin endangering the soul's eternal life (Cook, Olaya & Dickens, 2009). The healthcare workers who were trained on manual vacuum aspiration; dilatation and curettage; and medical methods to conduct termination of pregnancy in the current study were significantly associated with having conscientious objection. This is supported by a study conducted in Finland (Nieminen, Lappalainen, Ristimäki, Myllykangas & Mustonen, 2015).

5.6 Conclusion

The current study revealed that conscientious objection to termination of pregnancy is not unique to the Capricorn District of Limpopo Province in South Africa. The overall prevalence of conscientious objection to termination of pregnancy was 55.4%. The overall prevalence of conscientious objection to pregnancy termination in males and females increased with increasing age. The healthcare workers in the current study were trained in different methods to terminate pregnancy services, such as dilatation and curettage; medical methods, and the use of manual vacuum aspiration. The current study found an increased to the prevalence of conscientious objection to termination of pregnancy. The current study is shedding light on the increasing rate of conscientious objection in the healthcare sector. Contrary to other studies, religion was found not to be significantly associated with a conscientious objection to the termination of pregnancy in the current study.

5.7 Limitations

The limitation of the study is that the findings will not be generalizable to the general population as the study was conducted only in public healthcare facilities, even though these facilities constitute the majority of healthcare facilities in Limpopo Province.

5.8 Recommendations

The study's recommendations are based on various issues that emerged from the findings and suggestions of multiple studies reviewed. The proposed recommendations are as follows:

- Future research with more emphasis on applied social science research, with a closer examination of the interactions between women and providers in the abortion setting.
- Governments and health services should collect more data on conscientious objectors and abortion service utilization to increase quantitative data on the prevalence of conscientious objection and its impact on abortion service access.
- To complement the current study's findings, further research into women's lived experience of abortion access is needed to examine their views on how conscientious objection impacts their access.
- Lastly, research exploring health professionals' understandings of conscientious objection laws and policies is needed to identify areas where further education and policy translation is required in South Africa.

REFERENCES

Amnesty International Report 2016/17. 2017. *The state of the world's human rights*. New York: Amnesty International.

Autorino, T., Mattioli, F. and Mencarini, L., 2020. The impact of gynecologists' conscientious objection on abortion access. *Social science research*, *87*, p.102403.

Awoonor-Williams, JK, Baffoe, P, Ayivor, PK, Fofie, C, Desai, S & Chavkin, W. 2017. *Prevalence of conscientious objection to legal abortion among clinicians in northern Ghana.* Int J Gynaecol Obstet. 2017 Jan;140(1):31-36. DOI: 10.1002/ijgo.12328. Epub 2017 Oct 13. PMID: 28940197.

Benson, J., Andersen, K. and Samandari, G., 2011. Reductions in abortion-related mortality following policy reform: evidence from Romania, South Africa and Bangladesh. *Reproductive health*, *8*(1), pp.1-12.

Bertolè, G., 2021. Abortion in South Africa: The Consequences of Conscientious Objection. *LSE International Development Review*, *1*(2).

Bo, M., Zotti, C.M. and Charrier, L., 2015. Conscientious objection and waiting time for voluntary abortion in Italy. *The European Journal of Contraception & Reproductive Health Care*, *20*(4), pp.272-282.

Bomela, NJ. 2020. *Maternal mortality by socio- demographic charecteristics and cause of death in South Africa: 2007-2015.* South Africa. BMC Public Health.
Bošnjak, S. 2001. *The Declaration of Helsinki - The cornerstone of research ethics. Archive of Oncology,* 9(3):179–184.

Brink, H, Van der Walt, C & Van Rensburg, G. 2012. *Fundamentals of Research Methodology for Healthcare Professionals.* Juta.

Cameron, S.T., Glasier, A., Chen, Z.E., Johnstone, A., Dunlop, C. and Heller, R., 2012. Effect of contraception provided at termination of pregnancy and incidence of subsequent termination of pregnancy. *BJOG: An International Journal of Obstetrics & Gynaecology*, *119*(9), pp.1074-1080.

Chavkin, W, Swerdlow, L & Fifield, J. 2017. *Regulation of conscientious objection to abortion: An international comparative multiple-case study.* Health and Human Rights, 19(1):55–68.

Cook, R.J., Olaya, M.A. and Dickens, B.M., 2009. Healthcare responsibilities and conscientious objection. *International Journal of Gynecology & Obstetrics*, *104*(3), pp.249-252.

Creswell, JW & Poth, CN. 2016. *Qualitative inquiry & Research Design*. 4th ed. London: Sage Publication.

Darzé, O.I.S.P. and Barroso Júnior, U., 2018. Prevalence, attitudes, and factors motivating conscientious objection toward reproductive health among medical students. *Revista Brasileira de Ginecologia e Obstetrícia*, *40*, pp.599-605.

Ehrhlic, R & Joubert, G. 2014. *Epidemiology: A Research Manual for South Africa*. Third Edition. Cape Town Unversity Press, Oxford

Favier, M., Greenberg, J.M. and Stevens, M., 2018. Safe abortion in South Africa:“We have wonderful laws but we don't have people to implement those laws”. *International Journal of Gynecology & Obstetrics*, *143*, pp.38-44.

