NARRATED EXPERIENCES OF THE PRE-TERMINATION OF PREGNANCY COUNSELLING HEALTHCARE ENCOUNTER IN THE EASTERN CAPE PUBLIC HEALTH SECTOR.

A thesis submitted in fulfilment of the

requirements for the degree of

DOCTOR OF PHILOSOPHY

Of

RHODES UNIVERSITY

By

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November 2017

Abstract

Research that has been conducted about experiences of pre-abortion counselling tends to investigate either womxn's[1] or healthcare providers' experiences separately, with research on womxn's experiences of abortion and abortion counselling dominating this area of research. Although some of the studies on womxn's abortion experiences have explored womxn's experiences of interactions between themselves and healthcare providers, these aspects have been underreported. To my knowledge, research that also explores womxn's interactions among themselves in the waiting room has not been done. Furthermore, research that explores the pre-termination of pregnancy healthcare encounter, where womxn's and healthcare providers' experiences of waiting room interactions and of pre-abortion counselling practices are seen as interrelated, has not been conducted. Research that has been conducted among womxn's experiences show that womxn have varying experiences of pre-abortion counselling, with some finding it useful while other womxn have found it to be lacking in relevance to their specific situation or needs. Research conducted among healthcare providers also points to varying experiences, with some healthcare providers stratifying womxn's reasons for abortion according to the acceptability of the request.

This study explores health service providers' and womxn's narrated experiences of the pre-termination of pregnancy healthcare encounter (waiting room interactions and pre-abortion counselling) in the Eastern Cape public health sector. An African feminist post-structural approach, which enables analysis of how discursive structures and power relations may underpin African womxn's experiences of oppression and resistance, was used. Fusing this approach with a narrative-discursive analysis, enabled an exploration of the discursive resources drawn upon and the power relations referred to by participants when constructing micro-narratives and accounts of their experiences of waiting room interactions and pre-abortion counselling practices. This fusion enabled an understanding of the micro (individual) and macro (social) and how they interact and come to bear on experiences of the pre-abortion counselling healthcare encounter. Womxn's micro-narratives and healthcare providers'

[1] I use the term 'womxn' here to acknowledge the social construction and fluidity of both sex and gender and therefore the arbitrariness of attributing the signifier 'woman' (and 'man') based on the presumption of 'female' (and 'male'). 'Womxn' thus recognises that transgender persons do access reproductive health services heteronormatively created for 'womxn'. 'Womxn' also foregrounds that the experiences of womxn of colour and womxn-identifying persons are often invisible in normative and mainstream knowledge production of 'women' and their experiences. In terms of distinguishing between 'woman' and 'women', I have not done so in this thesis, thus 'womxn' is both singular and plural (see discussion around terminology in the introductory chapter).

accounts were compared for convergences and divergences in the pre-abortion counselling practices they described. The implications of these convergences and divergences and of the power relations referred to by participants for pre-abortion counselling service provision are discussed.

The research referred to in this study were conducted in contexts where abortion is legal, although the conditions under which it may be accessed differ across and within contexts. This present study is contextualised by the Choice on Termination of Pregnancy Act No. 92 of 1996 which legalises abortion and stipulates that abortion counselling should be made available to womxn but should be non-mandatory and non-directive. Data were collected at three abortion facilities located in public hospitals in the Eastern Cape. Open-ended, semi-structured interviews were conducted with 30 womxn after they received pre-abortion counselling, and four healthcare providers involved in abortion service provision. Data were analysed using an extended narrative-discursive approach which entailed exploring patterns in and across participants' talk. These patterns took the form of discursive resources (discourses and the subject positions they made available, and canonical narratives), power relations, and micro-narratives and accounts of their experiences of pre-abortion counselling practices and waiting room interactions.

Participants described the following pre-abortion counselling practices: information-giving practices, consent practices, administering of LARCs, a waiting period and third-party involvement. In describing these processes, participants drew on an awfulisation of abortion discourse, moralising discourses, pronatalist discourses, and liberal discourses to construct (micro-)narratives in which liberal, pastoral and authoritarian counselling practices and power relations were constructed and referred to. In their micro-narratives, most womxn described the counselling as informative, beneficial and healing whilst also describing shock, hurt, pain and distress at the various kinds of information they received. Healthcare providers drew on discourses and canonical narratives (such as the hero and personal testimony) to justify liberal, pastoral and authoritarian counselling practices which were underpinned by constructing abortion and unintended pregnancy as problematic. The pre-abortion counselling practices that were described were directive in two ways: the coercion of contraceptive uptake post-abortion, and information provision practices which effectively work to delegitimise and persuade womxn against abortion.

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Glossary of terms used in the thesis

Term	Meaning
Ja	*'*Yes'. An *Afrikaans* word that is used in several South African languages.
Mos	Roughly translatable to '*At least' or 'Indeed'*. Of *Afrikaans* origin but used in several South African languages.
Hhayi	*'*No. Sometimes used emphatically. Used by *Xhosa* and *Zulu* speakers, as well as among other black African language groups in South Africa.
Hhayibo	Expression of disbelief or shock.
Neh/Aneh	Roughly translatable to 'Is it not so' or 'right'. Of *Afrikaans* origin but used in several South African languages.
Wethu	Used to mean 'man' as in 'that was difficult, man'.
Shem	Used by black African language groups in South Africa. Roughly translatable to 'shame' but used in the South African sense where it can but does not necessarily mean pity. It can also be used in a context of expressing warmth or a positive sentiment. Examples of use include: 'She's nice *shem*', 'No *shem*, I didn't want to go', 'hhayi *shem*, go if you want to then'
Sisi	Used in Nguni languages (*isiZulu*, *isiXhosa*, *siSwati*). It is a term meaning 'sister' (as in sibling) but can also be used as a term of respect for older womxn who are too young to be referred to as *uMama*.
Yoh	An exclamation used to express shock or surprise (both pleasant and unpleasant). Originally used by black African language groups but now used by most language groups in South Africa.
Hheyi	An exclamation used by black African language speakers in South Africa to express shock.
Nje	A word used in Nguni South African languages meaning 'just'.
Lantuka	Roughly translatable to 'this thing'. Usually used when one has forgotten the name of something. An equivalent might be "thingamajig" used by English speakers.
Sana	*'*Baby'. Used as a term of endearment by Xhosa speakers.
Qha	*'*Only'. Used by Xhosa speakers.
Ke	*'*Then'. A word used in isiXhosa and isiZulu.
Tjo	A variation of '*yoh'*.
Ntoni ntoni	'And so on' or etcetera
Kaloku	'Now'. Commonly used by isiXhosa speakers.

List of abbreviations

African National Congress	ANC
Abortion and Sterilisation Act	AS Act
Choice on Termination of Pregnancy Act	CTOP Act
Co-interviewer	CI
Co-researcher	CR
Department of Health	DoH
Interviewer	I
Pre-termination of pregnancy	PTOP
Post-Abortion Syndrome	PAS
Termination of Pregnancy	TOP

Acknowledgements

Several people have not only made my doctoral thesis possible, but have also played a vital role in providing me with invaluable support. I treasure the financial and emotional support, information, guidance and nurturance afforded to me throughout this process. As a result of your individual and collective efforts, and my own hard work, I am now a young, black womxn with a doctoral degree- the first doctoral graduate in my family.

To my supervisor, Professor Catriona Ida Macleod: I know that these past three years have been exceptionally busy for you- the Critical Studies in Sexualities and Reproduction (CSSR) research programme boasted 20 people whom who supervised for the year 2017. I am therefore incredibly grateful for your dedicated, thorough and supportive supervision of my work over these past three years.

During my time at the CSSR, I have attended a conference in Belfast, Ireland which was my first trip abroad. It is an experience I will carry with me always. And I thank you for the role you played in making it possible.

I wish you success in your future endeavours.

To my friends and colleagues in the CSSR (with special acknowledgments to Dr Malvern Chiweshe): thank you for engaging lunch-time conversations which were un-related to work. I found these to be a necessary break from the thesis. Your friendship and support have been noticed and appreciated.

Thank you especially to Dr Malvern Chiweshe, not only for your friendship and support, but also for your keen eye in identifying conferences which we could both attend.

To my friends: your friendship has been kind, supportive and celebratory regarding this doctoral achievement. Your friendship has also enabled me to move one step further into the kind of human being I would like to be. Thank you. I wish you great success.

To my family: You have let me vent about the stresses of my doctoral thesis and allowed me to express frustration when things weren't going well. You listened with confidence (that I sometimes did not have in myself) that I could overcome these obstacles. Thank you for this. And thank you also for supporting my goal to obtain my doctoral degree- this has been invaluable. The sacrifices you have made for me will not be forgotten.

I would like to acknowledge the **National Research Foundation SARchi chair** which provided funding for the first year of my doctoral studies, and the **National Institute for the Humanities and Social Sciences** (NIHSS)/**South African Humanities Deans' Association** (SAHUDA) who funded the last two years of my doctoral studies.

To the womxn and healthcare providers who participated in this study and shared their stories with me and others, thank you. I also acknowledge the invaluable assistance of Nosihle and Kuhle who managed to collect data on my behalf while being full time psychology honours students, and Kayakazi Mkhosana who provided valuable assistance with translating and transcribing data. Thank you.

Finally, to marginalised, especially black and brown, young people growing up in South Africa, Africa and elsewhere: your dreams are valuable. Your dreams are possible, whatever they may be. Pursue them.

Chapter 1: Contextualising abortion care in South Africa

1. Introduction

Research investigating termination of pregnancy services revolves around two main problematics: the use and effectiveness of a particular method of TOP, and the quality and/or content of various aspects of abortion service provision. Such research has been undertaken to improve the services womxn[2] receive at abortion facilities.

An example of the former kind of research are studies on medical (or medication) abortion. Current medical abortion practice involves the use of the drugs Mifepristone and Misoprostol in combination to induce abortion, primarily for first trimester pregnancies but also for pregnancies occurring in the second trimester (Harries, 2009; Brouns, Burger & Wijngaarden, 2010). Following the acceptance by various medical councils of Mifepristone and Misoprostol for use in medical abortion, a number of studies have been conducted to assess not only the efficacy of medical abortion (e.g. Brouns et al., 2010; Joensuu-Manninen, Kuvaja & Talvensaari-Mattila, 2010; Verma, Singh, Singh, Shankhwar & Srivastava, 2011) but also the feasibility of implementing this method, particularly in public sector facilities located in resource-poor settings (e.g. Kawonga et al., 2008; Mundle, Elul, Anand, Kalyanwala & Ughade, 2007; The Medical Abortion Research Group et al., 2006).

