NURSES’ EXPERIENCES OF ATTENDING WOMEN IN PRE- AND POST-ABORTION CARE

A QUALITATIVE INTERVIEW STUDY WITH NURSES IN THE PUBLIC HEALTH CARE SECTOR IN ARGENTINA

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Aim: The aim of the study was to illuminate the experiences of registered nurses attending women in pre- and/or post-abortion care in the public health sector in the provinces of Neuquén and Río Negro, Argentina.

Background: Nurses working in primary care are receiving women in need of abortion but due to the restrictive law the care provided depends on the individual health professional. Abortion is illegal in Argentina with few exceptions and even though health professionals in the public health sector are obliged to provide post-abortion care clandestine abortion is the major cause of maternal mortality.

Methods: A qualitative research design involving semi-structured interviews with seven nurses selected by purposive sampling. The collected data was analyzed using the method of content analysis outlined by Philip Burnard.

Results: Four categories emerged from the analysis; Nurse-patient relationship, Nurses approach to abortion and preventive measures, Significance of support and knowledge in providing care and Experiencing obstacles in abortion care. Each category was divided into two subcategories.

Conclusion: The nurse’s experiences of pre- and post-abortion care varied due to their background, workplace and attitude on abortion. Several nurses felt limited by the restrictive law and lack of knowledge and support from co-workers. However by educating themselves and creating networks with other health professionals many nurses were accompanying women in need of abortion or post-abortion care.

Keywords: Abortion care, Argentina, Ethics of care, Nurses, Women
Syfte: Studiens syfte var att belysa sjuksköterskors erfarenhet av abortvård i den offentliga vården i provinserna Neuquén och Río Negro, Argentina. Abort är olagligt i Argentina, med några få undantag, och även om sjukvårdspersonal är skyldig att erbjuda eftervård vid abort så är illegala aborter den vanligaste orsaken till mödradödlighet i landet.

Metod: En kvalitativ studiedesign med semi-strukturerade intervjuer med sjuksköterskor, som valdes genom ändamålsenligt urval. Insamlad data analyserades genom Philip Burnards metod för innehållsanalys.

Resultat: Analysen resulterade i fyra kategorier; Relationen mellan sjuksköterska och patient, Betydelsen av stöd och kunskap för att vårda, Sjuksköterskans inställning till abort och förebyggande metoder och Upplevelsen av hinder i abortvården. Varje kategori delades in i två underkategorier.


Nyckelord: Abortvård, Argentina, Kvinnor, Omvårdnadsetik, Sjuksköterskor
# CONTENTS

INTRODUCTION 1

BACKGROUND 1
  The abortion law in Argentina 1
  Theoretical framework 2
  Abortion care 3
  Women’s experiences of medical abortion 4
  Civil society, La revuelta and abortion 4
  Previous research 5
  Area of concern 5
  Aim 6

METHOD 6
  Sample 6
  Data collection 6
  Analysis of data 7
  Trustworthiness of the study 7
  Pre-understanding 8
  Ethical considerations 8

RESULT 8
  The nurse-patient relationship 9
    Trust issues 9
    Experience of caring for women in vulnerable conditions 10
  Nurses’ thoughts on abortion and preventive measures 11
    Nurses’ approach to abortion and abortion care 11
    Experience of providing contraceptives and sex education 12
  Significance of support and knowledge in providing care 13
    Filling the knowledge gap and getting confident in your role 13
    Depending on co-workers and feeling support at work 14
  Experiencing obstacles in abortion-care 15
    Relating to the law 15
    Dealing with resistance to abortion 16

DISCUSSION 17
  Discussion of methodology 17
  Discussion of the results 19

CONCLUSION 22

FUTURE RESEARCH & RECOMMENDATIONS 22

REFERENCES 24

APPENDIX 1 27
APPENDIX 2 28
APPENDIX 3 29
INTRODUCTION

Nurses are taught to provide person-centered care for individuals at different stages of life. This implies considering existential, social and psychological needs as well as physical needs (The Swedish Society of Nursing, 2010). In countries with restrictive abortion laws the nurses’ possibility of providing person-centered care is limited due to women’s circumscribed right to decide over their own bodies by having access to a legal and safe abortion. Instead the decision is handed over to doctors, politicians, judicial authorities and religious groups (Zurbriggen & Anzorena, 2013). As a nurse student I believe that equal care is fundamental and that equal care involves safe abortion for all women and transpersons regardless of nationality, religion, social and economic background. Due to Argentina’s large economic and social disparities the criminalization of abortion mostly affects women from marginalized groups who do not have the necessary resources to pay for an expensive illegal abortion in a clinical setting (López, 2014). Every year around 500 000 women choose to abort in Argentina (Zurbriggen & Anzorena, 2013). According to a study on maternal mortality carried out in in the country by the World Health Organization (WHO) in 2002, complications after abortion is the major cause of death (27.4%). The study also exposed the connection between social status, economic background and geographical area and maternal mortality (Ramos et al, 2007). There are nurses and other health professionals in Argentina who provide information on sexual and reproductive rights as well as treatment in order to meet the needs of women in need of abortions (Zurbriggen et al, 2013). This study illuminates the experiences of nurses working in the public sector in the provinces of Neuquén and Río Negro who are attending women in need of pre- and/or post-abortion care.

BACKGROUND

In Argentina 40 percent of all pregnancies end in abortion, hence criminalization does not stop women from aborting, it rather leads to unsafe abortions that risk the health of the woman (Zamberlin et al, 2012). The WHO defines an unsafe abortion as a procedure performed either by individuals lacking necessary skills and/or performed in a substandard medical environment (Dzuba et al, 2013). When states criminalize abortion women are discouraged to seek medical attention due to fear of being reported to the police by the health provider (Finer & Fine, 2013). Legal sanctions against doctors and midwives as well as ambiguities concerning legislation result in hospitals interpreting the law restrictively and consequently the access to legal abortions is limited (ibid).

The abortion law in Argentina

The Argentine penal code strictly regulates abortion in article 85-88 (Argentine Penal Code, 11.179 art. 85-88). The law states that both the woman inducing her own abortion and the person helping her can be sentenced to harsh punishments including imprisonment for several years (ibid). Physicians, surgeons, midwives or pharmacists who use their knowledge to perform abortions can be sentenced to prison as well as disbarment from work (Argentine Penal Code, art. 86). Abortion performed by a licensed physician is only legal when it is done to prevent danger
to life or health of the mother, fetal abnormalities incompatible with extra uterine life or if the pregnancy is a result of rape or abuse (Argentine Penal Code, art. 86).

In 2005, despite the restrictive abortion law, the Ministry of Health in Argentina passed resolution 989/2005, *Modelo Integral de Atención Post Aborto*, which gives women who have gone through a clandestine abortion the right to receive medical care in the public sector (Resolución 989/2005). Resolution 989/2005 is directed to health care professionals and covers instructions for medical attention and personal approach. The staff should ask about the woman’s situation, fears and worries and her wishes should be respected at all times. Furthermore, she should receive information concerning sexual and reproductive rights as well as information regarding the care she is receiving. (Resolución 989/2005). In spite of the resolution, women who seek medical attention continue to be judged, discriminated and sometimes even reported to the police by the hospital staff (Ramos et al, 2014).

The support for the current law varies amongst health professionals. Szulik et al (2008) found that a great majority of obstetricians and gynecologists in Argentina thought that the legalization would decrease maternal mortality and that contraception and abortion are important public health issues. The opinions of critical care providers were examined by Vasquez et al (2012) and the result revealed that 95% supported abortion in cases of malformations of the fetus, 89% in cases of rape, 77% when the woman’s mental health is at risk and 47% if the pregnancy is unintended. The increased support for decriminalization could be understood as a consequence of being exposed to maternal mortality and seeing the negative effects of the restrictive law (ibid).

**Theoretical framework**

The result of the study will be discussed from a perspective of different relations of care as well as factors that may affect the possibility for nurses to create ethically successful relationships when caring for their patients.