Fiala, C. and Arthur, J.H., 2017. There is no defence for ‘Conscientious objection’in reproductive health care. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *216*, pp.254-258.

Fink, L.R., Stanhope, K.K., Rochat, R.W. and Bernal, O.A., 2016. “The fetus is my patient, too”: attitudes toward abortion and referral among physician conscientious

objectors in Bogotá, Colombia. *International perspectives on sexual and reproductive health*, *42*(2), pp.71-80

Freeman, E. and Coast, E., 2019. Conscientious objection to abortion: Zambian healthcare practitioners' beliefs and practices. *Social Science & Medicine*, *221*, pp.106-114.

Fink, LR, Stanhope, K, Rochat, R & Bernal, O. 2016. *The fetus is my patient, too: Attitudes toward abortion and referral among physician conscientious objectors in Bogotá, Colombia.* International Perspectives on Sexual and Reproductive Health, 42(2):71–80. DOI: 10.1363/42e1016.

Fleming, V, Frith, L, Luybeen, A & Ramsayer B. 2018. *Conscientious objection to participation in abortion by midwives and nurses: A systematic review of reasons*. BMC Medical Ethics, 19(1):1–13. doi: 10.1186/s12910-018-0268-3.

Freeman, E & Coast, E. 2019. *Conscientious objection to abortion: Zambian healthcare practitioners' beliefs and practices.* Social Science and Medicine. Elsevier, 221(December 2018):106–114. doi: 10.1016/j.socscimed.2018.12.018.

Govender L & Moodley J. 2012. *Late termination of pregnancy by intracardiac potassium chloride injection: 5 years' experience at a tertiary referral center*. S Afr Med J 2012; 103(1): 47-51. http://dx.doi.org/10.7196/SAMJ.6006 PMID: 23237125 (accessed December 24, 2020).

Grove, SK, Gray, SR & Burns, N. 2015. *Understanding Nursing Research: Building Evidence-Based Practice.* 6th edition. Missouri: ELSEVIER SAUNDERS http://www.doh.limpopo.gov.za/?q=node/36 (accessed 13/11/2021) the department of health Limpopo province website.

Harries, J., Cooper, D., Strebel, A. and Colvin, C.J., 2014. Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study. *Reproductive health*, *11*(1), pp.1-7.

Harris, L.F., Halpern, J., Prata, N., Chavkin, W. and Gerdts, C., 2018. Conscientious objection to abortion provision: why context matters. *Global Public Health*, *13*(5), pp.556-566.

Government of South Africa. 2020. Terminate Pregnancy. https: //www.gov.za/services/birth/terminate-pregnancy. (accessed 24 December 2020).

Harries, J, Cooper, D, Strebel, A & Colvin, CJ. 2014. Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study. Reprod Health, 26,11(1):16. doi: 10.1186/1742-4755-11-16. From: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3996040/pdf/1742-4755-11-16.pdf (accessed 24 December 2020).

Harris, LF, Awoonor-Williams, J, Gerdtse, C, Gil Urbano, L, Gonzalez Velez, A, Halpern, J, Prata, N & Baffoe, P. 2016. *Development of a conceptual model and survey instrument to measure conscientious objection to abortion provision.* PLoS ONE, 11(10):1–18. DOI: 10.1371/journal.pone.0164368.

Hodes, R. 2016. *The Culture of Illegal Abortion in South Africa.* Journal of Southern African Studies, 42(1):79–93. DOI: 10.1080/03057070.2016.1133086.

Ipas Africa Alliance for Women's Reproductive Health & Rights. 2013. Interpreting and Implementing Existing Abortion Laws in Africa. From: https://www.sexrightsafrica.net/wp-content/uploads/2016/06/African-abortion-laws-compendium-from-the-African-Union-December-2013.pdf (accessed 20 December 2020).

Keogh, L.A., Gillam, L., Bismark, M., McNamee, K., Webster, A., Bayly, C. and Newton, D., 2019. Conscientious objection to abortion, the law and its implementation

in Victoria, Australia: perspectives of abortion service providers. *BMC medical ethics*, *20*(1), pp.1-10.

Kung, SA, Wilkus, JD, Diaz de Lean, F, Huaraz, F & Pearson, E. 2021. *"We don't want problems", reasons for denial of legal abortion on conscientcious objection in Mexico and Bolivia*. Reprod Health (2021) 18:44 https://doi.org/10.1186/s12978-021-01101-2

Lachman, V.D. 2014. *Conscientious objection in nursing: definition and criteria for acceptance.* Medsurg Nurs, 23(3):196-8. PMID: 25137800.

Landman, WA. 2012. *End-of-Life decisions, ethics, and law: A case for statutory legal clarity and reform in South Africa 2012.*

Loeber, O.E. and Muntinga, M.E., 2017. Contraceptive counselling for women with multiple unintended pregnancies: the abortion client's perspective. *The European Journal of Contraception & Reproductive Health Care*, *22*(2), pp.94-101.

Magelssen, M. and Ewnetu, D.B., 2021. Professionals' experience with conscientious objection to abortion in Addis Ababa, Ethiopia: an interview study. *Developing World Bioethics*, *21*(2), pp.68-73.