A common focus area of the small body of research on abortion services is the quality or content of these services. For much of this research, abortion services are evaluated by obtaining womxn's experiences of the services (e.g. Curley & Johnston, 2014; Devjee, Khedun & Moodley, 2003; Fisher & Lafarge, 2015; Guilbert & Roter, 1997), documenting both womxn's satisfaction and dissatisfaction abortion service provision. This has included womxn's experiences of their interactions with abortion staff which have been characterised as empathic on the one end (e.g. Nicholson, Slade & Fletcher, 2010), and rude, unfeeling or judgemental on the other (e.g. Harries, Stinson & Orner, 2009). To a lesser extent, health care workers' experiences of performing termination of pregnancy services have also been documented with

[2] I use the term 'womxn' here to acknowledge the social construction and fluidity of both sex and gender and therefore the arbitrariness of attributing the signifier 'woman' (and 'man') based on the presumption of 'female' (and 'male'). 'Womxn' thus recognises that transgender persons do access reproductive health services heteronormatively created for 'womxn'. 'Womxn' also foregrounds that the experiences of womxn of colour and womxn-identifying persons are often invisible in normative and mainstream knowledge production of 'womxn' and their experiences. See later discussion on terminology where I explain my decision to not distinguish between the singular and plural.

healthcare providers expressing ideas around the limited acceptability of abortion (Beja & Leal, 2010; Beynon-Jones, 2013; Nguyen, Martin, Chinh & Cong., 2010), experiencing TOP service provision as emotionally demanding and strenuous work which requires support (Lipp & Fothergill, 2009; Mauri, Ceriotti, Soldi & Contini, 2014) and as necessary for womxn's empowerment (Christensen, Christiansen & Petersson, 2013; Möller, Öfverstedt & Siwe, 2012).

Research which specifically addresses pre-abortion counselling is limited. Such research has usually focused either on womxn's or healthcare providers' experiences of pre-abortion counselling. Studies investigating womxn's experiences have been conducted in different settings, including the United States of America. (e.g. Moore, Frohwirth & Blades, 2011; Ely, 2007), the United Kingdom (e.g. Baron, Cameron & Johnstone, 2015; Brown, 2013), and Malaysia (e.g. Tong, Low, Wong, Choong & Jegasothy, 2012). To my knowledge, one such study has been conducted in South Africa (e.g. Birdsey, Crankshaw, Mould & Ramklass, 2016). These studies have found that womxn's experiences of pre-abortion counselling differ substantially, and that whether womxn find the counselling useful depends on their particular needs and the kind of counselling they received (whether the counselling was responsive to those needs or not). For example, Birdsey et al. (2016) found that half of the womxn in their study experienced the counselling as useful while half found the information to be irrelevant to their personal set of circumstances. In Moore et al.'s (2011) study, most womxn were not seeking more information on their options with respect to the pregnancy, having already reached a decision. Furthermore, where womxn are given a choice of whether to receive counselling, studies show that relatively few womxn decide to do so, citing the lack of need for counselling (Baron et al., 2015; Brown, 2013).

Studies exploring providers' experiences of providing pre-abortion counselling have been conducted in contexts such as the UK (e.g. Beynon-Jones, 2013), Portugal (e.g. Beja & Leal, 2010), Nepal (e.g. Möller et al., 2012) and Vietnam (e.g. Nguyen et al., 2010). Some of this small body of research has found that healthcare providers stratify womxn's reasons or requests for abortion in terms of (un)acceptability (Beynon-Jones, 2013; Möller et al., 2012) and that this is based on womxn's age, and whether they had been using contraception prior to becoming pregnant, among other factors. Research in this area has also illuminated the content (as discussed by providers) of pre-abortion counselling, which, despite being conducted in different geographical settings, appears to have common elements such as contraceptive counselling and procedural information (Nguyen et al., 2010; Beja & Leal, 2010).

Womxn's experiences of seeking and accessing abortion services, including finding out accurate and complete information on abortion, and their experiences of their interactions with healthcare staff and the abortion facility, may shape and even form part of womxn's experiences of the PTOP healthcare interaction. Certainly, in the present study some womxn addressed some of these aspects in their narratives, for example how being able to access information beforehand enabled womxn to prepare and be less affected by the content of the counselling. Furthermore, interactions with healthcare providers tended to shape their experiences in both negative and positive ways. Notably, what is missing from the above research on womxn's experiences are womxn's experiences of their interactions with each other, for example in waiting room spaces, prior to their abortion procedure. As will be discussed in the analysis chapters, womxn's interactions with each other significantly shaped their experiences of the PTOP healthcare interaction, and sometimes shaped their understanding of abortion itself. Furthermore, research on womxn's emotional and physical experiences during and after their abortion procedure has highlighted how these experiences are shaped by various interactions and parts of the abortion process which precede the actual procedure (see discussion in literature review). Therefore, a study that incorporates the perspectives of both can shed light on the ways in which healthcare providers' and womxn's understandings of abortion and abortion counselling may diverge or converge and how these understandings might shape their experiences of the PTOP healthcare encounter.

Social discourses provide an important context in framing how abortion, and abortion counselling specifically, is to be understood. Abortion and notions around motherhood/womxnhood may be used to position womxn requesting abortion, and the health service providers providing abortion services, in ways which may shape the way counselling is conducted and thus shape experiences of the counselling. Thus, a study which explores experiences of the PTOP healthcare encounter by looking at the discursive practices which not only underpin but enable certain experiences, would help to illuminate how abortion counselling is conducted. As Vincent (2012, p.131) explains: “counselling practices can act as a vehicle for constituting the truth about what it is to be a woman”, as well as what it is to be a womxn utilising abortion services. Paying attention to the discourses used by both health service providers and womxn when narrating their counselling experiences may make visible the implications, particularly for womxn’s experiences of the counselling service, of the discursive practices employed in pre-abortion counselling.

This present study aimed to explore and compare womxn's and health service providers' talk about their experiences of the PTOP healthcare interaction (waiting room interactions and pre-termination of pregnancy counselling) in the Eastern Cape public sector. The following questions guided the study throughout the various stages of research:

1) How do health service providers describe/speak about their experiences of providing pre-abortion counselling and interacting with womxn in the waiting room? What discursive resources are drawn on and what practices are described?

2) How do womxn describe/speak about their experiences of receiving pre-abortion counselling and interacting with health service providers in the waiting room? What discursive resources are drawn on and what practices are described and how are they constructed?

3) How do womxn and health service providers position themselves and the other party in talking about PTOP counselling and waiting room interactions?

4) How do health service providers' and womxn's accounts of the PTOP counselling diverge or converge? And how might these have implications for PTOP counselling service provision?

5) What power relations are referred to or evident in health service providers' and womxn's talk? And what are the implications of these for PTOP counselling service provision?

In the following section, I outline the methodological and theoretical approaches that guide the present study.

2. Using Foucauldian post-structuralism to advance African Feminisms' aims

The theoretical foundations for this study lie in an African feminist approach which uses Foucauldian concepts as tools in advancing its aims of making visible the injustices faced by African peoples, particularly womxn, and the conditions which produce these injustices. African feminisms are attuned to the historical ways in which black African womxn have been mal-represented as 'the oppressed' in relation to 'empowered' (African) mxn and 'empowered' womxn from western/global north contexts (Mekgwe, 2008; Tamale, 2006, 2011). As such, African feminisms work to produce scholarship that is not only cognisant of this historical tradition, but that works to actively disrupt it by being attuned to the complexities and varying experiences of African womxn (Mekgwe, 2008, Chilisa & Ntseane, 2010; Tamale, 2011).

Blay (2008) argues that African feminisms' cognisance around the historical monolithic representations of African womxn must occur alongside a recognition that gender discrimination, gender inequality, and gender oppression (which is intersected by oppressions along various lines) *are* a reality for many African womxn. A central aim of African feminisms is therefore to bring about an end to womxn's varying and intersecting oppressions. Achieving the dual aims of African feminisms thus requires an understanding of power wherein power is conceptualised as "negotiated and negotiable, assessed in relative rather than absolute terms, and rightfully framed within cultural, historical, and generational contexts" (Blay, 2008, p. 69). In other words, within an African feminist approach, power is and must be understood as dynamic and relational. Relatedly, gender, and therefore ideas of 'womanhood' is understood to not only be socially constructed and socially constituted, but also as negotiable: an open signifier to which meaning is socio-culturally attached (de Saussure, 1974) so that 'woman' might carry different meanings and normative expectations depending on one's social, geographic and historical locations. An African feminist post-structural approach views power and subjectivities/experience in just this way.

To enable an analysis which highlights the complexities of womxn's experiences and the various ways in which they are similar and dissimilar, I draw from knowledge that has been produced by post-structural writers. Such work brings with it a capacity for analysing how individuals are governed and called upon to self-govern within and by different, multiple and interacting forms of power which operate through knowledge (Foucault, 1963/1976, 1982, 1991). These forms of power include liberal power where individuals are produced into autonomous self-directing subjects who make responsible decisions, and sovereign/authoritarian power which exercises force and coercion in governing the conduct of subjects. Importantly, a Foucauldian post-structural conceptualisation of power emphasises the productive and constraining aspects of power. Power, understood as action upon action, is also conceptualised as dynamic, while allowing for a recognition of the ways in which power relations may be patterned in certain ways. Thus, African feminist and post-structural notions of power share much in common.

I borrow from post-structuralism the notion that subjectivity and (in this case) experience are discursively situated to the extent that they depend for meaning on various discourses which enable us to make sense of the world and the various ways in which we are socially positioned. Feminist work on embodiment is also used to understand experience as being dependent on and shaped by the materiality of the body which enables and limits the possibilities for

discursive (re)construction (Burkitt, 1999; Howson, 2005). Foucault's (1975/1995) own work on the body and the ways in which it is governed and managed, complement this understanding of the body as both product and producer of discursive constructions.

Foucault's work around knowledge and power has been previously put to work, and in various ways, in research which draws on feminist theorising. For example, Chiweshe (2016) infused Foucauldian post-structuralism into a post-colonial/African feminist framework in his doctoral thesis on womxn's and health providers' narratives of abortion decision-making in Zimbabwe. Mavuso (2015) also drew on Foucault, pairing it with post-structural feminism, in her study on womxn's narratives of the abortion-decision-making process. Indeed, Salo (2001) and Tamale (2011) argue for a need to recognise the heterogeneity in (mainstream) feminisms produced in western/global north contexts, highlighting the usefulness of post-structural and Foucauldian informed feminisms for knowledge production on African womxn's realities. Thus, despite some African feminists' misgivings about the relevance and applicability of theoretical paradigms from (mainstream) western and/or global north contexts (for discussions on this subject, see Mekgwe, 2008; Salo, 2001) in African contexts, this has been successfully achieved when paired with critical feminisms which are cognisant of the stigmatising ways in which 'Third World' peoples have historically been, and continue to be, represented, and which view power as dynamic and relational.

Drawing on Foucault (1972), discourses are understood as statements that cohere around an object and construct it in particular ways. Thus, discourses are action-oriented. That is, discourses achieve certain things, such as enabling/limiting, legitimising/delegitimising, and constructing certain realities, practices, or ways of being. Discourses also require certain kinds of action/conduct. For example, a discourse which constructs abortion and unintended pregnancy as problems, and pastoral relations of power which position healthcare providers as responsible for the conduct of those in their care, may enable, justify and require practices such as the coercive imposition of long-term family planning on womxn accessing abortion services, within pre-abortion counselling.