Bowden (2000) discusses how relations of care can be divided into two categories: care for persons who are more vulnerable than the one caring and care for persons that are less vulnerable than the one caring. Bowden (2000) suggests that nurses in their daily work form part of both these relationships, where the more vulnerable are the patients and the less vulnerable are doctors and administrators (Bowden, 2000). To examine these different relations of care two approaches of ethics of care are described. The ‘feminine’ ethics of care focuses on the intimate relationships whereas the feminist ethics of care examines the effects of the institutionalized social orders in women’s ability to ethical self-expression.

The ‘feminine’ ethics of care have been criticized for not considering social orders of inequality. Furthermore, these ethics of care contribute to the perception of nurses as “natural carers”, with an unlimited capacity of unselfish giving, equal to the traditional stereotype of women. Bowden (2000) argues that these concerns do not necessarily have to be opposites and how a broader understanding of ethics of care might provide tools to approach both perspectives. She maintains that a feminist perspective is vital since the feminine ethics of care has failed to take into account the social powerlessness of clinical nurses as a result of institutional structures of power (Bowden, 2000). A feminist standpoint implies the
acknowledgement of a patriarchal world structure that constantly discriminates women resulting in relationships being characterized by oppression and subordination of the women (Bowden, 2000).

The relationships that develop when caring for the more vulnerable are described by Bowden using the maternal relationship (Bowden, 2000). The description is used to clarify the ethical dynamics of the relationship between the nurse and the patient. Firstly, in order for this relationship to be ethically successful it should provide moral autonomy, this is enabled by the backing of other emotionally engaged persons (ibid). Individual moral autonomy does not occur in isolation but is always a result of a nurturing relationship created between the nurse and the patient. Secondly, the dynamic of maternal relationships also implies relational reciprocity, this means that there are gains and rewards for both parts. The third and last perspective concerns the moral justification of the interference in the life of the more vulnerable (Bowden, 2000). This often creates moral conflict, for example when the patient does not agree to a certain treatment. In structuring the ethical possibilities of care both mutuality and reciprocity are necessary as well as justice, caution and self-respect. Bowden (2000) concludes that ethically successful relationships are mutually empowering. The nurse has to, when caring for someone more vulnerable, be aware of the risk of reproducing internalized perceptions of subordination in the other. This can manifest itself by control or the one caring putting him- or herself in an authoritarian position in relation to the one cared for (ibid).

The other relation of care, when the relational structure is dominated by the dependency or subordination of the one caring, implies that the care serves the interest of a person higher up in the social hierarchy (Bowden, 2000). Hence a feminist ethic is required. The feminist ethics discuss how the sociopolitical structures and social inequality might lead to an ethical care that is positive as long as the interests of the dominant are isolated from those of the marginalized (ibid). Bowden (2000) goes on to suggest that it is not possible to view ethical decision-making as independent or free from political influence, therefore ethical relationships of care must consider the context of inequality within which they occur.

The hierarchy within the health sector, where the nursing care is often secondary to medical decisions, also reflects the subordinate position of women in society (Bowden, 2000). Furthermore, Bowden (2000) means that the power of medicine over life and death has made it possible for medical institutions to influence state policies. She goes as far as to suggest that the lack of resistance indicates that these institutions are complicit with the agenda of the state. The bureaucratic system also contributes to the focus of care being moved from ethical relationships to financial interests and this further increases the disempowerment of nurses. According to Bowden it is important to have access to knowledge and supplies in order to overcome this vulnerability. However, also regarding this issue, the institutionalized social order is working against the nurses as they often become unable to put their knowledge and values into practice due to prevailing social hierarchies (ibid).

**Abortion care**
Caring for women’s sexual and reproductive health is to listen to the woman’s experience and respect her legal and moral personhood, this implies her right to
self-determination (Correa & Petchesky, 2013). Therefore it is important that the nurse treats the woman as a subject and take the woman’s desires and wishes seriously, may it be the wish to terminate a pregnancy (ibid). However, when the right to safe and legal abortion is denied the respect for the woman’s personhood is abused and at the same time the legal possibility of the nurse to provide care and support the woman in her right to self-determination is taken away (Correa & Petchesky, 2013). The nursing process ought to include the five phases of assessing, diagnosing, planning, implementing and evaluating (Florin, 2009). The process is interrupted as the nurse is left without legal means to provide the care that the patient is in need of. Concerning women’s sexual and reproductive health the nurse has an important role both in providing education on different contraceptive methods as well as contributing to safe abortion care (Correa & Petchesky, 2013).

Women’s experiences of medical abortion
In areas where women lack the access to safe, legal and free abortion the method of medical abortions has changed the abortion practice (Zamberlin et al, 2012). Medical abortion refers to the use of drugs, where a combination of Mifepristone followed by Misoprostol is known to be the most effective administration (Dzuba et al, 2013). The method of medical abortion gives women the opportunity to have a self-induced home abortion which is often perceived as safer and less expensive and traumatic compared to surgery (Zamberlin et al, 2012). The physical experiences that women go through during the abortion are individual but the majority suffer from pain of different intensity. The medication also has side effects such as diarrhea, nausea, headache and fever (ibid). Despite being regarded as a safe method some women still require medical attention due to incomplete abortions or other complications like infections, abdominal pain or hemorrhage (Zamberlin et al, 2012).

Going through an abortion can be connected both with self-stigma, when the woman internalizes the existing prejudices in society about abortion, and/or enacted stigma, when another person adds stigma to a woman (Lipp, 2011). Self-stigma might prevent the woman from talking about the abortion and the risk of enacted stigma can result in health care avoidance (ibid). Women also experience different degrees of fear connected to pain, bleeding and anxiety about the entire process (Zamberlin et al, 2012). Women who carry out clandestine home abortions without being fully informed about the procedure and lacking medical contacts often experience the abortion as even more stressful (ibid).

Civil society, La revuelta and abortion
When the state fails to care for women who abort, community-based interventions give assistance to women, who often find themselves alone in a difficult situation (Dzuba et al, 2013). In Neuquén the feminist collective La Revuelta organized ‘Socorristas en Rosa’ (Lifeguards in pink) in 2009, a network that supports women who wish to have a medical abortion (Reynoso, 2011). Since then, the network has grown and is present in several provinces all over the country. They provide women with necessary personal support as well as information on the internet on how to abort with Misoprostol, the contraindications and the importance of making a post-abortion control at a clinic or hospital (La Revuelta, 2015). In 2012 their activism contributed to the creation of a post-abortion clinic in Neuquén where women get post-abortion care from obstetricians, gynecologists and nurses (Bellucci, 2014). La Revuelta put the women in contact with health
professionals who are described as “amigables”, amicable. These are health professionals that attend women in need of abortion care in a professional and respectful way. The women are given the contacts so that they know where to have an ultrasound, in case of complications or for a post-abortion control (La Revuelta, 2014) La Revuelta is carrying out street outreach and workshops to spread information on the right to legal abortions and ‘Socorristas en Rosa’ as well as organizing trainings on sexual and reproductive rights for health professionals (Reynoso, 2011).

Previous research
Limited data exists on how nurses perceive working in abortion care but studies have been carried out in countries with legal settings (Lipp, 2011; Nicholson et al, 2010). Nicholson et al (2010) investigated the experiences of nurses involved with termination of pregnancies and found that the unconditional acceptance of the abortion led to understanding and empathy. The possible traumatic event for the woman going through an abortion made the nurse provide physical and emotional comfort as well as ensuring themselves that the woman was properly informed about the procedure (ibid). The nurses felt a need to share their experiences with others and they also described how their approach to the job could change over time due to work and life experience. (Nicholson et al, 2010). Psychological care for the women was regarded as a fundamental part of the work and with growing experience the nurses felt more competent and confident in providing good care (ibid). Studies have also revealed that the stigma connected with abortion is not only applied to the woman but can also include nurses caring for the woman, this is known as affiliate stigma (Lipp, 2011). The term “wise” have been used to describe the health professionals that care for women in need of abortion without experiencing affiliated stigma. The “wise” are not considering the women having abortions as stigmatized but instead the women are viewed as “ordinary others”. The nurses had often been present at traumatic abortions that had a large impact on their approach to the women and abortions but to become “wise” they also had to be accepted as credible by the woman (ibid).