Magelssen, M, Le, NQ & Supphellen, M. 2019. *Secularity, abortion, assisted dying and the future of conscientious objection: Modelling the relationship between attitudes.* BMC Medical Ethics, 20(1):1–7. DOI: 10.1186/s12910-019-0408-4.

Maina, B.W., Mutua, M.M. and Sidze, E.M., 2015. Factors associated with repeat induced abortion in Kenya. *BMC public health*, *15*(1), pp.1-8.

Michel, AR, Kung, S, Lopez-Salam, A &Navarrette, SA. 2020. *Regulating conscientious objection to legal Abortion in Argentina, taking into consideration its use and consequences.* VOLUME 22 NUMBER 2 Health and Human Rights Journal. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7762910/pdf/hhr-22-02-271.pdf

Minerva, F., 2015. Conscientious objection in Italy. *Journal of Medical Ethics*, *41*(2), pp.170-173.

Morrell, K.M. and Chavkin, W., 2015. Conscientious objection to abortion and reproductive healthcare: a review of recent literature and implications for adolescents. *Current Opinion in Obstetrics and Gynecology*, *27*(5), pp.333-338.

Morris, N. and Prata, N., 2018. Abortion history and its association with current use of modern contraceptive methods in Luanda, Angola. *Open Access Journal of Contraception*, *9*, p.45

Mothiba, TM, Muthelo, L & Mabaso, K. 2020. *Experiences leading to the Choice of Termination of Pregnancy Amongst Teenagers at a Regional Hospital in Mpumalanga Province, South Africa.* University of Limpopo. South Africa.

Mukwevho, N. 2016. *Limpopo fighting illegal abortion clinics.* Health24, 1(1) From: https://www.news24.com/health24/Parenting/Pregnancy/Birth/limpopo-fighting-illegal-abortion-clinics-20160707. (accessed December 2, 2020)

Mulaudzi, FM, Mokoena, J D & Troskie, R. 2019. *Basic Nursing Ethics in Practice. 3rd ed.* Cape Town: Pearson.

Nabaneh, S., 2020. *Power dynamics in the provision of legal abortion: a feminist perspective on nurses and conscientious objection in South Africa* (Doctoral dissertation, University of Pretoria).

Ngwena, C. 2003. *Conscientious objection and legal abortion in South Africa: delineating the parameters.* Journal for Juridical Science 28(1): 1-18

Nieminen, P., Lappalainen, S., Ristimäki, P., Myllykangas, M. and Mustonen, A.M., 2015. Opinions on conscientious objection to induced abortion among Finnish medical and nursing students and professionals. *BMC Medical Ethics*, *16*(1), pp.1-9.

Ode, M.C. 2017. *Getting the Terminology Right for Healthcare Facilities: Codes and Standard.* Dictionary of English Language. Retrieved from 'Interpreting and Implementing Existing Abortion Laws in Africa

Ormer, P & De Bruyn M.2021. *A qualitative exploration regarding HIV positive pregnant womens descision making regarding abortion in Cape Town. https://southafrica.unfpa.org/sites/default/files/submissions/terms_of_reference_cac_.pdf*

O'Shaughnessy, E., O'Donoghue, K. and Leitao, S., 2021. Termination of pregnancy: Staff knowledge and training. *Sexual & Reproductive Healthcare*, *28*, p.100613.

Panchaud,C, Keogh,S.C, Melissa Stillman, Kofi Awusabo-Asare, Angélica Motta, Estelle Sidze & Ana Silvia Monzón.2019. *Towards comprehensive sexuality education: a comparative analysis of the policy environment surrounding school-based sexuality education in Ghana, Peru, Kenya and Guatemala, Sex Education*, 19:3, 277-296, DOI: 10.1080/14681811.2018.1533460

Paul, J & Criado, A.R. 2020. The art of writing literature review: What do we know and what do we need to know? *International Business Review, Elsevier*, 29(4).

Pickles, C. 2012. *The termination-of-pregnancy rights and fetal interest in continued existence in South Africa: The Choice on Termination of Pregnancy Act 92 of 1996.*

Popinchalk, A. and Sedgh, G., 2019. Trends in the method and gestational age of abortion in high-income countries. *BMJ sexual & reproductive health*, *45*(2), pp.95-103.

Potchefstroom Electronique Regsblad 2012; 15(5): 403-34. [http://dx.doi.org/10.17159/1727-3781/2012/v15i5a2530] (accessed December 24, 2020).

Ramón Michel A, Kung S, López-Salm A, Ariza Navarrete S. Regulating Conscientious Objection to Legal Abortion in Argentina: Taking into Consideration Its Uses and Consequences. Health Hum Rights. 2020;22(2):271-283.

Renner, R.M., Brahmi, D. and Kapp, N., 2013. Who can provide effective and safe termination of pregnancy care? A systematic review. *BJOG: An International Journal of Obstetrics & Gynaecology*, *120*(1), pp.23-31.