The present study draws on and extends Taylor and Littleton's (2006) narrative-discursive approach in which narrative, conceptualised as both construction and resource, is defined as "a construction, in talk, of sequence or consequence" (p.92). Following Morison (2011), a Foucauldian understanding of discourse as constitutive of reality and ways of being is augmented with an understanding of discourse as a discursive resource which people may take

up, an activity which is, however, constrained by the availability and force of particular discourses. From a narrative-discursive approach, narratives have been borrowed as a useful concept in which the stories that people construct to make sense of their lives are both resource and construction. Narratives and discourses are interrelated in that narrative construction is constrained and enabled by the availability and force of discourses.

By approaching womxn's and healthcare providers' experiences of the pre-abortion counselling encounter from an African feminist perspective that draws on post-structuralism and a narrative-discursive approach, an analysis of the discourses and narratives which participants draw on and construct in making sense of their experiences is enabled. Also enabled is how these discursive conditions shape their experiences: the effects of drawing on particular discourses and narratives during pre-abortion counselling. What is further enabled, then, is the capacity to understand pre-abortion as a practice that is *discursively constituted* and therefore subject to discursive (re)constitution.

In the next section, I provide some context for how abortion has been understood in South Africa and elsewhere. I also highlight the knowledge that has been produced on abortion counselling. Thereafter, I discuss past and present abortion legislation in South Africa, and provide a snapshot of the Eastern Cape province in terms of socio-economic status and the health system(s) operating in the Eastern Cape.

3. Context: Abortion and abortion counselling

Despite being one of the most common procedures to take place both within and outside of healthcare spaces, abortion is often framed as an inherently controversial practice (Pollit, 2015). The reason for this, it has been argued, is that abortion, as it is currently constructed and understood, is more than a simple and safe medical/health procedure. It sits uncomfortably at the very centre of moral and religious debates about when life begins, debates which prioritise responsibility to that life and subordinate the needs of womxn. Still-dominant expectations about womxn's childbearing duties, constructions of womxnhood which fix womxn as nurturers, and which call upon womxn to adequately plan their pregnancies for the benefit of their children continue to frame abortion.

Notwithstanding its proven safety when conducted in formal healthcare settings by qualified and trained healthcare providers or guided by them (in the case of medical abortion which may be safely self-administered by womxn themselves at their homes) (Sparrow, 2004), abortion continues to be constructed, in dominant discourses on abortion, through language which

frames termination of pregnancy as posing a great risk to womxn's future fertility, their mental/psychological health and as posing the risk of contracting cancer. This contested information (Joffe, 2013; Major et al., 2009) about the so-called risks of abortion can be understood to be part of what feminist scholars have termed the 'awfulisation of abortion' (Lee, 2003; Sparrow, 2004; Wahlström, 2013). Through the awfulisation of abortion, abortion is constructed as an inherently difficult experience, ranging from the conflict and emotional struggle presumed to be present in the decision-making process, to womxn's experiences of trauma during and after the abortion procedure. Included, too, is the idea that abortion is "a necessary evil" (Wahlström, 2013) which must be tolerated but only insofar as it is deemed *necessary*. That is, tolerance for abortion does not extend to its use as a socially acceptable, legitimate form of fertility regulation. In fact, part of the 'truth' about abortion is that it is not comparable with or even preferable to contraception (Wahlström, 2013).

As Lee (2003) argues, the force of the construction of abortion as awful is exemplified in its use by both those who identify themselves as anti-abortion and those who support legal abortion. An 'anti-abortion' position on abortion is a position that encompasses beliefs that "motherhood [i]s a biological and moral imperative" (Luker, 1984 as cited in Jones, Frohwirth & Moore., 2008, p.81) and that abortion only serves to allow womxn to evade their mothering responsibilities (Luker, 1984 as cited in Jones et al., 2008). It also encompasses a 'pro-woman' stance that constructs abortion as deleterious to womxn's health, as well as the construction that abortion is murder due to the belief that life begins at conception (Trumpy, 2014). In contrast, support for legal abortion is not associated with being either for or against abortion but is characterised by the belief that womxn should have the right to decide for themselves what do to about a pregnancy.

Unfortunately, literature suggests that the awfulisation of abortion has come to be incorporated into mandated counselling in some states in the United States (Beckman, 2016) and in some parts of Central and Eastern Europe (Louis-Dunant, 2015). As Hoggart (2015) argues, when such discourse is incorporated into abortion counselling, it can serve to delegitimise abortion as a reasonable and appropriate choice, and, when womxn decide to continue with abortion in the context of receiving such information, it can create the trauma that abortion counselling is apparently expected to prevent or mitigate. Given this, it is troubling that little is known about womxn's experiences of mandated counselling which draws on the awfulisation of abortion, or about womxn's experiences of pre-abortion counselling in general. What is known suggests that while womxn's experiences of abortion counselling vary greatly, womxn generally

appreciate empathic care, and, perhaps most importantly, have different needs and requirements of abortion counselling (Brown, 2013; Moore et al., 2011; Birdsey et al., 2017). That womxn have different requirements from abortion counselling, according to their different needs, makes a compelling argument for womxn to be able to choose not only whether they receive counselling, but also what kind of counselling they wish to receive and what sorts of information they would like to receive.

Predominant ways in which abortion is framed masks the reality that, for some womxn, abortions take place within a variety of often intersecting relations of power (between womxn and mxn, womxn and policy-makers, and womxn and health service providers) which largely disenable womxn from having control over their own bodies regarding their reproductive decisions, including whether to become pregnant and whether, once pregnant, to have an abortion. However, understanding abortion as *only* or even *largely* occurring under circumstances of constraint may play into and reinforce the awfulisation of abortion by implying that abortion can never be simply desired, *outside* a context of socio-economic or other constraints. It may thus also mask the reality that womxn may simply prefer abortion *as* a method of contraception or fertility regulation.

Indeed, research has shown that womxn's reasons for having an abortion are extremely variable. Thus, womxn tend to terminate their pregnancies in the following circumstances: domestic violence which impacts on the use of contraceptives (Kaye, 2006); unintendedness of the pregnancy (Floridia et al., 2010; Mdleleni-Bookholane, 2007); an inability to adjust to child-rearing (Mdleleni-Bookholane, 2007); male partner support in the decision to terminate (Tsui et al., 2011); a socio-economic status that would be adversely affected (Font-Ribera, Pérez, Salvador & Borrell, 2007; Ngene et al., 2013; Puri et al., 2007; Tsui et al., 2011; Varga, 2002); disruption of school, stigma of early child-bearing and expectations that paternity will be denied (Varga, 2002). Among HIV positive womxn in Italy, having a lower CD4 count and having a partner who is HIV positive were associated with the decision to terminate a pregnancy (Floridia et al., 2010). Orner, de Bruyn and Cooper's (2011) South African study shows how womxn who are living with HIV may feel compelled to terminate their pregnancies due to HIV stigma which reinforces normative expectations around who should or should not have children. Research on factors associated with abortion have also found that womxn seeking abortion tend to have at least one existing child (Holla et al., 2014; Ngene et al., 2013). Furthermore, research in India (Holla et al., 2014) and in South Africa (Ngene et al., 2013) has suggested that lack of contraceptive use or contraceptive failure have also been reported by

womxn as reasons for requesting an abortion. Although research around contraceptive use might mask gendered power relations and socio-economic conditions which inhibit the use of 'socially acceptable' forms of contraceptives, womxn may nevertheless prefer abortion both within and outside of gendered power relations and socio-economic conditions.

For abortion counselling to best serve womxn, healthcare providers need to reflect this understanding in their abortion counselling practices. Indeed, the limited research around healthcare providers' experiences of providing abortion counselling suggests that the context in which womxn's reproductive decisions take place is not well understood, resulting in counselling practices which frame abortion as acceptable only for certain womxn (Beynon-Jones, 2013), and as acceptable only in certain circumstances, including situations where abortion care workers deem that it is not being used as a substitute for fertility regulation (Möller et al., 2012; Nicholson et al., 2010). Research, especially in contexts where abortion counselling is voluntary, on how healthcare providers' construct their experiences of abortion counselling, is lacking. Certainly, no such research has been done in South Africa, at least to my knowledge.

Having discussed introduced the discursive context around abortion and research that has been conducted around abortion counselling, I now turn to South African past and present abortion legislation which is an important aspect of contextualising abortion counselling practices and experiences thereof.

4. Past and present abortion legislation in South Africa

Abortion counselling, and the PTOP healthcare encounter in general, must be located within certain socio-historical and political contexts, which have implications for how abortion counselling is understood, practised and experienced. A country's abortion law(s), as well as the rhetoric used by civil society groups in securing the legislation, give indication of how abortion and abortion care is constructed as well as how womxn and abortion providers are positioned within these constructions of abortion discourse. For example, a reproductive rights framework constructs abortion as a legitimate reproductive health service to which womxn, positioned as autonomous reproductive subjects, are entitled and which healthcare providers have a duty to provide. Furthermore, abortion legislation plays a significant role in shaping whether and in what manner abortion services will be provided. Finally, how abortion is legislated has implications for how abortion care will be experienced by both those providing the service and those seeking it.

South African legislation on abortion has changed much since British Common Law was applied in South Africa (Ngwena, 2004a). Under Common Law, abortion was treated as a crime in South Africa and in other countries under British colonial rule (McGill, 2006; Ngwena, 2004a). In Section 58 of the Offences Against the Person Act of 1861, which specifically dealt with abortion, obtaining an abortion was deemed unlawful unless it was done to save the life of the pregnant womxn. Abortion carried out on any other grounds was considered a punishable criminal offence. Although, in South Africa, abortion could only be legally carried out to save the life of the pregnant womxn (following British Common Law), in practice doctors who performed abortion were able to use their own discretion to determine whether a termination of pregnancy was needed or not. The decision therefore rested with the healthcare providers (as I will show later, the current legislation has gone some way in amending this).

Since abortion was effectively criminalised under Common Law, the period from 1975 to 2004 was marked by increasing legislative reform regarding abortion. In this section, I shall discuss the Abortion and Sterilization Act (No. 2 of 1975) and the Choice on Termination of Pregnancy Act (No. 92 of 1996) and the Choice on Termination of Pregnancy Amendment Act of 2004. The two pieces of legislation will be located within the political climate in which they occurred. In doing so, I will focus on how abortion could be, and was, practised, suggesting that this will have implications for how womxn and healthcare providers construct and experience pre-abortion counselling practices.

4.1. The 1975 Abortion and Sterilisation Act

In 1975 the South African apartheid government reformed Common Law on abortion with the Abortion and Sterilisation Act. The run-up ─as described by Cope (1993) ─ to the passing of the Abortion and Sterilization Act took a period of approximately nine years, starting with numerous requests made in 1966 by various womxn's groups and organisations to Ministers of Health for therapeutic abortion to be allowed. These requests came at a time when illegal abortion had become increasingly visible in the political sphere (Klausen, 2015). In 1969, the first formulation of legislative reform was made by the National Council of Womxn. The request, made to the Prime Minister, was for a commission of inquiry to take into consideration the possibility for therapeutic abortion. In April of 1971, the Commission of Inquiry into the Mental Disorders Act recommended that the conditions under which abortion could be procured be expanded so that it may be permitted to preserve the life and health of the pregnant patient, where there existed a chance of a mentally or physically 'handicapped' child being born,

in cases of rape or incest or where the womxn was not capable of understanding the consequences of sexual intercourse (Cope, 1993; Klausen, 1971). Then in September of 1971, The Family Planning Association of South Africa pushed for conditions to include where the pregnant womxn is a minor (Cope, 1993). Importantly, calls for reform also came from doctors, among them those belonging to the South African Society of Obstetricians and Gynaecologists (Cope, 1993; McGill, 2006). Doctors were calling for legal reform because, while they often performed abortions for grounds other than to save the life of the pregnant womxn, they wanted a guarantee that they would not be prosecuted (Klausen, 2015). This pressure continued when, in the same year, the South African Medical and Dental Council referred the issue of abortion law reform to its executive committee and the South African Medical Association formed its own committee to examine the issue (Klausen, 2015). This request had been motivated by a desire for more clarity regarding the Common Law on abortion (Cope, 1993; Klausen, 2015).