An interview study investigating the experiences of women going through abortion showed that many of the women were dissatisfied with the approach of the health professionals. Their experiences were more related to the psychological aspects of care than the technical procedure as they felt that the health professionals’ attitudes were judgmental (Astbury-Ward et al, 2012).

Both national and international studies have been carried out on the consequences of restrictive abortion laws and how it affects the reproductive health of women in Argentina. The research shows the need for increased pre- and post-abortion care, as well as information to care providers about the interpretation of the abortion law (Dzuba et al, 2013; Ramos et al, 2014; Zamberlin et al, 2012).

Area of concern
Nurses’ experiences of abortion care in Argentina are of interest since their knowledge, attitudes and scope of action directly affects the health of women. According to the International Council of Nurses’ Code of Ethics the fundamental responsibilities of nurses are; to promote health, to prevent illness, to restore health and to alleviate suffering (International Council of Nurses, 2012). A restrictive abortion law might limit the nurses’ possibilities to follow the code of ethics and provide a person-centered care. The nurses are key persons in abortion
care, both because working in primary care often implies being the first to get in contact with women in need of an abortion and since working at the emergency room involves receiving women suffering from complications after abortions. Furthermore, as previous studies have presented, nurses in abortion care have expressed a need to share their experiences both inside and outside their workplace, the current law in Argentina might also affect this possibility.

**Aim**
The aim of the study was to illuminate the experience of registered nurses attending women in pre- and/or post-abortion care in the public health sector in the provinces of Neuquén and Río Negro, Argentina.

**METHOD**
In order to illuminate the experiences of the nurses a qualitative research design was chosen. A qualitative research implies that the design evolves as the study was progressing (Polit & Beck, 2012). This gives the researcher the possibility to base the investigation on the realities and experiences of the informants that are not known in the planning phase of the study (ibid). A study design, including content analysis on qualitative data, can be described as a descriptive qualitative study (Polit & Beck, 2012). Data was collected through semi-structured interviews between the 9th and 21st of April 2015. The interviews were audio recorded and then transcribed and translated to English. The transcripts were analyzed according to Philip Burnard’s method of content analysis (Burnard, 1991).

**Sample**
The nurses in the study were chosen by purposive sampling. The sampling technique implied selecting informants that would benefit the study (Polit & Beck, 2012). The nurses were selected due to their special experiences of abortion care at their workplace. Criterion sampling, a form of purposive sampling, were used to select nurses in the primary health sector that provided abortion care. Criterion sampling give the researcher the opportunity to include informants that meet a predetermined criterion (ibid). The nurses that were chosen had experience of attending women in pre-abortion care and were helping the women in different ways. Further sampling was made in order to include the experiences of nurses attending women in post-abortion care in the hospital at the gynecology wards. The seven informants were all women, aged 28-59 years and registered nurses working in the public health sector in the provinces of Neuquén and Río Negro. Five of the nurses worked in clinics and two of the nurses worked in a hospital and their experience of attending women in pre-and/or post-abortion care ranged from one to 20 years. The contact with some of the nurses was facilitated by La Revuelta. Several of the informants worked in clinics that were located in socially and economically deprived areas. Hence, all the informants met the inclusion criteria of the study, being registered nurses that had been attending women in need of pre- or post-abortion care for at least one year.

**Data collection**
Data was collected through semi-structured interviews with open-ended questions (Appendix 1). The seven individual interviews were made in Spanish and took
place between the 9th and 21st of April 2015. The first interview was regarded as a pilot interview in order to evaluate the question in the interview guide. The nurses were asked to recount a situation when they had attended a women in need of pre- and/or post-abortion care. This interview was then included in the result of the study and the data obtained also served to learn more about the context and to write down follow-up questions that were asked in the succeeding interviews. The interviews lasted between 25 and 35 minutes and were conducted in a location chosen by the informant. The interviews took place in clinics, in the hospital, in a café and in the home of one nurse. There was a briefing before the interview where the nurse was given information about the study and she was then given time to read through the letter of information and ask questions before signing the consent form. The nurses were also asked to answer demographic questions including age, education and the number of years that they had been working in abortion care. In accordance with the method of content analysis of Burnard (1991) all the interviews were audio recorded, after the approval of the informant, and memos were taken throughout the interviews. Follow-up questions served to illuminate areas that other nurses had brought up in their interviews. In order to clarify or get a deeper understanding of the informant’s statements and experiences specifying questions were made. The interviews were rounded of by asking if the informant had anything else to add. The informants were also asked to leave their contact information for follow-up questions. The audio recorded data was transcribed in full using a computer and the transcripts were read through by a native Spanish speaker while listening to the recordings. All the transcripts were then translated into English.

**Analysis of data**

The analysis of the transcribed interviews followed the method outlined by Burnard (1991) based on content analysis. Firstly, the transcripts were read through and notes were made of what was expressed in the text, a process known as open coding (Burnard, 1991). In this way a category system, that covered the whole transcripts except for the fillers was created. At this point the transcripts were also sent to one more person for her to read the transcripts and produce her own list of categories. The transcripts were then reread various times so that I could get familiar with the text, this step also allows the researcher to get acquainted with the “frame of reference” of the informants (ibid). I continued working with the category system and reduced the number by arranging similar categories into broader categories until I could present a final list. In the following stages I read through the transcripts with the list of categories in order to make sure that the categories included all parts of the interviews. The final list of categories were then compared to the list of the other person and some adjustments were made. The transcripts were read through and the text belonging to each category was underlined with marker pens of different colours. The transcripts were cut into pieces and rearranged so that all items belonging to one subcategory was collected together and then glued to a blank sheet of paper. The writing process of presenting the findings included having both the sheets with the different subcategories as well as the complete transcripts nearby.

**Trustworthiness of the study**

The trustworthiness of a study depends on its credibility, dependability and transferability (Graneheim & Lundman, 2004). Credibility involves the selection of informants, the method used to collect data, how the analysis was carried out and how well this responded to the aim of the study (ibid). Aiming for credibility
implied carrying out semi-structured interviews both with nurses working at hospitals and at clinics. Furthermore one more person carried out the analysis of the research findings and the lists of categories were compared before a final list was made. The dependability of a study depends on how the research process has progressed over time and to what extent the decisions of the researcher has been altered (Graneheim & Lundman, 2004). I aimed at keeping consistency in the process of data collection by giving all informants a similar briefing and debriefing, following the interview guide and asking the nurses questions on the same issues in the process of data collection. Finally, according to Graneheim & Lundman (2004) the transferability has to do with whether the result can be generalized to other settings or not. The transferability of the study was facilitated by describing the Argentinian context as well as the characteristics of the group of informants represented in the study.

Pre-understanding
Throughout the working process I have at all times tried to identify, be aware of and question my pre-understanding concerning the Argentinian context and the experiences of the nurses. Pre-understanding implies the prior knowledge that the researcher has even before analyzing the interviews (Thomsson, 2010). To reduce the effects of bias I have reflected on and tried to be aware of my own position and how it affected the study in different ways ranging from choice of subject, interview questions and situations, the analysis of the material and the result. My intention has been to keep an open mind and learn from the new situations that I have found myself in.

Ethical considerations
The study was approved by the ethical board at the University of Malmö. Carrying out research on abortion in countries with restrictive abortion laws might imply ethical obstacles since it deals with a controversial subject (Zamberlin et al, 2012). Therefore all the informants in the study were given written and oral information prior to the interviews (Appendix 2). They were given the possibility to ask questions and they were then offered to agree to participate in the study by signing a consent form (Appendix 3). In order to protect the identity of the informants no hospitals or clinics are named in the study.