Roller, M.R & Lavrakas, P.J. 2015. *Applied Qualitative Research Design: A Total Quality Framework Approach.* New York: The Guilford Press

Ronald, B, Jr, J, Mishra, V, Lavelanet, F & Ganatra B. 2017. *A global database of abortion laws, policies, health standards, and guidelines*, (June):542–544.

Sibuyi, MC. 2004. *Provision of Abortion Services by Midwives in Limpopo Province of South Africa.* African Journal of Reproductive Health 8(1):75-8. DOI: 10.2307/3583309

Singh, S., Shekhar, C., Acharya, R., Moore, A.M., Stillman, M., Pradhan, M.R., Frost, J.J., Sahoo, H., Alagarajan, M., Hussain, R. and Sundaram, A., 2018. The incidence of abortion and unintended pregnancy in India, 2015. *The Lancet Global Health*, *6*(1), pp.e111-e120.

South Africa. 1996. Choice on termination of pregnancy Act, no. 92, 1996. Government Gazzette.
https://www.parliament.gov.za/storage/app/media/.../womens.../Act92of1996.pdf (accessed 24 December 2020).
https://www.sanews.gov.za/south-africa/sas-illegal-abortion-rate-alarmingly-high

Teffo, M.E. and Rispel, L.C., 2017. 'I am all alone': factors influencing the provision of termination of pregnancy services in two South African provinces. *Global health action*, *10*(1), p.1347369.

Truong, M & Wood, SY. 2018. *Unconscionable: When providers deny abortion care*. International Women's Health Coalition. From: https://iwhc.org/wp-content/uploads/2018/06/IWHC_CO_Report-Web_single_pg.pdf. (accessed December 24, 2020).

WHO. 2020a. Environmental health in emergencies: Health-care facilities. Geneva: World Health Organization. From: https://www.who.int/environmental_health_emergencies/services/en/ (accessed December 24, 2020).

WHO. 2020b. Preventing unsafe abortion. Geneva: World Health Organization . https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion (accessed December 24, 2020).

WHO. 2018. Facts sheets: Adolescent Pregnancy 2018. Geneva: World Health Organization. From: https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy (accessed December 24, 2020).

WHO. 2018. Facts sheets: Preventing unsafe abortion 2018. Geneva: World Health Organization. From: https://www.who.int (accessed December 24, 2020).

WHO. 2016. *Preventing unsafe abortion*. Geneva: World Health Organization. From: https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion (accessed December 24, 2020).

WHO. 2013. *Transforming and Scaling Up Health Professionals' Education and Training: World Health Organization Guidelines.* Geneva: World Health Organization. From: https://www.ncbi.nlm.nih.gov/books/NBK298950/ (accessed December 24, 2020).

WHO. 2011. *Valuing Water, Valuing Livelihoods.*. Geneva: World Health Organization.

Warriner, I.K., Wang, D., Huong, N.M., Thapa, K., Tamang, A., Shah, I., Baird, D.T. and Meirik, O., 2011. Can midlevel health-care providers administer early medical abortion as safely and effectively as doctors? A randomised controlled equivalence trial in Nepal. *The Lancet*, *377*(9772), pp.1155-1161.

Appendix A: Permission letter to the Department of Health

Department of Public
Health University of
Limpopo
Sovenga 0727
Date:

The Head of Department
Limpopo Provincial Government
College Avenue
Hospital Park, 0699

RE: PERMISSION TO CONDUCT RESEARCH ON THE PREVALANCE OF CONSCIETUOIS OBJECTION TOWARDS ABORTION SERVICES IN CAPRICORN DISTRICT SELECTED HEALTH FACILITIES.

My name is Tshepo Kabelo Mohale student number 202065550, a Masters student in the Department of Public Health at the University of Limpopo (Turfloop Campus). I am interested in conducting a study to determine the prevalence of conscientious objection towards abortion services among healthcare providers in Capricorn district selected health facilities.

I hereby apply to be granted permission to conduct this research at the above-mentioned hospital. I would like to reassure than ethical considerations are put in place before the study and will be maintained throughout the study to protect the rights to confidentiality of the patients. Data will be collected through use of a questionnaire tool which will be provided to the healthcare providers that are selected randomly.

Your approval will be highly appreciated

Yours Faithfully

Mohale Tshepo Kabelo (Masters Student)

Date_____

Appendix B: Questionnaire

CONSCIENTIOUS OBJECTION TO ABORTION QUESTIONNAIRE
Interview date:
Section A: Demographic information
Please answer the following questions:

1.1. What is your Gender?

Male ☐ Female ☐ Other ☐

1.2. How old are you?

☐

1.3. Country where you were born:

☐

1.4 Country where you obtained your healthcare qualification:

☐

1.5 What is your religion?

- Christianity
- Islam
- Buddhism
- Traditional
- Other specify below

☐

1.6 How do you classify yourself in terms of race?

- African
- White
- Coloured
- Indian
- Other

1.7 What is your marital status?

- Never married
- Married
- Single
- Divorced
- Widowed

1.8 What is your qualification?

1.9 What is your position at this facility?

1.10 The unit where you are working:

SECTION B: INFORMATION ABOUT PERSONAL TOP PRACTICES

2.1 How long have you been working in this unit?----------

2.2 Is your unit one of the designated TOP provision facilities? ----------

2.3 When (year & month) was your unit designated to provide TOP services: -------

2.4 Does you unit provide TOP services? Yes /No

2.5 When last (year & month) did your unit provide TOP? ----------

2.6 Do you provide TOP? Yes /No. **(If "NO" skip questions 2.7 & 2.8)**

2.7 When was your first time (year & month) you provided TOP? ----------

2.8 When was the last time (date,month & year) you provided TOP? ----------

a. Do you assist during TOP services? Yes /No. **(If "NO" skip questions 2.10 & 2.11)**
b. When was your first time (year & month) you assisted during TOP? ----------
c. 2.11 When was the last time (date,month & year) you assisted during TOP? ----------