The apartheid government's response to these calls for reform was lacking, however (Klausen, 2015). Twice (in 1973 and in 1974) draft legislation of the Abortion and Sterilization Act was tabled and read in parliament. In both cases, the opportunity for liberal reform was missed. As Cope (1993, p. 38) writes of the first draft of 1973: "this Bill took no socio-economic consideration into account, and made no allowance for contraceptive failure". The conditions under which abortion could be procured were restricted to: a threat to the life of the womxn or to her physical or mental health posed by continuation of the pregnancy, the substantial risk of physical or mental abnormality developing in the child, and pregnancy resulting from "unlawful carnal intercourse" (Cope, 1993; Drower & Nash, 1978; Klausen, 2015). This Bill was referred for consideration to the Select Committee on the Abortion and Sterilization Bill in 1973 (Cope, 1993; Klausen, 2015). The Select Committee consisted of (white) mxn only. The report of the committee was that a commission of enquiry (which consisted of the same mxn) was needed to complete the task. Submissions were made by various organisations and groups. In 1974, the second, amended, draft legislation (following the recommendations of the commission) was tabled: it specified, with regard to mental health grounds for abortion, that the damage had to be permanent and called for scientific evidence with regard to the risk of mental or physical abnormality in the child.

In 1975 the Abortion and Sterilization (AS) Act was finally passed on the grounds that it did not amount to 'abortion on demand' (Cope, 1993; McGill, 2006), and was regarded by many as a "legislative miracle" due to the conservative attitudes at the time (McGill, 2006, p.201). Under this Act, abortion could be obtained if: continuation of the pregnancy would pose a threat

to the womxn's life; continuation of the pregnancy would put the womxn's physical health at serious risk; the mental health of the womxn would be under serious threat as a result of the pregnancy which would also cause irreparable damage to the womxn's physical health; the 'unborn child' was at serious risk of suffering a mental or physical defect that would result in an permanent disability; and the pregnancy came about as a result of unlawful sexual intercourse such as rape or incest. According to Section 3(e) of the Abortion and Sterilization Act of 1975, abortion was also considered lawful where the womxn's mental disability meant that she would not be able to understand the sexual act or be able to be responsible for the child. The Act made no mention of abortion counselling.

4.1.1. Access to abortion under the AS Act

When comparing the Abortion and Sterilization Act to Common Law, the Act was certainly an improvement as it extended the grounds under which abortion was legally permitted. Despite limited legislative reform, the administrative procedures and requirements meant that the Act was highly restrictive in terms of its implementation, resulting in unequal and very limited access (Ngwena, 2004a, 2004b). Ngwena (2004a, 2004b) outlines the process of obtaining an abortion under the Abortion and Sterilization Act. To begin with, the womxn was required to speak to a doctor (only doctors were legally permitted to perform abortions). Following this, the doctor intending to perform the procedure had to send an application for abortion to the medical superintendent of the facility. This was to occur after the question as to whether to the womxn met the legal grounds for abortion was verified by two medical practitioners (excluding the one intending to perform the abortion). Of the two practitioners, at least one was required to have practiced medicine for a minimum period of four years.

Certain situations required further administrative procedures in addition to the above-mentioned process (Ngwena, 2004a, 2004b). Where a womxn was attempting to obtain an abortion because the pregnancy constituted a serious risk to her mental health, one of the two practitioners had to be a psychiatrist in the employment of the state. Where a womxn wanted to obtain an abortion due to the pregnancy having been the result of unlawful sexual intercourse, the Abortion and Sterilisation Act required her to have lodged a complaint with the police against the person(s) responsible for committing the act prior to requesting an abortion. Of the two practitioners tasked with verifying whether the womxn met the legal ground(s) for abortion, one must have been a surgeon who examined her when she lodged a complaint with the police. A magistrate had to then certify that the complaint had indeed been lodged. If a complaint had not been lodged, the womxn was required to account for why she

had not done so. In this instance, a magistrate was tasked with verifying that the explanation given by the womxn for why she had not lodged a complaint was a good and reasonable one. A magistrate was also tasked with establishing that an unlawful sexual act had most likely taken place.

Table 1*: Legal abortions performed in South Africa, 1975-1993*

Year	**Legal Abortions**
1975	570 (population 22.5 million)
1976	625
1977	539 (population 27.01 million)
1978	541
1979	423
1980	347 (population 29.08 million)
1981	381
1982	464
1983	474
1984	566
1985	712
1986	770
1987	810 (population 34.46 million)
1988-1989	963
1989-1990	916
1991	1021
1992	1449
1993 (until November)	1301

Sourced from Klausen, S. M. (2015). *Abortion under Apartheid.* p.210.

As Klausen (2015) and Mhlanga (2003) note, these bureaucratic procedural requirements had the effect of severely undermining womxn's access to abortion. Table 1 above, which appears in Klausen (2010, p. 210) and has been adapted here, depicts the small number of legal

abortions that were performed annually. Figures from 1975 to 1990 ranged from 381 in 1981 to 916 in 1990. I have included population figures to demonstrate that the number of abortions performed legally were out of step with the populations figures. Thus, for the year 1977 when the total population was 27.01 million, 539 abortions were performed and for the year 1987 when the total population numbered 34.46 million, only 810 abortions were legally performed. Access to abortion was also stratified by race/class. As a result, the large majority of the womxn represented in these figures were White. For example, Klausen (2015) notes how 485 of the 570 womxn who procured an abortion in 1975 were White; of the remainder, 56 were Coloured womxn, 20 were Black womxn and eight were Indian womxn. Similarly, of the 712 abortions procured in 1985, 78.7% were procured White womxn, with 11.1%, 5.3% and 4.9% having been procured by Coloured, Black and Indian womxn respectively. Thus, the implementation of the AS Act was fraught with both racial and class biases with white middle-class womxn constituting the majority of those granted an abortion (Ngwena, 2004a).

Access to legal abortion under the Abortion and Sterilization Act (1975) has also been discussed in terms of the number of unsafe abortions performed. Table 2 below (reproduced from Klausen (2015, p.212)) depicts figures for incomplete abortion[3].

Table 2: *Number of reported "Operations for removal of residues of pregnancy", 1978 to 1991*

Year	**Operations for removal of residues of pregnancy**
1978	19 818
1979	36 851
1980	29 979
1981	33 194
1982	35 759
1983	32 839
1984	29 596
1985	32 500
1986	36 062
1987	35 882

[3] Although these figures are taken to represent incomplete, illegal abortions, there is some debate around the likelihood that these may also represent miscarriages. However, Jewkes Rees, Dickson, Brown and Levin (2005) suggest that incomplete abortion is usually distinguished by factors such as a body temperature and sign of infection at the time of admission. These, too may be problematic as is discussed in Jewkes, Fawkes, Rees and Lombard (1997).

1988-1989	35 038
1989-1990	38 020
1991	33 305

Sourced from Klausen, S. M. (2015). *Abortion under Apartheid*. p.212.

As the table above shows, the numbers of reported illegal abortion greatly outnumbered the abortions that were legally performed at the time. For example, comparing the two tables, in 1983, 474 legal abortions were performed compared to 32 839 reported cases of unsafe abortion. Klausen (2015) points to how the raced (and classed) nature of access to abortion was also reflected in the fact that a large proportion of womxn who were admitted to hospital requiring treatment for an illegal and incomplete abortion were Black. Thus, in 1979, for example, of the 36 851 womxn who were admitted for unsafe abortion, 28 156 were Black womxn. The end of the Apartheid era presented a new opportunity for abortion law reform. Below, I discuss the Choice on Termination of Pregnancy (CTOP) Act.

4.2. The Choice on Termination of Pregnancy Act, no.92 of 1996

The passing of the CTOP Act by the government of the African National Congress was motivated by the high rates of maternal morbidity and mortality stemming from unsafe abortion practices (Mhlanga, 2003) under the previous abortion legislation. Research conducted in 1994 on the morbidity associated with incomplete abortions informed the passage of the CTOP Act (Jewkes, Brown, Dickson-Tetteh, Levin & Rees, 2002). This research suggests that the incidence of incomplete abortion resulting from illegal induced abortions was high, with figures of 375 incidents per 100 000 womxn (Jewkes et al., 2002, p.1252). The 1994 study also measured mortality as a result of incomplete abortion: three deaths were recorded in the study (Jewkes et al., 2002, p.1525).

This focus on the public health aspect of unsafe abortion, which was partly based on the "assertion that access to safe and legal abortions would reduce costs to the health system given the existing costs of addressing complications from unsafe abortion" (Klugman & Varkey, 2001, p.258), was a prominent approach used to bring about legislative reform. Another prominent approach lay in locating the need for legislative reform within a human rights discourse. Thus, it would be expected that public health and human rights discourses would form part of the discursive milieu around abortion: that is, that abortion is a necessary health service and a reproductive right to which womxn are entitled. Indeed, research by Potgieter and Andrews (2004) on South African healthcare providers' motivations to become involved

in abortion care work centre on public health discourses wherein legal abortion services are viewed as necessary to save womxn from the consequences of illegal abortion, as well as a human rights discourse. Notably, however, the absence of a rights discourse constituted a significant silence in the present study, both in womxn's own constructions of abortion and among the health providers interviewed.

The CTOP Act came into effect early 1997 (Haroz, 1997). It has since then been heralded as an exemplary piece of legislative reform (see Klausen, 2015; Mhlanga, 2003; Ngwena, 2004b). Under the Act a termination of pregnancy is legally permitted on the following grounds: upon request from the pregnant womxn up to 12 weeks; from the 13th to the 20th week in circumstances where the pregnancy is the result of rape or incest, continuation of the pregnancy will threaten the physical and/or mental health of the womxn, the 'unborn child' will suffer severe abnormalities, or the womxn's social or economic status will be significantly adversely affected by the continued pregnancy; and after the 20th week where the continued pregnancy would endanger the life of the pregnant womxn, would lead to foetal malformation, or would seriously threaten the life of the foetus. According to the Amendment of 2004, during the first 12 weeks of pregnancy the termination of pregnancy (TOP) procedure may be performed by a doctor, or a trained midwife or nurse. From the 13th until the 20th week, however, the procedure may only be performed by a doctor after they[4], in conjunction with another doctor or a midwife, are satisfied that the grounds for abortion contained within the CTOP Act have been met as the risks associated with the procedure increase with the gestation of the pregnancy. The Amendment Act (2004) further increases access to termination of pregnancy services by allowing for facilities which offer a 24hr maternity service to be designated as legal abortion facilities.