RESULT
The experiences of the nurses are presented in four categories; Nurse-patient relationship, Nurses approach to abortion and preventive measures, Significance of support and knowledge in providing care and Experiencing obstacles in abortion care. Each category was divided into two subcategories. The result of the analysis of the data is displayed in Table 1.
Table 1. Categories and subcategories identified through content analysis

<table>
<thead>
<tr>
<th>Categories</th>
<th>Subcategories</th>
</tr>
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<tbody>
<tr>
<td>Nurse-patient relationship</td>
<td>Trust issues</td>
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<td></td>
<td>Experience of caring for women in vulnerable conditions</td>
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<tr>
<td>Nurses’ thoughts on abortion and preventive measures</td>
<td>Nurses’ approach to abortion and abortion care</td>
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<td></td>
<td>Experience of providing contraceptives and sex education</td>
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<td>Significance of support and knowledge in providing care</td>
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<tr>
<td>Experiencing obstacles in abortion care</td>
<td>Relating to the law</td>
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<td></td>
<td>Dealing with resistance to abortion</td>
</tr>
</tbody>
</table>

The nurse-patient relationship
The result revealed that the women in need of terminating an unwanted pregnancy or suffering from post-abortion complications found themselves in a difficult situation when they turned to the public health sector for help. The analysis of the data showed that the confidence and relationship between the patient and the nurse differed. The following subcategories emerged through the content analysis; Trust issues and Experience of caring for women in vulnerable conditions.

Trust issues
Nurses working in primary care at the clinics often experienced how women came to the nursing reception and asked to talk to them about terminating a pregnancy or asking for a pregnancy test. Some of the girls and women were patients from before, the nurses had accompanied them in previous pregnancies or met them at HPV vaccinations or controls. Other women had heard that the nurses at some of the clinics provided help with abortions and had travelled far to get there. The information was spread by word of mouth.

Women often came alone since they had not wanted or been able to share their decision with anyone else. Especially when there were cases of abuse and rape the women turned to the nurse for help. The nurses also experienced how the women shared their life story and not only the decision to have an abortion. The analysis also showed that women who, even though they had the right to a legal abortion, had chosen to consult the nurses at the clinics. According to the nurses the women were afraid of being treated badly at the hospital so even when they had severe post-abortion complications some were coming back to the clinic before being referred to the hospital by the physicians.

It seemed to be a common stand that the confidence between the nurse and the woman ought to be mutual. When there were stories of abuse or rape the woman herself was responsible for the things that she denounced. It was regarded as very important to trust the patient without questioning and the nurse should listen and react by putting the patient in contact with an amicable physician. The nurses were moved by the trust that the women felt in them and how they were coming to
the clinic with the sensation that the nurses were open to talk about abortion and provide help. The nurses had also experienced how women that had asked for a pre-abortion consultation, but had later decided to go on with the pregnancy, had come back to show the baby. The nurses thought that this was a sign of the support that women felt from the nurses no matter what they decided.

However, the analysis also showed that the nurses had different experiences when it came to trust. The nurses who had been working, or was working, at the gynecology wards expressed that there was a lack of confidence in the health professionals.

“I think she got scared because she realized that her life was at risk, and she had a son. So I think she changed her mind because of that and confessed” (3)

Usually women did not tell if they had induced the abortion, out of fear of being yelled at or not being attended. Even when there had been remains of pills in the vagina or the lab results had indicated that the abortion had been induced, the women still denied everything. Whether or not the women talked to the nurses and shared their story depended on the nurse and her approach.

Experience of caring for women in vulnerable conditions
The result revealed that all the nurses felt that their work implied encountering women in difficult situations. Several of the clinics were localized in neighborhoods where the population was living in difficult socioeconomic conditions and therefore many of the women were already struggling prior to discovering that they were pregnant and needed to abort.

“What the women experience in the moment of an unwanted pregnancy, and confronting that there is no legal way out, that they have to look around to see who they can talk to, who is not going to treat them badly, who is not going to judge, it is a lot of anguish.” (7)

The nurses received women or family members that came to look for help, crying and full of anguish due to an unwanted pregnancy that was a result of abuse by partners, relatives or other men.

The nurses talked about the importance of not only accompanying the woman in these situations but to also provide support for the family or the partner that was there with the woman. However, most women came alone and in these situations some nurses put the women in contact with la Revuelta. La Revuelta would help them with information and economic support to obtain the medication. The analysis of the data also showed that the nurses gave the phone number of La Revuelta to be reassured that the woman had a person to call if she was alone during the process of abortion. The activists in la Revuelta would call and see how the woman was doing when the nurse could not be there. However there were also nurses that handed out their private phone number in order to be able to accompany the women themselves.

Nurses working at the emergency room and gynecology wards had experienced how women arrived with hemorrhage, hypovolemic shocks or infections due to
clandestine abortions carried out with herbs or crochet hooks. Some of the women had developed septic shocks that resulted in hysterectomies and even death. The result revealed that situations like these had a great impact on the nurses and the medical team that felt powerless as they could not help the women. These severe complications created a feeling that this could have been prevented somehow.

**Nurses’ thoughts on abortion and preventive measures**
The analysis of the data showed that the nurses had different attitudes on abortion and their own role in providing abortion care and taking preventive measures to avoid unwanted pregnancies. This result is presented in the following subcategories; Nurses’ approach to abortion and abortion care and Experience of providing contraceptives and sex education.

**Nurses’ approach to abortion and abortion care**
The majority of the nurses expressed that abortion had to be legalized and offered by the public system. The reasons mentioned were that women should have the right to decide over their own bodies and whether or not to have children. The nurses also thought that legalization would save lives.

As nurses, a majority, saw it as their duty and responsibility to attend the needs of the women that were looking for help. It was viewed as a part of nursing and they saw the necessity of decriminalization in order to stop professionals and others from profiting on clandestine abortions. If they did not provide care the women could end up in the hands of whomever, desperate to terminate an unwanted pregnancy. The result illuminated the importance of not judging the decision of the other and many of the nurses felt that they had to accompany this vital decision of the women, beyond their own opinion. Still, some of the nurses felt that they were in a process of transformation in their approach to abortion care. This implied respecting the decision of the other as much as respecting their own feelings but being pro-life did not signify that they could not accompany the women. The decision to have an abortion was viewed as a difficult decision as an abortion often included a before and an after and the nurse ought to be there accompanying all these phases.

The analysis of the data also presented differences as abortion was talked about in terms of illegality instead of seeing it as a human right. Abortion, no matter if it was induced or spontaneous, was a pregnancy that would not reach full term and that required different post-abortion medical treatment due to the condition of the woman. The amount of gestational weeks affected the experiences of the nurses, it was perceived as more difficult to care for women having an abortion in week 20 when the fetus was more developed. Compared to the nurses that felt that they could accompany the decision and talk to the women the result also showed how other nurses felt that they could not really get involved since this would not change anything. However, when women arrived with complications after clandestine abortions the focus was always on recuperating the person’s health and nurses with experience from the gynecology ward said that all patients received the same care. They felt that the health professionals worked for the wellbeing of the patient no matter what their stand on induced abortions.

In contrast to this approach other nurses felt that their job was to accompany the woman through the whole process and to coordinate the care.
“[...]it is really important to accompany her from this first moment when she makes the decision. There are doubts, anger, anguish, so I think the nursing care starts there. It is not only to see if she bleeds, if she is in pain, not only the biological effect, but all the psychosocial effects [...]” (4)

The analysis showed that nurses considered listening as a vital part of nursing when accompanying the women. The nurse should be attentive both to what the woman said as well as the silence and try to interpret what the woman needed. They also experienced the importance of their own words and the extra caution that was needed when accompanying abortions, how to refer to the decision, the pregnancy and the fetus. Abortion care implied seeing and understanding the whole situation and it was often not just the termination of a pregnancy, but many woman needed further care or support.