2.12 Do you refer women seeking TOP services to other facilities or unit Yes/ No. (**If "NO" skip questions 2.13 & 2.14)**

2.13 When was the first time (year & month) you referred a woman seeking TOP to other facilities or units? ----------

2.14 When was the last time (year & month) you referred a woman seeking TOP to other facilities or units? ----------

2.15 Have you ever refused to refer a woman seeking TOP to other facilities or units? Yes/No. (**If "NO" skip questions 2.16 & 2.17)**

2.16 When was the first time (year & month) you refused to refer a woman seeking TOP to other facilities or units? ----------

2.17 When was the last time (year & month) you refused to refer a woman seeking TOP to other facilities or units? ----------

SECTION C. TRAINING IN TOP PROCEDURES AND PROVISION PRACTICES

3.1 Have you been trained in the provision of abortion using medical methods?

- Yes
- No

3.2 Have you been trained in the provision of abortion using manual vacuum aspiration?

- Yes
- No

3.3 Have you been trained in the provision of abortion using dilatation and curettage.

- Yes
- No

3.4 Have you ever provided TOP information to clients seeking abortion in your institution

- Yes

- No

3.5 Have you ever helped a woman find TOP unit, provided directions or escort.

- Yes
- No

3.6 Have you ever provided positive support to women seeking abortion services?

- Yes
- No

3.7 Have you ever tried to convince women seeking TOP that she should not have TOP?

- Yes
- No

3.8 Have you ever told a woman seeking TOP that she is too young and should come with a guardian/parent?

- Yes
- No

3.9 Have you ever told women that TOP services are not being provided at the facility?

- Yes
- No

Please state whether you personally agree, disagree or have mixed feelings in the following statements.

3.10 Every woman has the right to access TOP to the full extent of the law?

- Agree
- Mixed feelings
- Disagree

3.11 The needs of a woman seeking TOP services are more important than the personal beliefs of the healthcare provider?

- Agree
- Mixed feelings
- Disagree

3.12 Healthcare workers have the responsibility to counsel patients against having an abortion?

- Agree
- Mixed feelings
- Disagree

3.13 I feel that TOP is morally wrong?

- Agree
- Mixed feelings
- Disagree

3.14 A women having TOP is committing a sin?

- Agree
- Mixed feelings
- Disagree

3.15 TOP providers are committing murder?

- Agree
- Mixed feelings
- Disagree

3.16 TOP providers are committing a crime?

- Agree
- Mixed feelings
- Disagree

3.17 TOP providers don't care about women's health?

- Agree
- Mixed feelings
- Disagree

Please state how you will handle the following situations described by the following scenarios. By choosing one of the listed responses.

3.18 A 13 year old rape survivor requests TOP, she is 18/40 of gestation?

- Willing
- Somewhat willing
- Not willing

3.19 Please indicate the reason for the response you chose in 3.18 by choosing one response from the ones below:

- Gestation age
- Religious beliefs
- Personal reasons
- Other (Specify) ----------

3.20 A 20 years old medical student requests TOP. She tells you that if her parents knew about the pregnancy they will stop paying for her tuition fees? Indicate your response by choosing one response below:

- Willing
- Somewhat willing
- Not willing

3.21 Please indicate the reason for the response you chose in 3.20 by choosing one response from the ones below:

- Gestation age
- Religious beliefs
- Personal reasons
- Other (Specify) ----------

3.22 A 26 years old prim gravida requests TOP, she tells you that she was recently diagnosed with cervical cancer and her oncologist recommends that she terminates her 8/40 pregnancy? Indicate your response by choosing one response below:

- Willing
- Somewhat willing
- Not willing

3.23 Please indicate the reason for the response you chose in 3.22 by choosing one response from the ones below:

- Gestation age
- Religious beliefs
- Personal reasons
- Other (Specify) ----------

3.24 Would you support the right to object for the following reasons. Indicate YES/NO in the space provided.

- Moral or religious reasons ----------
- Abortion before week 12 ----------

- Abortion for medical reasons ----------
- Referral for abortion ----------

3.25 Would you perform TOP for the following reasons. Indicate YES/NO in the space provided.

- The rights of women to the right to freedom of choice -------
- The rights of women to health -------
- The right to access sexual and reproductive health services -------
- Abortion before week 12 -------
- Abortion for medical reasons -------
- Abortion after week 12 -------
- Abortion for congenital abnormalities before 24 weeks -------
- Abortion due to rape & incest -------