Unlike the previous legislation, the CTOP Act extended to minors the right to determine whether to terminate or continue with a pregnancy. According to Mhlanga (2003), this clause was included for two reasons: firstly, among minors requesting a termination of pregnancy, some may have been sexually violated by their parents or guardians; and, secondly, where the parent's/guardian's will conflicts with that of the minor, mandatory parental/guardian consent would impinge on the reproductive rights of the minor. Furthermore, the Act requires health service providers to advise minors to consult with a trusted adult but states that they cannot insist that the minors do so to receive the TOP services.

[4] I use 'they' here as to avoid using the binary pronouns 'he' or 'she'.

4.3. Abortion counselling under the CTOP Act

Unlike the Abortion and Sterilisation Act, the CTOP Act makes provisions for abortion counselling. The CTOP Act stipulates that voluntary (as opposed to mandatory) pre- and post-abortion counselling must be made available (i.e. womxn may choose whether to use these services). Apart from this information, the CTOP Act provides no information on how counselling should proceed or what, if any, kinds of information should be provided to womxn requesting an abortion. This relative lack of legislation to guide the provision of abortion counselling care has implications for the experience of abortion care provision.

As legal abortion care providers will presumably be expected, and trained, to provide abortion counselling in a particular way, I sourced other policy documents, the Western Cape Department of Health's (2000) *TOP Policy, guidelines and protocol*[5] and The International Pregnancy Advisory Services' (Ipas) (2014) *Woman-centred comprehensive abortion care: Trainer's manual*, to get an idea of the expectations around abortion counselling provision.

4.3.1. Western Cape Department of Health TOP Policy, guidelines and protocol

The Termination of Pregnancy guidelines and protocol provided by the Western Cape Department of Health (DoH) (2000) provides healthcare providers with some guidance on the content of pre-abortion counselling. According to the Western Cape DoH TOP guidelines and protocol, pre-abortion counselling should involve the following: assuring the client of the confidentiality of abortion, requesting and listening to the client's reason(s) for accessing abortion services, and allowing the client to express their views, concerns and feelings about the abortion, discussing the adoption and parenting alternatives to having an abortion, providing technical and procedural information about the surgical or medical abortion procedure that will be used, ensuring the client understands that once medical abortion has been initiated it must be completed, and providing information about available and suitable contraceptive methods to be used post-abortion. The counselling guidelines also specify that the counselling should be conducted in a non-judgemental way that respects and supports the client's decision. The guidelines explicitly state that abortion is to be understood, by the healthcare provider, as "an emergency measure only and must not become an alternative method of contraception" (Western Cape Department of Health, 2000, p.5) and further stipulate

[5] No documents were found for the Eastern Cape province. As these were the only provincial policies and guidelines documents that could be sourced at the time, they were used.

that the abortion care provider is responsible for ensuring that contraceptives are taken up to prevent future unintended pregnancies. Thus, both abortion and unintended pregnancy are problematised.

Two things are worth noting about the Western Cape DoH guidelines as they may have implications for the manner in which counselling proceeds, as reported by participants in this study. The first is that once womxn have consented to receive counselling, they are not expected to decide on what kinds of information they wish to receive, or even to refuse a method of contraception. The second is that the guidelines do not specify that abortion providers should provide (contested) information around the risks of abortion, such as risk of infertility, contracting cancer and developing psychological trauma post-abortion.

4.3.2. Ipas Woman-centred comprehensive abortion care: Trainer's Manual

Ipas, a non-governmental organisation (NGO), has made available online several documents relating to how healthcare providers are to go about providing abortion counselling. Their *Woman-centred comprehensive abortion care: Trainer's manual* (2014) is geared towards the training of abortion care providers in providing what they term a 'woman-centred' approach to comprehensive abortion care. In South Africa, Ipas was involved in providing training to healthcare providers and facilitating Values Clarification Workshops with healthcare providers before and after the passing of the CTOP Act. It is therefore possible that Ipas has been influential in how pre-abortion counselling takes place currently in South Africa.

Unlike the Western Cape DoH policy document, the Ipas (2014) trainer manual includes information on what counselling is, with the following definition provided: "[a] structured interaction in which a person voluntarily receives emotional support and guidance from a trained person in an environment that is conducive to openly sharing thoughts, feelings and perceptions" (p.91). 'Woman-centred' counselling is distinguished as being responsive to and guided by each womxn's unique physical and emotional state, needs and concerns, and is marked by the absence of a 'standard script'. Like the guidelines and protocols provided by the Western Cape Department of Health (2000) discussed above, Ipas' (2014) trainer manual trains healthcare providers conducting abortion counselling to discuss the client's options concerning the pregnancy, and to provide information around contraception with the implication that womxn should take-up a method of contraception post-abortion. Unlike the Western Cape Department of Health guidelines and protocol, the trainer manual states that womxn need to be informed about the advantages of abortion, in addition to the risks which are described as

expected effects, side effects and potential complications. It also provides information on effective communication during counselling, such as active listening, attentiveness to the words used by the client in talking about their feelings and perceptions, the use of non-verbal cues to convey concern and the posing of open-ended questions.

What is worth noting about the Ipas (2014) document is that healthcare providers are guided to understand abortion counselling in particular ways and to speak to the advantages of medical abortion. Providers are furthermore encouraged to note that womxn may have already decided to have an abortion upon arrival at the healthcare facility, and that abortion counselling should not proceed as if dictated by a script to which the provider needs to rigidly stick. Despite this, however, the elements of abortion counselling are listed as pregnancy options, procedure option and voluntary informed consent.

While having liberal and comprehensive abortion legislation is certainly important for how abortion and abortion services are understood, also important is that the services provided for within the legislation are in fact accessible. The accessibility or inaccessibility of abortion may not only shape experiences of the PTOP healthcare interaction but may also play out within the PTOP healthcare interaction itself.

4.4. Access to legal abortion under the CTOP Act

Access to termination of pregnancy since the CTOP Act was passed in 1996 has been measured in two ways. The first compares the number of legal abortions performed with the total number of abortions requested. The most recent statistics were produced in a study by Mendes, Basu & Basu (2010) who conducted a descriptive cross-sectional study of facilities providing termination of pregnancy services in the Johannesburg Metropolitan area in Gauteng Province. The study found that for the year 2008, out of the 14 683 abortions that were requested, only 4921 first trimester abortions were performed (Mendes et al., 2010, p.614). For the following year, only 5338 first trimester abortions were performed out of the 16 031 abortions that were requested (Mendes et al., 2010, p.614). Although these statistics are for Gauteng province only, it is significant that only a third of the total abortions requested were being performed at the time of the study in the province that has the highest number of functioning facilities designated to provide termination of pregnancy services (Dickson et al., 2003; Mendes et al., 2010).

The second way in which access to termination of pregnancy has been measured is by comparing past and present figures of maternal morbidity and mortality as a result of unsafe

abortion. Jewkes et al. (2002) conducted a study in which they replicated research by Rees et al. (1997) to determine morbidity associated with incomplete abortion at 47 hospitals. The findings of Jewkes et al. (2002) show a decrease both in the incidence of incomplete abortion (362 for the year 2000 compared with 375 for the year 1994) and mortality arising from incomplete abortion (one death for the year 2000 compared with three deaths in 1994). Reliable, up-to-date statistics, however, are often difficult to obtain. This is due to difficulties in estimating the number of unsafe abortions performed (as Jewkes, Fawcus, Rees, Lombard and Katzenellenbogen (1997) discuss in their paper on the methodological problems the authors encountered in conducting the 1994 study on morbidity regarding abortion). Nevertheless, the most recent statistics for abortion-related morbidity and mortality suggest that there has been a considerable decrease since the implementation of the CTOP Act (Harries, 2009; Harries, Orner, Gabriel, & Mitchell, 2007). It has been repeatedly noted, however, that womxn wanting or needing a termination of pregnancy still face several obstacles in acquiring the procedure. I discuss these below.

4.4.1. Barriers to access

Despite liberal abortion legislation and legislative measures taken to increase service provision, there are still obstacles to accessing TOP services. These barriers include: general ignorance of abortion legislation, a shortage of health service providers who perform TOP procedures (particularly second trimester abortions), a low percentage of functioning designated facilities, and stigma/social attitudes towards abortion. Each of these will be discussed, briefly, in turn.

4.4.1.1. Knowledge of abortion legislation

In more than one study (e.g. Harries et al., 2007; Jewkes et al, 2005; Morroni, Myer, & Tibazarwa, 2006) it has been found that womxn are largely unaware, in the first place, that abortion is legal in South Africa. In the second place, they are unaware of the conditions under which abortion may be legally performed and the time restrictions involved. This has important implications when a womxn is faced with a pregnancy that they do not want to have and/or a pregnancy for which there is simply no support. Recently, Macleod, Seutlwadi and Steele (2014) conducted research in Buffalo City, Eastern Cape, on grade 11 learners' knowledge of abortion legislation. The results revealed that the learners had poor knowledge of the conditions under which an abortion may be performed, as well as poor knowledge of the stipulations of the Act regarding gestation restrictions and parental consent for minors. As revealed in the present study, many womxn may be unaware that the CTOP Act stipulates that counselling

must be an available part of abortion services but that womxn may *choose* whether to receive it or not.

As discussed in Harries et al. (2007), lack of knowledge regarding the time restrictions for obtaining an abortion may mean that womxn delay seeking an abortion until the second trimester when the procedure carries more risks and there are fewer service providers willing to perform abortions (Alblas, 2008). Macleod et al. (2014, p.7) summarise the implication that poor knowledge of abortion legislation carries:

> If, as suggested, a woman's ability to make an informed reproductive decision rests on, firstly, access to sufficient information and, secondly, understanding that information, there is cause for concern. Whilst adequate information is not a *sufficient* condition for the exercise of reproductive rights, it certainly is a *necessary* condition.

Thus, a basic requirement for womxn to be able to access legal abortion services is access to information that abortion is legal in South Africa, where it may be procured and under what conditions. Even when womxn have this information, however, other barriers may still exist. I discuss these below.

4.4.1.2. Number of functioning facilities

Poor implementation of the CTOP Act and a lack of structural resources in the public health sector has meant that there are not enough facilities to meet the need for abortion. This low number of functioning facilities is affected by a dearth of abortion providers, which in turn is affected by attitudes to abortion and conscientious objection to abortion (discussed below). According to Trueman and Magwentshu (2013), in 2013 only 50% of the 260 public health facilities designated to provide abortions were actually doing so. An insufficient number of functioning facilities means that womxn may end up using precious resources going to a designated facility that is not performing abortions. It also means that those facilities that are functioning according to their designation become over-burdened, resulting in long waiting lists or womxn being turned away.