The nurses had experienced how attitudes towards abortion had changed over time. Both their own approach and the way people talked about abortion in society were developing. From abortion being taboo they now felt that it was easier to raise the subject, even though it was still difficult in some contexts.

Experience of providing contraceptives and sex education
The analysis showed that nurses working in primary care dedicated a lot of time to inform about sexual and reproductive health and the post-abortion consultation always implied information on contraceptive methods and talking about sex and sexuality. The motto of La Revuelta “contraceptives to avoid abortion” was used to describe how they took the initiative and talked about safe sex also when the women came to the clinic for other reasons. The analysis revealed that it was often nurses who were in charge of ordering contraceptives and keep a stock at the clinics. They provided information and tried to help the women find a contraceptive method that they could sustain. This implied administering contraceptive pills for several months, giving the quarterly contraceptive injection to women that lived far away from the clinics or promoting the Intra Uterine Device (IUD). Some nurses used information brochures and material provided by the state and the nurses talked about the importance of being able to show all the different methods during the consultation, so that the woman could see and touch them. Several of the nurses also mentioned the possibility for the men to have a vasectomy. Up to now this was very uncommon due to the patriarchal social structures and instead the women had tubal ligations, even though this was much more invasive. In general the nurses experienced that women took a bigger responsibility for having safe sex but some of them had seen minor changes and more men had started to come to the clinics to talk or to get free condoms.

The result showed that all nurses worked a lot with the emergency contraceptive pill and it was provided for free both at the clinics and at the hospital. However it was expressed that this method was being misused and that it should not be administered to whomever. Although, when administering emergency contraception other nurses described how they always evaluated the woman, for example to see that it was not too late to use it. They also took the opportunity to inform about other contraceptive methods and the importance of using a condom to be protected from sexually transmitted diseases and pregnancy. In some areas the nurses felt that the population was uninformed about the possibility of having the emergency contraceptive pill to avoid unwanted pregnancies. They tried to
provide information by arranging workshops on sexual and reproductive rights in the waiting rooms or other areas in the clinics. Most meetings were arranged for women but men were welcome, even though their presence at the clinics was not common. When teaching the women how to use condoms the nurses had realized that the women handed over this responsibility to the men and there were cases when neither the man nor the woman knew how to use the condom in a safe way.

“When we showed the women how to use the condoms with the right technique they said ‘he doesn’t put it on like that’ or ‘he doesn’t open the pack in that way’ so we say that they shouldn’t leave it in the hands of the men, something that is important for them too” (1)

Some nurses went to schools to provide education to the students. Sex education was supposed to be provided at all schools but according to the nurses this law was not completely obeyed. It was also a common opinion that this should not be a sporadic class by a nurse from the outside, but that it ought to be incorporated in the everyday teaching from a young age. Therefore some nurses talked about sexuality already with the small children at the health controls, it was a way of trying to prevent abuse. When youngsters came to the clinic to talk about sex and contraceptives the nurses repeated the law concerning patient confidentiality, since some of them were afraid that they would talk to their parents. When attending the patients some of the nurses did not only talk about safe sex but they also saw the necessity of speaking to their patients about how to have a pleasurable sex life. They talked to the patients about the importance of getting to know themselves and what they liked and not to have sex to please someone else.

The nurses that had been providing post-abortion care at the gynecology ward said that the physicians prescribed a contraceptive method before the women left the hospital. However they felt that at least the young girls also ought to be offered a consultation and a follow-up but there were no cooperation between the hospital and primary care. The girls had to arrange the appointment by themselves, and according to the nurses this was not always done. They experienced frustration when some women kept getting pregnant and did not protect themselves even though they were offered contraceptives for free at the hospital.

**Significance of support and knowledge in providing care**

The nurses talked about how they cooperated with co-workers and acquired knowledge in various ways to ensure the care of their patients. This category includes the subcategories; Filling the knowledge gap and getting confident in your role and Depending on co-workers and feeling support at work.

**Filling the knowledge gap and getting confident in your role**

The result revealed that none of the nurses felt that university had prepared them for pre- and post-abortion care. A biologist focus had dominated the education and the need to change this paradigm in order to be prepared to care for the patients in a better way was expressed. The nurses believed that many health professionals were uninformed on the issue of abortion and that this led to mistakes being made. However, it was expressed that this mostly had to do with one’s own interest, since the information was there if you wanted it. The need of their patients or personal experience had made them interested in learning more about abortion care. Many of the nurses had started reading by themselves or
together with colleagues and it was a road that they had been walking alone. The issue had been brought up from below and had not been a part of public politics.

“I started to talk to a colleague who was a social worker, and the two of us got in contact with la Revuelta. But voluntarily, not within the system. That is how my process started.” (7)

Learning from colleagues and studying in interdisciplinary teams were common ways of gaining knowledge. The experience of finding likeminded co-workers to talk to also made the nurses feel more confident and calm in their role as a nurse when accompanying the women in need of abortion. Practice had given them a certain amount of security and taught them about the socio-psychological complexity of these situations, but the nurses expressed that they had a constant need to go on educating themselves. Everyday experience was not sufficient as the only source of knowledge. Therefore, they attended workshops on sexual and reproductive rights or la Revuelta was invited to hold trainings at the clinics. In Río Negro there had been talks at the hospital where a lawyer had explained the law and under what circumstances women had the right to a legal abortion at the hospital. There were also nurses and directors working together with a multidisciplinary team on a document with guidelines for all health professionals on how to provide legal abortions. Learning about the law had made the nurses feel more confident in what to demand from the hospital staff when they had to refer their patients there. The nurses had different tools and experiences that they felt were of use when they attended women in pre- and post-abortion care, some had attended courses like psychology at the university and others had several years of practical experience from the gynecology ward. Studying and talking with colleagues did not only make the nurses feel more confident but it also led to personal changes that made them more open-minded and ready to provide good care for women. The analysis showed that the focus of the trainings at the gynecology ward differed as they referred more to physical conditions and complications such as hypertension and critical post-labor hemorrhage.

**Depending on co-workers and feeling support at work**

When providing abortion care the nurses experienced different amounts of support at their workplaces. The analysis of the data showed that it was known by all the co-workers at the clinics that the nurses were accompanying women in need of abortion. Nevertheless this did not imply that all nurses could talk about it openly.

The nurses had experienced changes in their workplaces over the last years and they had either been the ones raising the subject or they had colleagues or directors that had started to talk about abortion. Some were working at clinics where the need of abortion care was recognized by the director and they felt supported in their work. At these clinics they also had the possibility to provide medical abortions and there were information in the waiting room about the circumstances that give you the right to a legal abortion. The clinics were known in their neighborhood for doing accompaniments. Some workplaces had weekly debriefings and the nurses were able to discuss their experiences of accompanying the women through abortion and evaluate the situations together with their co-workers. Talking about the cases and seeing that they had been able to provide a solution for the women had encouraged everyone to go on working on this issue. The analysis showed the strength of interdisciplinary teams and the importance of getting to know each other both to feel support in your job and to be sure that your
patients were being treated in a good way when you referred them to your co-workers. Some nurses felt alone at their work as they were the only nurse doing accompaniments but everyone had managed to start cooperating with someone, a physician, social worker or psychologist. In primary care all the nurses felt that they had at least one amicable physician that they could refer the patient to. Both in pre- and post-abortion care the nurses were depending on the cooperation with amicable physicians. The physicians were the ones prescribing ultrasounds, providing medication and performing the post-abortion controls. The network of amicable physicians both in primary care and in the hospital was experienced as facilitating the process when patients needed to be referred in order to receive more complex treatment.

“There is already like a network between the physicians so they contact each other and one day when one of them was working she went to the hospital and had the abortion done there” (6)

The nurses felt secure knowing that they could refer their patients to a physician and that they would organize the care of the woman. The coordinated care amongst the amicable health professionals also implied that women more easily could get a legal abortion at the hospital and that revictimization was minimized as the women did not have to repeat their story every time a new professional intervened.