SECTION D: TOP CONSCIENTIOUS OBJECTION PRACTICES

4.1 During the past 30 days, on how many days did you exercise your right to practice CO because you felt tired and overworked? ----------

4.2 During the past 30 days, on how many days did you exercise your right to practice CO because you felt women were using abortion as a contraceptive method? ----------

4.3 During the past 30 days, on how many days did you exercise your right to practice CO because you were concerned about quality of care within the health facility? ----------

4.4 During the past 30 days, on how many days did you exercise your right to practice CO because of comments and attitudes of colleagues for providing TOP services? ----------

4.5 During the past 30 days, on how many days did you exercise your right to practice CO because you wanted to stop performing TOPs? ----------

4.6 During the past 12 months, how many times have you exercise your right to practice CO because you wanted to stop performing TOPs? ----------

4.7 During the past 12 months, how many times has someone threatened or called you names because of providing TOP services? ----------

Thank you, you've reached the end of the questionnaire.

APPENDIX C: INFORMED CONSENT

- Participants informed consent

Study Title: Prevalence of conscientious objection towards abortion services in Limpopo, Capricorn district hospitals.

Introduction:

You are invited to take part in a research study. Before you decide to participate, you need to understand why the research is being done and what it would involve. Please take the time to read, or to listen as I read, the following information. You may talk to others about the study if you wish. Please ask me if anything is not clear, or if you would like more information. When all of your questions have been answered and you feel that you understand this study, you will be asked if you wish to participate in the study. If yes, you will be asked to sign the informed consent form. You will also be given a copy to keep for your records.

Purpose of the study

What is the study?

The purpose of the study is to evaluate the prevalence of conscientious objection in Capricorn district Polokwane municipality health facilities.

Why have I been invited to take part?

You have been invited to take part because you work in a health facility that is situated within the study setting.

Study Procedure

What will happen if I take part?

If you agree to participate in the study, you will be asked to sign this form indicating your consent to participate. The health facilities participating in the study have been randomly selected.

Risks

What are the risks of the study?

Some of the questions asked on the survey might bring up feelings or make feel uncomfortable. This might happen to you. If you are feeling upset during or after the

survey and would like to speak to someone else, we can refer you to someone who can talk with you. Please remember that your participation in the study is voluntary. You may refuse to answer any of the questions, and you can stop the survey at any time.

Benefits

What are the benefits of participating?

You will not get any direct benefits from participating in this study. However, you may benefit indirectly from the knowledge gained by participating in this study. The results of this study will be shared with you.

Confidentiality

All questionnaires answers will be kept private and confidential.no one will be told that you participated in this study. All paper consent forms and surveys will be stored in a locked filling cabinet. Only study staff will have access to these.

Voluntariness

What are my rights as a research participant?

Your participation in this study is completely voluntary, and you can decide to stop participating at any time. You may refuse to participate or withdraw without penalty or loss of benefits to which you are entitled. If you decide that you no longer wish to continue in this study, you can tell us, and we will remove you from the study list. If you decide to take part, you can skip or not answer any questions you do not want to answer, for any reason.

Alternatives

The alternative to participation in this study is not to participate. Participation is voluntary and choosing not to participate will have no impact on your employment or benefits to which you are entitled.

Additional Information

What will I receive for participating?

You will not receive compensation for participating in this study.

What will happen to the results of the research study?

The results of the study may be shared with local organisations and/or the ministry of Health. Additionally, they may be presented at conferences and published in a journal. No names or identifying aspects of any participant will be shared anywhere.

Who has reviewed the study for ethical issues?

This research has been approved by University of Limpopo ethical clearance to conduct research.

What if I need more information?

Feel free to ask me, or any other researcher, any other questions you have, and we will do our best to answer your questions. You may also contact the Principal Investigator at any time: Tshepo Kabelo Mohale Masters of Public Health student at +27 81 505 2181 or at tshepo.kabelo@gmail.com.

Statement of Consent

If you don't have any/any more questions, and want to participate in the study, I will read a statement and ask if you agree.

> *I have read the information in this consent form including risks and possible benefits or it has been read aloud to me. All my questions about the study and my participation in it have been answered to my satisfaction. I understand what my involvement in the study means, and I voluntarily agree to participate. I understand my participation is study means, and I voluntarily agree to participate. I understand my participation is voluntary, and I can refuse to participate at any moment, for any reason, without penalty.*

I consent to participate in the study.

Signature

The signature below indicated your permission to take part in this research.

_____	_____
Signature of participant	Date
_____	_____
Signature of person obtaining consents	Date
_____	
Printed name of person obtaining consent	

Appendix D: Permission letter to Provincial Department of Health

Box 4197
Ga- Kgapane
0838

Date:

The Head of Department
Department of Health
Limpopo Province
Polokwane
0699

RE: Permission to conduct research on the prevalence of conscientious objection towards abortion services at selected healthcare facilities in Capricorn District.

My name is Mohale Tshepo Kabelo student number 202065550, a Masters student in the Department of Public Health at the University of Limpopo (Turfloop Campus). I am interested in conducting a study of the prevalence of conscientious objection towards abortion services among healthcare providers in Capricorn Distrct health facilities within the obstetric units.