4.4.1.3. Dearth of abortion providers

Even with adequate knowledge of the CTOP Act, access to TOP services may be hindered by a shortage of health service providers (doctors, midwives and nurses) willing to provide the service as well as a shortage of functioning facilities. This has several consequences. Firstly, in some facilities, termination of pregnancy services are often sporadically available or even not available at all where there are no willing health service providers (Alblas, 2008). Facilities

that cannot provide TOP services, due to a shortage of personnel, no longer function (Dickson et al., 2003; Mendes et al., 2010). This has resulted in the provision of abortion services (particularly second trimester abortion) by small teams of roving doctors in areas such as the Western Cape (Alblas, 2008). Secondly, when there are more womxn requesting TOP than a facility can handle, it is not uncommon for many of the womxn to be told to return weeks later (Bateman, 2011), or to be put on a long waiting list (Jewkes et al., 2005). For some of these womxn, returning at a later date may put their pregnancy within the second trimester, for which there is an even greater shortage of doctors (Harries et al., 2007). Thirdly, healthcare workers who are involved in abortion care may feel over-burdened, strained and suffer from-burnout, leading to retirement from abortion service provision which further impacts on the unavailability and inaccessibility of abortion (Harries, et al., 2009).

4.4.1.4. Attitudes to abortion

In contextualising the paucity of health service providers who provide abortion services, two arguments have been made in literature on the subject. The first revolves around how health service providers' negative experiences of providing abortion may make them less likely to continue providing abortion services (Sibuyi, 2004). The second posits that many healthcare providers invoke the right to conscientious objection which often revolves around the question of when life begins and thus may be informed by religious or personal/moral beliefs (Alblas, 2008; Harries et al., 2009; Ngwena, 2003; Turner, Hyman, & Gabriel, 2008). Research has shown that health service providers who do perform or participate in TOP procedures experience judgement, stigma and sometimes ostracization, as well as harassment, name-calling and intimidation by colleagues who refuse to perform or participate in the procedures (Harries et al, 2009; Sibuyi, 2004). Research on health service providers' attitudes towards abortion and abortion service provision suggests that attitudes towards provision of TOP services greatly depends on health service providers' own understandings of which womxn *should* be allowed access to these services (Birdsey et al., 2016; Mokgethi, Ehlers & van der Merwe, 2006; Nguyen et al., 2010) and the circumstances under which abortion provision is considered to be intrinsic to their role as healthcare providers (da Costa & Donald, 2003).

Recognising that access to abortion may be hindered by healthcare providers' negative attitudes towards abortion which may manifest in their delivery of abortion services, Values Clarification (later, Values Clarification and Attitude Transformation) workshops were implemented and run by Ipas prior to and after the passing of the CTOP Act to enable womxn's access to abortion services (Mitchell, Trueman, Gabriel, & Bock, 2005; Turner et al., 2008).

To do so, the workshops aimed to bring about a shift in the attitudes and behaviour of various stakeholders – such as nurses, midwives and doctors, traditional leaders and healers, healthcare managers, and various policymakers – who may have an influence on implementation of the CTOP Act and access to abortion services. As part of the workshops, participants engaged in facilitated activities, each of which were designed to enable critical self-reflection on their current beliefs and attitudes about abortion and therefore facilitate change from opposition to abortion, to acceptance and support, and eventually to abortion advocacy (Mitchell et al., 2005; Turner et al., 2008).

Turner et al. (2008) provide an example of an activity. In the 'Last Abortion', participants must imagine that they belong to a fictitious country in which the last abortion will be performed and must select, from six possible candidates, who will receive the last abortion. The aim of the activity is to encourage participants to see the impossibility and undesirability of making objective judgments about which clients are deserving of abortion and which are not. Indeed, globally, research on abortion care workers' experiences of providing pre-TOP counselling is beginning to show that providers are in fact making such judgments as part of their counselling practices. Curiously, however, five out of the six womxn presented in the activity "have difficult circumstances" (Turner et al., 2008, p.111) which necessitate an abortion: rape, foetal impairment, living with HIV, domestic abuse, and struggling with alcoholism with two prior children suffering from foetal alcohol syndrome. The implication is that while acceptance may be fostered when abortion is requested by womxn whose circumstances collectively portray abortion as a difficult decision to make, a last resort, and necessary, other reasons for requesting abortion are stigmatised. Thus, while such interventions are indeed necessary and invaluable, careful attention needs to be paid to the construction of abortion so as not to close down the very thing these interventions seek to enable: access to abortion services.

Experiences of the pre-abortion healthcare encounter, including the decision-making that may take place during it, are shaped by and predicated on womxn's and healthcare providers' understandings of the viable options (un)available to womxn deciding what to do about a pregnancy. Where abortion has been legalised, and may be requested or granted under numerous grounds, a safe abortion may become a viable option for womxn who are faced with a decision about what to do about a pregnancy. However, the viability of abortion as an option will also depend on other factors. These include the ease or difficulty in accessing abortion services, constructions of and abortion counselling which may operate in the PTOP healthcare encounter. Other conditions are also influential in shaping abortion as an illegitimate option,

pushing womxn towards illegal and unsafe services. For example, Jewkes et al. (2005) conducted a study to determine why womxn in South Africa are still aborting outside of designated facilities. The study, conducted in Gauteng Province, found that the most cited reasons were not knowing the law, being aware of the law but not knowing where facilities are located, and, particularly significant for the present study, anticipating hostile attitudes and mistreatment from staff (Jewkes et al., 2005). Furthermore, constructions of abortion may be informed by abortion legislation and policies which may then shape healthcare providers' understandings of how counselling should proceed and experiences of abortion counselling thereof. Thus, abortion legislation *and* access to TOP services form a significant part of the context in which PTOP healthcare interactions are experienced.

In the next section, I describe the socio-economic profile of the Eastern Cape province and give an indication of what is known about abortion service provision within the province specifically. This provides an important backdrop to the study as it gives some idea of the larger context in which the PTOP healthcare interaction takes place.

5. Healthcare provision in the Eastern Cape Province of South African

According to the Department of Economic Development, Environmental Affairs and Tourism (2013) as stated in its Eastern Cape Socio-economic Review and Outlook which reports statistics for the year 2011, latest population estimates for the province are around 6.7 million people, which corresponds to about 12.7% of the national population. Demographically, 87.6 % of the population in the province are “Black” mxn and womxn, with “Coloured”, “Indian” and “White” mxn and womxn representing 7.5%, 0.3% and 4.7% respectively as reflected in statistics for the year 2007 (Makiwane & Chimere-Dan, 2010, p.64). In terms of languages spoken, isiXhosa is the home language spoken by a majority of the provincial population (87%), with Afrikaans and English being spoken at home by 9% and 4% respectively (a further 4% of the population speaks at home in languages other than those just listed).

The 2016 Community Survey provides various socio-economic indicators, including grants and subsidies received for the year 2015 as a percentage of total income and poverty headcount (Statistics South Africa, 2016). These figures vary greatly across districts in the Eastern Cape. Figures for 2015 grants and subsidies as a percentage of total income range from 25.3% for the Buffalo City district, to 94% for Alfred Nzo. The poverty headcount also varies substantially: 4.5% for the Cacadu district to 22% for Alfred Nzo district.

Given the extent of poverty in the Eastern Cape, private health facilities are financially inaccessible to most of the population. This necessitates a reliance on public health facilities. Regarding termination of pregnancy services in the Eastern Cape, a paper by Dickson et al. (2003) represents statistics for the availability of abortion services in the public health sector. In their paper, the authors state that of the 829 public health facilities (that is, clinics, community health centres and hospitals), the 10 public health facilities designated to provide services were functioning when the study was conducted in 1999 (Dickson et al., 2003, p.279). As Dickson et al. (2003) show, and as I discuss above in the previous section, access to TOP services is not only about whether there are facilities that provide abortions. Access can be affected by the distribution of services. In their study, distribution figures for the Eastern Cape were such that 41% of womxn aged 16-50 lived more than 50km from first trimester TOP services, and 7.6% lived more than 100km from facilities providing these services (Dickson et al., 2003, p.280). The figures were higher for second trimester TOP services: 48% and 16.5% respectively (Dickson et al., 2003, p.280). In terms of the number of abortions performed, of the 288 TOPs performed on average per month (translating to 3456 for the year 1999) in the Eastern Cape, 69% were first trimester while the remaining 31% were second trimester abortions. Up to date figures on the number of safe, legal abortions performed are difficult to obtain. Available reported figures seem to show a drastic decline in the number of TOPs performed in the Eastern Cape with 9370, 11 540, 13 870 being reported for the years 2010, 2011 and 2012 respectively compared with 3590 for the year 2013 (Johnston's Archive, 2017). Such figures may point to an increased reliance on illegal abortion service or to poor collection of statistics.

Statistics on the availability and accessibility of abortion services do not specifically address or distinguish pre- (and post-) abortion counselling services from abortion services. Thus, the extent to which PTOP counselling is conducted in the Eastern Cape public sector has, to my knowledge, not been determined or made available. Regarding pre-abortion counselling specifically, interviews with participants suggest that pre-abortion counselling is not always offered at functioning facilities- one participant described an absence of counselling at a different facility which she had initially visited, and which had subsequently referred her to the site at which I interviewed her. Furthermore, where it is offered, it is not always voluntary: in the present study it appeared that pre-abortion counselling was voluntary, to some extent, at sites 2 and 3. At site 1, however, it appeared, at least during the period of data collection, that

womxn were not informed of the voluntary nature of the counselling, nor were they given the option of opting-out of the counselling.

The relative lack of access to healthcare and the extent of poverty in the Eastern Cape described above must be contextualised by British Colonial and Apartheid era racial, socio-economic and health policies, the effects of which have persisted in contemporary, democratic South Africa. The establishment of Apartheid entrenched and reinforced socio-economic policies which systematically impoverished Black populations which were under-educated for their primary role as labourers (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). In terms of health policies, the government of the African National Congress (ANC) inherited in 1994 a health system that was racially segregated and fragmented. This fragmentation occurred within the public health care system, as well as between private and public healthcare systems with curative and preventive healthcare being fragmented. Under Apartheid, South Africa was separated into independent underdeveloped 'Bantustans' or rural homelands for Black populations, and White South Africa. As such, the Eastern Cape province formerly compromised of the Ciskei and Transkei 'Bantustans' and White South Africa. This division of the country meant that there were great economic and health inequities between the 'Bantustans' and White South Africa. For example, Coovadia et al. (2009) note how during apartheid public health services in the 'Bantustans' were greatly underfunded with spending per head ranging from R23 in Lebowa to R91 in the Ciskei (both former 'Bantustans'), compared with R150 in the Transvaal and R200 in the Northern Province (both former White South Africa).

Under the ANC government, the public healthcare system, on which most South Africans rely, was consolidated and transformed in to a comprehensive health system to increase access to essential healthcare. However, as the figures discussed earlier suggest, health and economic inequities still exist between and within provinces. In the following section I provide rationale for important terminology which will be used throughout this thesis. I conclude this chapter by presenting an overview of the discussions that will take place in the different chapters of this thesis.

6. Notes on terminology

In keeping with the reflexive tradition in qualitative, particularly feminist research (Edwards & Mauthner, 2002), I refer to myself throughout this thesis in the first person so to as acknowledge that this document is discursively constructed, and therefore contested, and to firmly locate myself within the process of knowledge production. Relatedly, I refer to myself as researcher and as interviewer (for the interviews I conducted) to situate myself in the data production process. As such, in the analysis chapters, where relevant I highlight my own contributions and silences in co-producing participants' narratives/accounts.