Experiencing obstacles in abortion-care
The nurses experienced difficulties or limitations when caring for the women. These experiences were divided into the subcategories; Relating to the law and Dealing with resistance to abortion.

Relating to the law
The analysis revealed that the nurses had different ways of relating to the prevailing law on abortion. However, they all agreed on that legality would change the abortion practice in Argentina. Several nurses, although they experienced the law as an obstacle, had chosen to actively accompany women having abortions no matter what the reason. The nurses thought of the law as limiting their work and some expressed that the law ought to be obeyed but nevertheless it did not stop them from referring the patient to an amicable physician or providing information.

“We cannot encourage women to have an abortion because of the legal issue, that in Argentina it is still illegal and we cannot go against the law” (5)

The illegality of abortion made the nurses careful with whom to talk to and the nurses experienced that the most common reason amongst physicians for not attending women in need of an abortion was that they were afraid of breaking the law and having their licenses withdrawn. The law made them prioritize their own safety instead of providing the help that the women were looking for. The result showed that all the abortions at the hospital was viewed as spontaneous since induced abortions were a crime that ought to be punished. However the nurses had never experienced that other health professionals had filed any reports. The abortions that were made at the gynecology ward were not called “legal
abortions” but instead the nurses talked about therapeutic abortions when the procedure was carried out due to fetal malformations or when the pregnancy was putting the woman’s health at risk.

The result also presented that the nurses working more actively in providing help for women in need of abortions experienced a frustration concerning the law and the lack of knowledge in society, both amongst the public and colleagues, on the possibilities to have a legal abortion at the hospital if the pregnancy was a result of rape or when there were risks for the women’s health. However, despite of this feeling of being restrained by the law, and the law not being followed, the majority of the nurses talked about the possibilities of referring to the premises of legal abortion when demanding treatment for the women at the hospitals, in this sense they felt that they could use the law.

**Dealing with resistance to abortion**

Some nurses experienced talking about abortion as a constant battle. The lack of interest and/or resistance amongst certain colleagues made the nurses search for support from other professionals or people that they knew agreed with the practice.

The nurses in both provinces had experienced resistance at the gynecology ward both from the nurses working there and the directors. The nurses had all gotten into contact with conscientious objectors to abortion within the public health care system. One example that was given was when a girl with a mental disability who had been abused was denied a legal abortion by the director at the gynecology ward. The staff at a clinic had to intervene by contacting the director of the hospital and eventually the girl was hospitalized and had the abortion that the law guaranteed her. Other nurses who had previous experience of working at the emergency room, felt that the nurses were judgmental and that they tried to make the woman feel guilty. There were also a lot of prejudice against the women arriving with post-abortion complications or women coming to the hospital to have a legal abortion. Talking behind the patients back or making faces also affected women having spontaneous abortions, it was common that the nurses treated the woman as if she had induced the abortion herself.

> “The director is against abortions and that affects the nurses, perhaps you get there with one idea and then with time you change and become like your colleagues” (2)

The nurses had also experienced how the majority of the health professionals questioned the women even in cases of legal abortions. Even though the law stated that rape does not have to be reported to the police, but the woman was to receive an abortion at the hospital following her request to the physician and after signing a document. It was also mentioned how physicians at the emergency room did not perform abortions at the hospital but outside of their working hours in the public health sector they provided abortions and made profit.
DISCUSSION

In the discussion of methodology, thoughts on the methods used are elaborated together with the flaws and strengths of the study as well as the measures taken to improve validity. The discussion of the results includes an analysis of the experiences of the nurses from a perspective of the ethics of care, discussed by Bowden (2000), as well as a brief comparison with previous research.

Discussion of methodology
The study aimed at illuminating the experiences of nurses attending women in pre- and/or post-abortion care in the public health sector in the provinces of Neuquén and Río Negro in Argentina. A qualitative study design was chosen in order to obtain data on the experience of the nurses. On one hand, the design of descriptive qualitative studies has been described as lacking an interpretive depth (Polit & Beck, 2012). On the other hand, the findings produced by this design have been regarded as more “data-near” compared to other qualitative study designs (ibid). In this study the result of the content analysis was first presented in a more descriptive way and then discussed from a perspective of ethics of care. This last stage added an extra level of analysis to the study findings and put the experiences of the nurses in a broader context of nursing.

The method of semi-structured interviews was used as it allows the informants to talk more freely about their experiences. According to Kvale (2009) an introductory question such as “Can you tell me about…” may encourage the informant to describe their own experiences in a spontaneous and detailed way. The method also allowed for follow-up and specifying questions to be asked along the interview as well as for the informant to add new perspectives that the interviewer might not have included (ibid). However, the Argentinian anthropologist Rosana Guber (1991) states that the researcher establishes the frame of interpretation of the informant’s answer already when asking the question. The context is set by selecting the themes to be covered in the interview and the type of questions to be answered (ibid). This would imply that even though the method of semi-structured interviews was chosen and measures were taken to encourage the nurses to speak more freely, their answers were limited by the questions asked by the interviewer.

As stated by Kvale (2009) qualitative research interviews involve an asymmetrical power relation. Taking this into account and acknowledging the possible asymmetry that existed during the interviews, the fact that the informants were registered nurses and that the method used allowed them to raise their own concerns and key issues, might have contributed to a more equal relation of power. Furthermore, the informants were asked to choose both the location and the time of the interviews and they were given a briefing with written and oral information about the study as well as a debriefing. The debriefing is important since it gives the informant the possibility to add information or feelings that might have come up during the interview (Kvale, 2007). The informants were also aware of the possibility of withdrawing their consent at any time and their approval were requested before the audio recording started. These different measures hopefully made the nurses feel informed and in control of their participation in the study.
Moreover, the interviews were made in Spanish to make sure that the informants were able to describe their experiences as precise as possible. However, sometimes this led to language difficulties and the informant was then asked to repeat her words or explain a statement. Perhaps the complexity and depth of the data would have been more diverse if the informant and the interviewer would have shared the same first language. To prevent misinterpretations the transcripts were read through by a native Spanish speaker while listening to the recorded interviews, this step also served to strengthen the validity and reliability of the transcripts.

In the process of collecting data through interviews and transcribing it is important to be aware of the difference between written and oral language (Kvale, 2007). The interview is a face-to-face interaction that implies body language, facial expressions and tone of voice. In the process of transcription the written word becomes a construction of the oral language and the context of the interview setting is lost (ibid). To minimize distortion of the data the interviews were always transcribed the same or the following day that the interview had taken place. Notes and memos were also used so that the scenery of the interview would not be forgotten. In the process of analysis the recorded versions of the interviews were replayed while reading through the transcripts so that the feeling of the spoken word would not get lost.

The method of content analysis by Burnard (1991) allowed for the collected data to be analyzed in a systematic way and presented in categories and subcategories. Yet, Burnard discusses whether or not it is possible to find common categories that represent the words of a group of people (ibid). This issue was brought up to discussion when the lists of categories produced by the interviewer and the other person were compared. The experiences and thoughts of some of the nurses differed a lot and the first readings of the transcripts resulted in several categories and it seemed hard to reduce the number by creating broader categories. Nevertheless, in the process of rereading, analyzing and adjusting the list of categories a final list of eight subcategories was produced. The credibility of the categories is somewhat strengthened by the fact that only few adjustments were done between the list of categories produced by the interviewer and the person invited to read the transcripts and present her own list.

Kvale (2007) and Burnard (1991) is discussing the collection of “data”. “Data” is also the term used in this study to describe the material collected through interviews. However, Guber (1991) suggests that while conducting a field study the researcher is exposed to “information” that transforms into “data” only in the process of collection. Guber (1991) maintains that the researcher has an impact on the material gathered and the making of a reality already at this point. When the researcher intervene in the field of the informant the pre-understanding of the researcher traverse with the originality of the field (ibid). I think that this idea is of interest, especially due to the different backgrounds of the interviewer and the informants in this study. The experiences shared by the nurse and how this information was received and used depended on our individual frame of reference and perhaps also the impression that we had of the other person in that moment.