I hereby apply to be granted permission to conduct this research at your institution. I would like to reassure that ethical considerations are put in place before the study and will be maintained throughout the study until completion to protect the rights of the patients. Data will be collected by use of a questionnaire and participants will be randomly selected to participate after providing informed consent.

Your approval will be highly appreciated

Yours Faithfully

Mohale Tshepo Kabelo (Masters Student) Date_____

Appendix E: Faculty approval

University of Limpopo
Faculty of Health Sciences
Executive Dean
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 2149, Fax: (015) 268 2685, Email: tebogo.mothiba@ul.ac.za

DATE: 28 November 2021

NAME OF STUDENT: MOHALE TK
STUDENT NUMBER: 202065550
DEPARTMENT: PUBLIC HEALTH
SCHOOL: HEALTH CARE SCIENCES
QUALIFICATION: MPH

Dear Student

FACULTY APPROVAL OF PROPOSAL (PROPOSAL NO. FHDC2021/8)

I have pleasure in informing you that your MPH proposal served at the Faculty Higher Degrees Meeting on the 17 November 2021 and your title was approved as follows:

Approved Title: "Prevalence of Conscientious Objection to Termination of Pregnancy Among Health Professionals in the Capricorn District of the Limpopo Province".

Note the following:

Ethical Clearance	Tick One
Requires no ethical clearance Proceed with the study	
Requires ethical clearance (TREC) (apply online) Proceed with the study only after receipt of ethical clearance certificate	√

Yours faithfully

Prof T.M Mothiba
Chairperson

CC: Supervisor: Prof XT Maluleke

Finding solutions for Africa

Appendix F: Ethical Clearance

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE

ETHICS CLEARANCE CERTIFICATE

MEETING: 23 February 2022

PROJECT NUMBER: TREC/30/2022: PG

PROJECT:

Title:	Prevalence of Conscientious Objection to Termination of Pregnancy among Health Professionals in the Capricorn District of the Limpopo Province.
Researcher:	TK Mohale
Supervisor:	Prof. XT Maluleke
Co-Supervisor/s:	N/A
School:	Health Care Sciences
Degree:	Master of Public Health

PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:

i) **This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.**

ii) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.**

iii) **PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.**

Finding solutions for Africa

Appendix G: Provincial Department of Health Approval

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
HEALTH

DEPARTMENT OF HEALTH
CAPRICORN DISTRICT
RECEIVED
09 JUN 2022
DISTRICT EXECUTIVE MANAGER
PRIVATE BAG X9530 POLOKWANE 0700

Ref : LP_2022-05-004
Enquires : Ms PF Mahlokwane
Tel : 015-293 6028
Email : Phoebe.Mahlokwane@dhsd.limpopo.gov.za

TSHEPO KABELO MOHALE

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below;

PREVALENCE OF CONSCIENTIOUS OBJECTION TO TERMINATION OF PREGNANCY AMONG HEALTH PROFESSIONALS IN THE CAPRICORN DISTRICT OF THE LIMPOPO PROVINCE

1. Permission to conduct research study as per your research proposal is hereby Granted
2. Kindly note the following:
   a. Present this letter of permission to the office of District Executive Manager a week before the study is conducted.
   b. This permission is for **Capricorn District Hospitals including Rethabile CHC Only**.
   c. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
   d. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   e. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   f. The approval is only valid for a 1-year period.
   g. If the proposal has been amended, a new approval should be sought from the Department of Health
   h. Kindly note that, the Department can withdraw the approval at any time.