I use 'abortion' (the more discursively loaded term) and 'termination of pregnancy (TOP)' (associated more as a medical/health procedure) interchangeably throughout. While I do note the possible nuances in the meanings attached to these terms, I use both these terms deliberately in the realisation that both terms still carry significant stigma. Therefore, I deploy these terms to neutralise and normalise the more negatively loaded term, 'abortion'. I also use the terms 'pre-abortion counselling' and 'pre-termination of pregnancy (PTOP) counselling' interchangeably. Both refer to the counselling that takes place before the medical or surgical abortion procedure.

I use the term 'womxn' as opposed to 'woman'/'women' for several reasons. Firstly, to disrupt normative assumptions about gender and sex, here taken to be socially constructed, which write gender and sex *onto* individuals, I use the term 'womxn' to denote and recognise all persons with the biological capacity to become pregnant (because this study is around abortion), including transgender, intersex, womxn-identifying and mxn-identifying persons. Secondly, I do so to foreground the experiences of womxn of colour, womxn from/living in the global south, trans, queer and intersex womxn, and all womxn-identifying persons who have been excluded from dominant constructions of 'womanhood' and feminist praxis on the subject (Ashlee, Zamora & Karikari, 2017; Merbruja, 2015). I use this term when referring to my participants whose gender and/or sex were not asked for and is thus unknown to me. For consistency, I have also used the term 'womxn' throughout this thesis (except when quoting others' words), including when citing others' research and when referring to discourses around 'womanhood' which are necessarily based on cisgendered[6], heteronormative, raced and classed understandings of who can and should be called a 'woman'. I have done this precisely to make

[6] Refers to persons who identify with the gender they were assigned at birth. See Merbruja's (2015) article for her usage of this term.

visible how womxn may have been defined and the possible exclusions that the usage of 'woman' carries. Similarly, I have used the term 'mxn' as opposed to 'men'.

Following Ashlee et al. (2017), I use the term 'womxn' to denote both 'woman' and 'women' with the surrounding text providing context as to whether the singular or plural have been referred to. Although the argument has been made that the lack of distinction between the singular and plural forms may be confusing, the use of the word 'womxn' is potent precisely in that it jars with the ways in which we have been socialised not only to construct womxn in particular ways but also to use language in particular ways. The word 'womxn' therefore continuously disrupts this automatic reading (Peters, 2017).

While I have capitalised the racial signifiers 'Black', 'White', 'Coloured' and 'Indian', I do so not to signal my own understanding of race as essential. Rather, my own view of racial identity is that while there are cultural differences between people of various cultural/racial groups, these differences are a lot less pronounced than normative discourses on race imply. Relatedly, I understand racial identities to be inscribed with particular meanings, while being attuned to how experiences of racial identity are formed by structural inequalities which have been inherited from the colonial and Apartheid eras.

To distinguish between participants, I refer to 'womxn' as those who were accessing abortion services and 'healthcare providers' as those involved in abortion work. However, it is important to keep in mind that the four healthcare providers interviewed were womxn.

Lastly, I use the term 'unintended/unplanned pregnancy' to recognise the circumstances surrounding the pregnancies of the specific womxn who were accessing abortion services who were interviewed as part of this study. While I also recognise that this term has historically been used and continues to be used in ways which inherently *problematise* these pregnancies by presuming that they are necessarily unwanted, this term is not inherently problematic and *can* be used in non-marginalising ways, as I endeavour to do. Furthermore, unintended pregnancy as a discursive construction is important in this study, as I will show.

7. Overview of the thesis

The following chapter (**chapter 2**) provides the theoretical foundation for the present study. In it I make an argument for an African feminist post-structural approach. I begin by outlining an African feminist approach. Following that I discuss Foucault's work on knowledge and power and other post-structural writers' work in this area. In doing so, I delineate my own understanding of discourse/knowledge, and power relations, and I demonstrate its suitability to

a study on the pre-abortion counselling encounter. Thereafter, I turn my discussion to how an African feminist perspective is enabled by the work of post-structural thinkers and attempt to show how it is useful particularly in African contexts. I ultimately argue that the use of both can make a valuable contribution to a compassionate and just understanding of the myriad experiences of womxn and abortion care workers in global south contexts.

In **Chapter 3** and **4** I speak to the literature (that was available at the time of writing) that provides important context for how I have, and how we might, understand womxn's and healthcare providers' constructions of their experience of waiting room interactions and the pre-abortion counselling session as it takes place in the public health sector in (the Eastern Cape province of) South Africa. To provide this necessary context, in chapter 3 I first talk to knowledge production on abortion counselling. I divide this work into (1) literature that does the theoretical work of how we might (and should) understand abortion counselling, thus speaking to various approaches to abortion counselling which circumscribe the role and duties of those providing abortion counselling; and (2) research that has been conducted to explore womxn's and healthcare providers' experiences of pre-abortion counselling. In the remainder of chapter 3 I discuss research on womxn's and healthcare providers' experiences of abortion in general. In chapter 4 I discuss the various ways in which abortion is constructed through various discourses which together and in inter-related ways produce certain 'truths' about abortion. This discussion, I argue, is necessary to situate pre-abortion counselling as a practice which is discursively shaped and underpinned. In the remainder of the chapter I discuss pertinent research that has been conducted around womxn's psychological outcomes post-abortion and womxn's decision-making around abortion. Although there is a vast body of research on abortion, I conclude that the exploration of womxn's and abortion care workers' narrated experiences of the pre-abortion counselling encounter is a significant and novel contribution to the extensive work on abortion.

Through **Chapter 5** I discuss the methodology deployed in this thesis. I begin by discussing my own understanding of a narrative-discursive approach and go on to argue that incorporating Foucauldian concepts of discourse and power relations extends Taylor and Littleton's narrative-discursive approach. Conversely, I make an argument for the inclusion of the concept of narratives in a post-structural discursive analysis. Thereafter, I speak to the various methods employed in the study: recruitment and sampling, data collection, analysis procedures, and ethics procedures. I include a section on reflexivity in which I locate various methodological decisions and the effects of these decisions on the present document. I also similarly address

my own role as researcher/interviewer/author and my identity as a young, black PhD student who identifies and is read as a womxn and what this meant for/within the process of producing this thesis.

My analytical work is presented in chapters 6, 7, and 8. In **chapter 6** I describe and analyse the processes and content of pre-abortion counselling as was described in womxn's interview talk. As such, I discuss the various discourses drawn upon and the subject positions taken-up by womxn and healthcare providers in giving accounts of their experiences of PTOP healthcare interactions. I point out how some of these discourses open up and close down certain forms of abortion embodiment. Importantly, I note discourses which did not feature in womxn's and healthcare providers' talk. Lastly, I speak to the pastoral and liberal counselling practices described by the womxn specifically. The various micro-narratives womxn constructed during their interviews are analysed in **chapter 7**. In this chapter, I therefore demonstrate how various discourses are put to work by the womxn in different ways and with different effects. Importantly, a discussion of these narratives enables a focus on the womxn's experiences of the PTOP healthcare interactions: their thoughts and feelings about the conversations had within and outside the counselling space and the implications that these had for their subsequent understanding of abortion. In the final analytical chapter (**chapter 8**) I present my analysis of the healthcare providers' accounts of their experiences of the PTOP healthcare encounter. I argue that the healthcare providers, in convergent and divergent ways, draw on discourses and canonical narratives to describe and justify PTOP healthcare practices and position themselves, and the womxn they service, in particular ways. I also show how liberal, pastoral and sovereign power operated in various ways and the ways in which womxn were incited to produce particular selves.

Chapter 9 concludes the thesis. It begins with a summary of the discussions had in the preceding chapters. I then draw together the findings of the three analysis chapters to comment on the PTOP healthcare encounter constructed by participants and the implications of this for pre-abortion counselling service provision. Following this discussion, I note the silences in participants' talk and discuss possible reasons for and implications of these silences. I conclude the chapter by addressing the limitations of the present research and suggesting possible directions for future research that will aid in improving womxn's and healthcare providers' experiences of the PTOP healthcare encounter.

Chapter 2: An African feminist post-structural approach

1. Introduction

Two main problematics are central to the present study. The first is the discursive resources (here referring to discourses and canonical narratives) used to construct micro-narratives and accounts of womxn's and health service providers' experiences of waiting room dynamics and the counselling practices deployed during pre-abortion counselling. The second is the various forms of power relations referred to in these narratives and accounts of these experiences.

In this chapter, I argue that an African feminist post-structural approach provides a useful theoretical framework for exploring womxn's and healthcare providers' narrated experiences of the PTOP healthcare context. Following Mekgwe (2008), I note that African feminism is not a uniform approach but rather consists of various approaches to how 'Africa' may be best defined. Differences exist on two levels. At the first level, African feminisms have variously defined who counts as African. At the second level, African feminists have debated about what socio-cultural and political realities are distinctly 'African' and what theoretical insights are best able to speak to these realities. The signifiers (de Saussure, 1974) given to African feminist approaches (e.g. African feminism, womanism, stiwanism) reflect different concerns at both levels. Broadly speaking, African feminisms aim to highlight and bring an end to the oppressions faced and experienced by African peoples, especially womxn. In this chapter I specifically draw on post-structural articulations of African feminism which foreground and explore how womxn's varying and intersecting oppressions are produced and reinscribed through social constructions of womxnhood and relations of power (Tamale, 2011). I draw on Tamale's (2011) notions of mothernormativity and marriagenormativity which Tamale argues form part of normative constructions of womxnhood.

In my discussion of African feminisms, I note that African feminisms share a common objective to make visible and resist what Mekgwe (2008) refers to as 'mal-representations' of African womxn as oppressed victims. In attempts to resist these monolithic constructions however, some approaches to African feminisms themselves homogenously portray African womxn in an attempt to define African realities in positive ways. I argue that African feminisms which understand power to be relational and dynamic, and womxnhood to be socially constructed and fluid, may resist the trappings of essentialist thought which claims that a true, underlying essence connects womxn's experiences into an undifferentiated whole (Sawicki,

1986). This acknowledges the increasing calls for transformation and decolonisation within universities, which are one of the sites where knowledge is produced, which require us to rethink the usefulness and applicability of certain theories/knowledges for African contexts. Indeed, Mekgwe (2008) and Salo (2001) discuss debates in which the use of post-structuralist work to explore African experiences has been critiqued. Following Ahluwalia (2010) I argue that an African feminist post-structural approach may be conceived as a framework that is able to speak to the multiple and varied African realities experienced by womxn (this argument will be taken up later).