Concerning the dependability, how the interviews were conducted and how the process progressed over time, there were differences in the way that the nurses elaborated their stories during the interviews. Some of the nurses were more shy
and laconic and this led to more specifying and follow-up questions being asked. This implied that the interview was controlled to a greater extent by the interviewer than by the interviewee. Hence some nurses talked more freely about their experiences and decided what to share while others were asked more direct or open-ended questions in order for the interviewee to share experiences in areas that other nurses had brought up by themselves.

The transferability of the study is affected by the method of purposive sampling that was used to choose the informants of the study. Purposive sampling is a subjective way of including informants and implies their typicalness cannot be assessed by an external objective method (Polit & Beck, 2012). The nurses that were contacted through La Revuelta were representing a group that view abortion care as necessary. Therefore the result should be regarded as less generalizable to a national level. However within this group the experiences were not uniform and the study also included nurses with other experiences and views on pre- and/or post-abortion care.

The limited amount of informants also affects the credibility of the study. Still, the number of informants was reasonable in relation to the time frame of the study of eight weeks. Nevertheless, a larger study carried out with more time and by a larger group of researchers would probably illuminate a wider range of experiences and it would also limit the effects of the pre-understanding and bias of one individual in the process of research.

Discussion of the results
The relationships of care described by the nurses fulfilled Bowden’s (2000) definition of ethically successful relationships of care to different degrees. The relationship of care that developed between some of the nurses and the women can be viewed as ethically successful since they seemed to imply what Bowden (2000) describes as moral autonomy. The nurses were there to listen and accompany the women without questioning or judging the decision of the other. By accompanying the women in this way the nurses can be regarded as the emotionally involved persons that Bowden (2000) considered necessary to achieve moral autonomy. The fact that some women also chose not to terminate the pregnancy after consulting the nurse on abortion, and later came back to show their babies, could be viewed as an example of the women experiencing unconditional support and a feeling that the nurse was accompanying either decision.

Many of the experiences that were told also included relational reciprocity, there were gains for both parts. Several nurses described how they felt obliged to care for the women or how they regarded abortion as a human right. They thought that all women have the right to decide over their own bodies and whether or not to have children and how this care was a part of nursing. The women had come back to the clinics to talk to the nurses after the abortions and they had expressed that they felt that it was the right decision to abort and that they had felt accompanied by the nurse. The debriefings at the clinics also revealed that the staff felt that they had acted in a good way when they had been able to help the women and that they wanted to go on accompanying women in need of abortions.

Concerning the moral justification of interference in the life of the patient, in abortion care this aspect can be more easily linked to the work that the nurses
were doing in sex education and in providing contraceptive methods. For example some nurses did not wait for the women to come and ask about contraceptive methods but instead they themselves took every opportunity to talk about sexuality or contraceptives with the patients. Nevertheless the nurses also talked about the importance of respecting the other person’s words, for example women were never obliged to tell anyone about the abortion. So perhaps we could assume that this respect also applied when talking about preventive measures. In order not to interfere in the private life the nurses made sure that the woman was accompanied either by the nurse herself, a coworker or the women in La Revuelta.

Many of the relationships of care that were experienced by the nurses could be regarded as mutually empowering since the women were provided with the help and the tools to decide over their own bodies and in doing this several of the nurses could follow their conviction that abortion was a right that these women ought to be guaranteed. Caring for the women also implied that the nurses went on educating themselves and developing as nurses and some of them expressed that the experience enabled them to provide the care and psychological support that they often saw as necessary in these situations.

Several of the nurses shared experiences of women being denied abortions or women being scared of turning to the hospital for help as well as co-workers being prejudiced or conscientious objectors. These situations, when the women are not regarded as subjects with rights and instead are being put in a subordinate position leads to what Bowden (2000) sees as control by the one caring. The nurses and physicians put themselves in an authoritarian position in relation to the one in need of care. When this unequal relationship of power is developed the possibility of providing ethically successful care is lost.

The nurses also shared stories about cooperating or relating to co-workers that did not share their thoughts on abortion. Depending on the workplace the possibility of the nurse to provide ethically successful care might have been affected. Bowden (2000) also discusses how the institutional structures of power results in a social powerlessness of clinical nurses. The nurses that had experienced prejudice or bad attitudes towards the patient with post-abortion complications at the gynecology wards also shared that the directors had been against abortions. It could be assumed that the ideology and approach of the persons higher up in the social hierarchy affect how the whole institution works with the issue of abortion care. According to Bowden (2000) ethical care is provided as long as the interest of the dominant does not oppose the interest of the marginalized. The interest of the directors at several of the clinics were to provide abortion care and here the nurses felt support in their work while one of the directors at the gynecology wards denied a legal abortion to an abused girl with a mental disability. These examples could support the statement made by Bowden (2000) saying that ethical decision-making is not independent of political influence, but is rather controlled and influenced by the prevailing norms and policies in the society where we live.

Bowden (2000) points out how the bureaucratic system also shifts the focus of care from ethical relationships to financial interests. The director that had obtained medication from a donor and offered the possibility for the women to have a medical abortion at the clinic can be viewed as going outside this bureaucratic system in order to keep providing care based on successful ethical relationships. In this way the nurses could overcome the vulnerability that the system has
created. By having access to medication, educating themselves and putting the women in contact with la Revuelta, the nurses were able to uphold a relationship of care that can be viewed as ethically successful.

However there were also other experiences; for example the physicians that did not provide abortions for free within the public health care system but instead they profited on the necessity of the women by performing abortions in other settings and charging the women. This example can also be linked to how Bowden (2000) views how the power of medicine over life and death has been able to influence state policies and that the institution is complicit with the agenda of the state. On one hand, the physician, due to her or his higher position in the hierarchy in the health sector is able to deny the woman an abortion. On the other hand, the nurse cannot perform the procedure due to lack of knowledge and neither can she or he prescribe the medication for a medical abortion. So the physician is able to first deny an abortion and then profit from the restrictive abortion law since the need to terminate unwanted pregnancies does not vanish by criminalizing abortion.

The results of the study was consistent with previous research exploring the experiences of nurses in abortion care. Like in the studies by Dzuba et al (2013), Ramos et al (2014) and Zamberlin et al (2012) several of the nurses interviewed for this study saw a need for an increased pre- and post-abortion care in Argentina, as well as the necessity of a decriminalization to save women’s lives. As in these previous studies the nurses also experienced how the education of health professionals was essential in providing care. That the lack of knowledge or misinterpretations of the law, that give women the right to a legal abortion, further limited the access to care. The acceptance of the women’s need to terminate a pregnancy also seemed to prepare the nurses to provide care and led to an understanding of the women’s conditions, the same conclusion was made in the study by Nicholson et al (2010). Similarly to Nicholson et al (2010) the results also showed that some of the nurses felt that their attitudes towards abortion or their way of providing care had been changing over time. Personal experience or encountering women in need of abortion or women suffering from complications after clandestine abortions had made the nurses get more interested in the subject and search for likeminded. When it came to the importance of accompanying the whole process of abortion and accept and respect the woman’s decision to decide over her own body the findings were comparable with those made by Nicholson et al (2010) where nurses expressed that psychological support was vital in providing abortion care. As formerly presented by Astbury-Ward et al (2012) the problem of stigma and prejudice against women having abortions was also discussed by some of the nurses, however none of the nurses mentioned that they experienced affiliated stigma as described by the nurses in the study by Lipp (2011). This suggests that at least some of the nurses interviewed could be regarded as “wise”, as a result of being accepted as credible by the women. Many of the nurses in this study experienced the confidence that the women had in them and perhaps this contributed to escaping stigma. The majority of the nurses interviewed also thought of abortion as a necessity and abortion care as a part of nursing.
CONCLUSION

The experiences of the nurses caring for women in pre- and/or post-abortion care varied due to their backgrounds, own thoughts on abortion and their workplace and co-workers. The possibility of providing care and helping the women to find a solution to the unwanted pregnancy was affected by their previous experiences, knowledge and the restrictive abortion law. The nurses experienced various degrees of support amongst their co-workers but all the nurses working in clinics, where they received women in need of abortion, were cooperating with at least one amicable physician. The experiences shared by the nurses who was working or had been working at the emergency rooms revealed another reality where induced abortions were viewed as a crime and many of the women were exposed to prejudiced health professionals. However, post-abortion complications were always treated. If there was a more open atmosphere at the workplace and whether or not the cases were discussed in the whole group of co-workers seemed to depend on the director of the clinic or the ward.