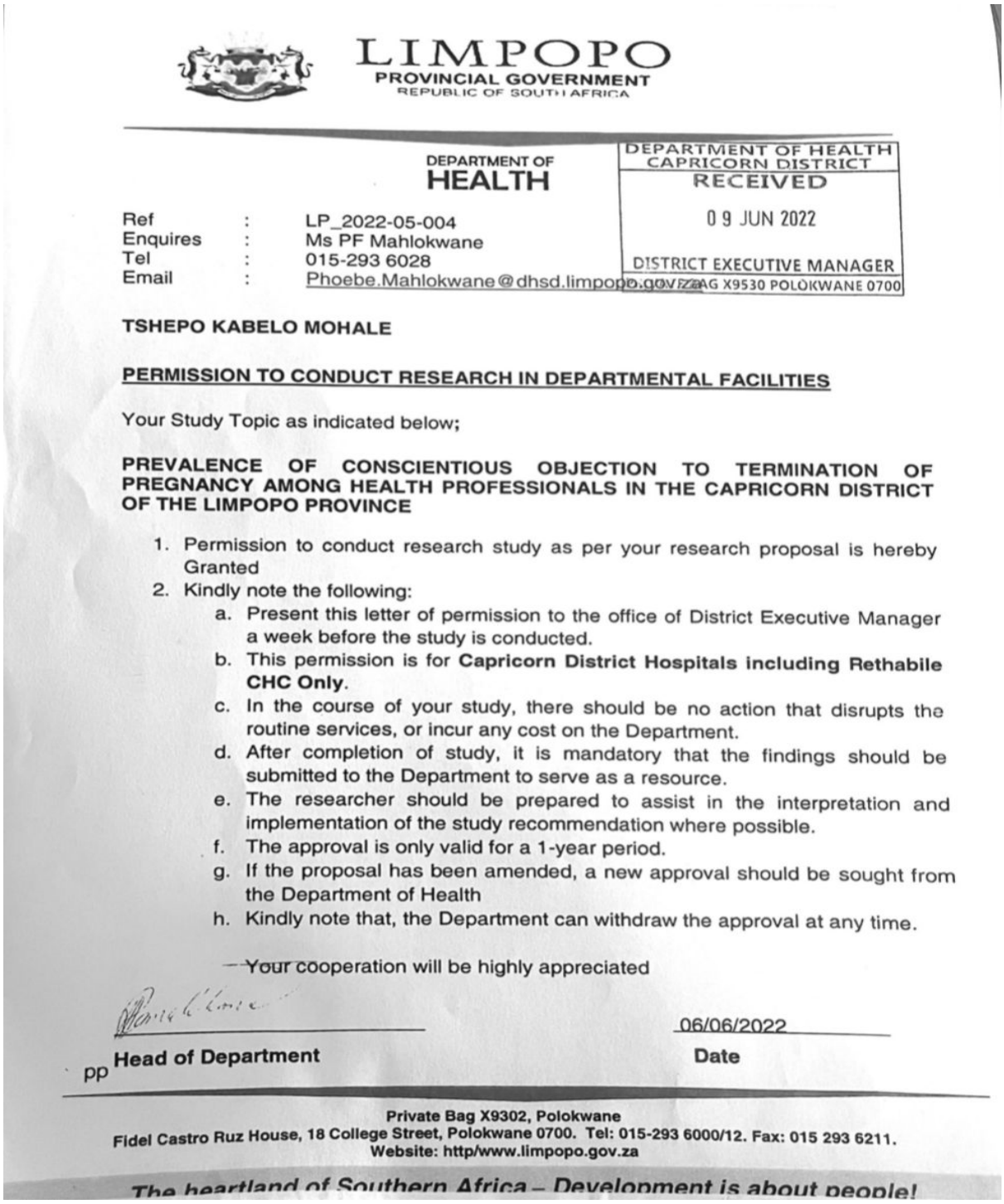
Your cooperation will be highly appreciated

pp **Head of Department** 06/06/2022 **Date**

Private Bag X9302, Polokwane
Fidel Castro Ruz House, 18 College Street, Polokwane 0700. Tel: 015-293 6000/12. Fax: 015 293 6211.
Website: http/www.limpopo.gov.za

The heartland of Southern Africa – Development is about people!

Appendix H: Capricorn District Department of Health Approval



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
HEALTH

DEPARTMENT OF HEALTH
CAPRICORN DISTRICT
RECEIVED
09 JUN 2022
DISTRICT EXECUTIVE MANAGER
PRIVATE BAG X9530 POLOKWANE 0700

Ref : LP_2022-05-004
Enquires : Ms PF Mahlokwane
Tel : 015-293 6028
Email : Phoebe.Mahlokwane@dhsd.limpopo.gov.za

TSHEPO KABELO MOHALE

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below;

PREVALENCE OF CONSCIENTIOUS OBJECTION TO TERMINATION OF PREGNANCY AMONG HEALTH PROFESSIONALS IN THE CAPRICORN DISTRICT OF THE LIMPOPO PROVINCE

1. Permission to conduct research study as per your research proposal is hereby Granted
2. Kindly note the following:
   a. Present this letter of permission to the office of District Executive Manager a week before the study is conducted.
   b. This permission is for **Capricorn District Hospitals including Rethabile CHC Only**.
   c. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
   d. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   e. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   f. The approval is only valid for a 1-year period.
   g. If the proposal has been amended, a new approval should be sought from the Department of Health
   h. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated

pp **Head of Department** 06/06/2022 **Date**

Private Bag X9302, Polokwane
Fidel Castro Ruz House, 18 College Street, Polokwane 0700. Tel: 015-293 6000/12. Fax: 015 293 6211.
Website: http/www.limpopo.gov.za

The heartland of Southern Africa – Development is about people!

Appendix I: Certificate from language editor

Tiyiselani & Rapetsoa scientific services

Desktop Publishing • Web Design • Proof-reading • Editing

Your one stop document handling service

85 Compensatie Street,
Duplex Park No 5,
Polokwane, 0699
Postnet Suite 179 • Private Bag X9307 • Polokwane •
0700 Tel: 074 8666 914 • Fax: 0864154022

Date: 21 September 2022

To Whom it May Concern

I hereby confirm that I have proof-read the document entitled: **"TPrevalence of conscientious objection to termination of pregnancy among health professionals in the Capricorn District of the Limpopo Province"** authored by Mr TK Mohale with student number 202065550 from University of Limpopo. The document has been edited and proofread for grammar, spelling, punctuation, overall style and logical flow. Considering the suggested changes that the author may or may not accept, at her discretion, each of us has our own unique voice as far as both spoken and written language is concerned. In my role as proof-reader I try not to let my own "written voice" overshadow the voice of the author, while at the same time attempting to ensure a readable document.
Please refer any queries to me.

Rapetsoa DB