The possibility to create ethically successfully relationships of care also depended on the nurse’s scope of action and how they related to the law. This shows that nursing care never occurs in a vacuum, it is not an isolated act but it is constantly affected and altered by laws or regulations as well as by the environment where the care is performed. Some nurses felt that they had to obey the law while others saw abortion as a human right that is supposed to be guaranteed to all women and that it was their duty as nurses to meet the needs of their patients. Working in abortion care also implied meeting women in difficult situations, both due to the anguish triggered by the unwanted pregnancy and the severe complications that some of the women arriving at the emergency room suffered after induced abortions. The nurses saw prevention of unwanted pregnancies as vital and hence several nurses shared their experiences from the post-abortion consultation and the focus on contraceptive methods. The nurses did not see pre- and post-abortion care as isolated parts of their duties as a nurse but rather as integrated in the care of the sexual and reproductive health of the women.

FUTURE RESEARCH & RECOMMENDATIONS

The experiences of the nurses revealed that pre- and post-abortion care in Argentina is provided both with and without the support of the law. The study showed how health professionals cooperated and that both nurses and physicians found ways of helping the women and not let patriarchal laws dictate the rules of care. Further research is needed to investigate how nurses and nursing are affected when care is provided in a setting where the law criminalizes certain procedures and treatments. The issue of restrictive abortion laws and abortion care is of interest from different perspectives. On one hand, all over the world women’s health is in danger and on the other hand health professionals are risking their licenses to respond to the needs of women in society. Nevertheless, the severe consequences of clandestine unsafe abortions are not unknown, on the contrary statistics revealed that it is the largest cause of maternal mortality in Argentina. This shows that it is not more research that is needed, we also have to use and implement the findings of the research already made. Women’s health need to be prioritized and health professionals need to have both the legal and the material
possibility to work. A decriminalization of abortion would imply that the nurses and other health professionals would be able to improve the care provided. Health professionals and activists are working to change the law at the same time as they are providing help and abortion care to the women. The thing that is missing is the full support from the people with legislative power.

Finally, in Argentina women are not guaranteed safe abortions, a procedure that we take for granted in Sweden. However, care all over the world is regulated by laws and regulations. Perhaps our experience in Sweden is above all that these documents serve to protect the interest of the patient. The question of nurses’ possibilities to provide person-centered care can nevertheless be linked to the Swedish context. Argentina has a generous public health system and people travel from neighboring countries to receive care for free. In contrast, in Sweden the care provided to a patient depends on the person’s status, asylum seekers and foreigners are not provided the same care as Swedish citizens. This implies that people are constantly being denied care in emergency rooms and clinics. Just like in Argentina there is a lack of knowledge among health professional about laws and for example how to interpret ambiguous legislative texts. Asylum seekers are guaranteed “health care that cannot be postponed” but it is up to the individual health professional to determine what this implies (Socialstyrelsen, 2013). While conducting the study in Argentina I thought a lot about the Swedish context and my own experiences from internships in the hospital and in primary care. I met nurses caring for people without documents as well as nurses being judgmental and discriminating in their approach to the patient. I agree with the nurses in this study, who talked about the importance of learning about the psychosocial complexity in order to develop as a nurse as well as understanding how socioeconomic factors affect people’s health. As nurse students we have to talk about this when we discuss person-centered care and how the system that we work within want us to make a difference between the need of one patient and the other.
REFERENCES

Argentine Penal Code, 11.179 art. 85-88.


La Revuelta, (2015) *Declaración de la Cuarta Plenaria Nacional de Socorristas en Red (Feministas que abortamos)*.


Socialstyrelsen, (2013) “*Vård som inte kan anstå*”.
>www.socialstyrelsen.se/vardochomsorgforasylsokandemedflera/halso- ochsjukvardochtandvard/vilkenvardskaerbjudas/vardsomintekanansta< (2015-05-17)


APPENDIX 1

Interview guide

Main question
Would you like to share a situation when you attended a woman in need of pre- or post-abortion care? Post-abortion care can also imply when a woman is arriving in the middle of the process of abortion.

Probing questions
Can you please elaborate?
Could you share another example?

Themes to cover
Emotional reactions and thoughts
Atmosphere at work-place
Cooperation with other health professionals
Contraceptive methods

Demographic questions

Age:

Education:

How many years have you been attending women in pre- and/or post-abortion care?
### APPENDIX 2

**Letter of Information**

<table>
<thead>
<tr>
<th>Project title:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Nurses’ experiences of attending women in pre- and post-abortion care</td>
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<table>
<thead>
<tr>
<th>Study manager: Frida Sjöstrand</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Your e-mail: <a href="mailto:fridasjostrand@gmail.com">fridasjostrand@gmail.com</a></td>
<td>Studying at Malmö University, Faculty of Health and Society, S-205 06 Malmö, Phone +46 40 665 70 00</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Education: Bachelor Programme in Nursing</th>
<th>Between April and May 2015 I will conduct a field study, for my bachelor thesis in nursing, in the provinces of Neuquén and Río Negro, Argentina. The aim of the study is to illuminate the experiences of registered nurses attending women in pre- and/or post-abortion care. It is a qualitative study that will be based on interviews with nurses and right now I am looking for nurses who would like to participate in one (1) 30 minutes long interview. The interviews will be carried out at a location of choice of the informant. The interviews will be audio recorded after approval of the informant and transcribed. All material will be handled with confidentiality implying that the identity of the informants will be protected at all times and data from the research will be kept under lock and key. The material will be coded, no individual identifiers will be used in the study and material will only be used for the bachelor thesis and then destroyed after publication. Participation is voluntary and all informants can withdraw their consent at any time without explanation.</th>
</tr>
</thead>
</table>

With the study I wish to illuminate the experiences of the nurses caring for women in pre- and/or post-abortion care. In Argentina around 500 000 women choose to abort every year in. This is 40% of all pregnancies and hence criminalization does not stop women from aborting, it rather leads to unsafe abortions that risk the health of the woman. Post abortion care was made legal in 2005 but complications after clandestine abortions continue to be the major cause of maternal mortality.

The study will be finished in July 2015 and the result can be requested by all informants. The study will be published at MUEP, Malmö University Electronic Publishing, this is Malmö University's open access repository for scholarly output by faculty staff and students. It is also the open archive for publications series published by Malmö University. The study will also be published at the Minor Field Study website of SIDA, The Swedish International Cooperation Agency.

If these arrangements meet with your approval you may agree to participate in the study by signing the informed consent form provided to you with this information letter. If you have any questions feel free to contact me.
### APPENDIX 3

<table>
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<th><strong>Consent form</strong></th>
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<tr>
<td><strong>Study manager: Frida Sjöstrand</strong></td>
<td><strong>Studying at Malmö University, Faculty of Health and Society, S-205 06 Malmö</strong></td>
</tr>
<tr>
<td>Your E-mail: Frida Sjöstrand</td>
<td>Phone +46 40 665 70 00</td>
</tr>
<tr>
<td></td>
<td>Education: Bachelor Programme in Nursing</td>
</tr>
</tbody>
</table>

I have been verbally informed about the study and read the accompanying written information. I am aware that my participation is voluntary and that I, at any time and without explanation, can withdraw my participation.

I hereby submit my consent to participate in the above survey:

Date: .......................................................... ..........................................................

Participant’s signature: ..........................................................

29