I begin this chapter with a section where I incorporate Taylor and Littleton's conceptualisation of narrative and discursive resources into a discussion on (Foucauldian) post-structural theorists work around knowledge and discourse as that which enables the exercise of power, and how the transformation of knowledge and discourse into 'truth' depends on the exercising of power. Foucault's work also highlights how power is exercised through other means (such as surveillance, measurement and normalisation). During this section on post-structural work on discourse and power, I speak to Foucauldian concepts that I have identified as useful in making visible the discursive conditions and power relations which shape and enable/constrain experiences of the PTOP healthcare encounter and tellings thereof. As such, I discuss discourse and how it is deployed in this study as a discursive resource. I also discuss subject positions and how I understand them to be an interactional process which individuals both act upon and are nonetheless constrained by through the limited availability and dominance of particular discourses. I then speak to the various formations of power (sovereign/authoritarian power, disciplinary power, pastoral power and confessional practices, the clinical gaze and bio-power). Throughout this discussion on power, I draw on the work of others who have built on and extended Foucault's conceptualisation of power. Moving from that, I speak to Foucault's analysis of the production of sexuality and argue that it has particular relevance for this study. Following this, I speak to my decision to use an African feminist post-structural approach. In doing so I discuss what is to be gained by doing so.

2. Foucault's analytics of power

Foucault (1982) argues that his work should not be read as theory on power. He asserts that, even though his work is often read to be speaking about power, it was more about the creation (in his earlier work), and regulation (in his later work on governmentality) of individuals and populations, which necessitated an analysis of power relations. Power, for Foucault, is thus imbricated in both the production and regulation of individuals. In his analytics of power,

which is varied, multiple and interacting, discourse and knowledge are not only mechanisms though which power is exercised, but are also sometimes produced within certain locales of power. His analytics of power is therefore useful in analysing the discourses which enable, call forth and legitimate certain abortion counselling practices, and produce and regulate the subjects of those discourses in particular ways.

To further analyse the relations of power which enable and constrain participants' experiences of the PTOP healthcare interaction, the concept of narratives will be drawn on. As I will show, the concept of narrative (understood within Taylor and Littleton's narrative-discursive approach) is useful in making visible these relations of power as they operate at the micro-level. By analysing womxn's interview data for the micro-narratives they construct (and the discursive resources used to construct these micro-narratives), researchers can show how an event, such as pre-abortion counselling, as well as the actions/practices and interactions which form part of that event, are constructed. When narratives and micro-narratives are understood as a site wherein discourses and power intersect (Tamboukou, 2008) and are thus made visible, we can see how power operates to: create the conditions in which a pregnancy comes to be terminated, by necessity and/or desire; enable or constrain experiences of waiting room interactions and the pre-abortion counselling session; and constrain or enable particular tellings of these experiences.

Through an analysis of participants' (micro-)narrative construction, then, how participants take up certain discourses and canonical narratives, will also be analysed. As I will demonstrate, a narrative-discursive understanding of the relation between individuals/subjects and discourse departs from Foucault's (1972) own conceptualisation. I argue that in fusing a narrative-discursive analysis with Foucauldian notions of power and discourse, discourse is extended somewhat into a more dynamic, bidirectional process where discourses act upon subjects and subjects act upon discourse (Morison, 2011).

To start off my discussion of Foucault's work, I unpack the concepts 'discourse', 'discursive resources', 'micro-narratives' and 'canonical narratives' and how I am using them in this thesis. Thereafter, I move on to discuss various formations of power which post-structural writers have analysed in their work. Then, I look at how African feminism and post-structural theory may be productively fused together.

2.1.Discourse

It is necessary to define the concept “discourse” as it is used in different ways and is thus conceptualised differently depending on its usage (Schiffrin, 1994). In the *Archaeology of Knowledge,* Foucault (1972) speaks of discourse as a "group of statements" (p.22) and as "practices which systemically form the objects of which they speak" (p.49). In doing so, Foucault highlights three aspects of discourse: that it is regulated, is a system, and is productive. I discuss each of these qualities of discourse, after which I discuss how a narrative-discursive approach extends this understanding of discourse.

As a "system for possible statements" (Foucault, 1972, p.22), discourse consists of statements which are not only interrelated and interconnected, but cohere around particular understandings of reality (Hollway, 1983 as cited in Gavey, 1989, p.464). Thus, discourse can be understood as a network: ways of thinking, speaking and writing about the world. For Schiffrin (1994, p.32), this operation of discourse as a system is integral to her understanding of discourse: “a system (a socially and culturally organised way of speaking) through which particular functions are realised” (Schiffrin, 1994, p.32). Parker (1992) adds to the notion of discourse as a system by noting that discourses are often interrelated, refer to other discourses and even rely on them for meaning. As Parker (1992, p.13) explains, this interconnectivity is part of what makes discourse a system of ideas: the "systematic character of discourse includes its systematic articulation with other discourses". For example, bio-medical, risk and responsibilisation, womxnhood and motherhood discourses work together to construct infertility as a significant risk associated with terminating a pregnancy. Without these discourses interactively working together, a womxn receiving pre-abortion counselling may not *hear* infertility as 'risk'.

Discourse is highly regulated, according to Foucault (1972). Thus, he notes that "one cannot speak of anything at any time; it is not so easy to say something new" (Foucault, 1972, p.44). What this brings to attention are the constraints that are placed, by and within discourse, on what can be said about something and how it can be said at particular socio-historical moments in time. Phelan's (1990, p.422) definition of discourse as “the body of rules which define and limit the sorts of statements that we can make” emphasises this regularity. For Foucault (1972, p.50), that discourse is bound by rules is apparent in not only what can be said but who is permitted to say it: "who is accorded the right to use this sort of language? Who is qualified?" A person's status or authority not only constrains what can be said and how, but also lends (il)legitimacy to what is said. The site from which a statement is made also lends (il)legitimacy

to the statement made. To illustrate this regularity of discourse, a health service provider conducting pre-abortion counselling in a consultation room of a hospital will not only be afforded the right to use the language of risk, but may also be heard, by a womxn requesting abortion, as an *authority* on risk related to abortion. The womxn in turn may be constrained to either accept this risk or may not be heard as a *legitimate authority* on the subject of risk should she question or challenge the very 'fact' of risk.

Lastly, discourse not only constrains but is productive as well, a point which Foucault (1972, 1976) emphasised. Firstly, discourse is productive in the sense that statements are not only about something (an object, such as abortion for example); they construct objects and practices as well. Within a particular discourse, different objects and practices may be constructed. For Macleod (2002), the constructive effects of discourse speak to discourses as the lens through which 'reality' emerges, is viewed, understood, made sense of and spoken about. Indeed, the regularity and constancy of discourse lies in the way in which the objects are constructed as related to each other in a particular way. Foucault (1972, p. 42) speaks to the productive nature of discourse when he states that "it would be quite wrong to see discourse as a place where previously established objects are laid one after another like words on page". Following Foucault, then, it is through and because of family planning, public health and dominant abortion discourses that we understand, for example, that it is 'good' to plan pregnancies through (acceptable) means of contraception. In other words, how we understand and relate to objects is a product of discourse and not inherent to the object or social practice itself.

Secondly, discourse produces subjects. As Parker (1992, p.9) states: "discourse makes available a space for a particular type of self to step in". For Foucault (1972), these selves or subjects do not pre-exist discourse nor do they lay somewhere outside it but are produced in and through discourse. This view does deny the materiality of people, but instead argues that how we relate to others and ourselves, as thinking, speaking, feeling, acting and moving bodies, what we do, our conduct, is shaped, made possible and even managed through discourse. For Parker (1992, p.8), this means that discourses enable "a sense of self…a location constructed within the expressive sphere which finds its voice through the cluster of attributes and responsibilities assigned to it". Similarly, Arribas-Ayllon and Walkerdine (2017, p.111) state: "[t]hat subjects occupy positions within discourse means we can only write, speak or think about a social object or practice in specific ways within a given historical period". Through discourse, for example, doctors (or health service providers in general), become "the supervisor, guardian, and guarantor of the health of the population" (Foucault, 1972, p. 51).

Through this positioning, certain actions are enabled or constrained on the part of both the doctor and client. For example, within this positioning of the health service provider, the health service provider may request and provide certain information from and to the client. They may also intervene and make decisions on behalf of the client.

For Foucault, then, power operates through discourse: by constraining what can be said, and by whom, about objects and social practices on the one hand, and by constructing objects and social practices, and producing selves which speak and act in particular ways, on the other. While I am drawing on Foucault's (1969/1972) understanding of discourse in this thesis, my conceptualisation of discourse is extended by my use of Taylor and Littleton's (2006) narrative-discursive approach and Davies and Harré's (2001) positioning theory which necessitate a revision of the concept of discourse. Below, I discuss discourse as a discursive resource and introduce the concepts of narrative, micro-narrative and canonical narratives (these will be elaborated upon in the methodology chapter). I also discuss the concept of subject positions as they are used by Davies and Harré (2001) and in much discursive/narrative work.

2.1.1. Discursive resources

Although Foucault understands discourse as both constraining and productive, for Foucault, discourse ultimately acts upon individuals in ways which render individuals knowable and governable, whether in constraining or productive ways. Critical discursive approaches, including Taylor and Littleton's narrative-discursive approach and Davies and Harré's positioning theory, extend this understanding of discourse to allow for individuals to 'act upon' discourse making the process of subject formation a bidirectional one. Thus, individuals use discourse to position themselves and others in particular ways. However, the ability to do so is constrained and made possible by the availability (and dominance) of particular discourses. This understanding of discourse and the relationship between discourse and individuals is captured in the concept of discursive resources.

Discursive resources may be understood as culturally-specific features of talk which are made available by and within an individual's socio-cultural context or community (Reynolds & Taylor, 2005). They constitute an individuals' discursive environment and thus shape what can be said and in what ways. However, as the word 'resources' implies, within a narrative-discursive approach as well as within other critical discursive approaches, these features of talk may be actively drawn upon and used by individuals for specific ends and goals, for example, to position themselves or others in particular ways, or to justify a practice, defend against expressed or anticipated criticism and so on (Reynolds & Taylor, 2005; Taylor & Littleton,

2006; Taylor, 2015). As Taylor (2015, p.10) states: discursive resources "amount to a historically accrued but ever-changing pool of meanings, associations and even patterns of words which pre-exist talk on a topic or issue and shape what is (and is not) sayable and said about it". Discursive resources include ideas, images, assumptions and expectations about objects and social practices. Discourses and narratives have also been conceptualised as resources to be taken up by people in their talk and writings (Taylor, 2015).

Within Taylor and Littleton's (2006) narrative-discursive approach, narratives are "a construction, in talk, of sequence or consequence" (p.95). This highlights two aspects of narratives. The notion of 'sequence' implies a temporal ordering of events and may be communicated minimally through words such as "and then" or through references to time (past, present and future). The concept of 'consequence' refers to causality which is attributed to an event or experience by individuals during their talk. The presence of either or both constitutes a narrative. What is distinct about a narrative-discursive approach, say from other narrative analyses, is that narratives are conceptualised as both resource and construction (Taylor, 2006). In other words, narratives are told by individuals but may also be drawn upon, alongside discourses, to construct other narratives.

Adapting Taylor and Littleton's (2006) approach, in this thesis I discuss two kinds of narratives which need to be distinguished: canonical narratives and micro-narratives. Canonical narratives, or grand/meta-narratives, are common stories with familiar plotlines and structures, such as the hero narrative (Reynolds & Taylor, 2005). Canonical narratives tend to reflect or speak to normative expectations and understandings of social reality and the way things are or should be. In contrast, micro-narratives are localised, small stories which are often constructed in the context of question and answer interactions, such as the research interview (Blommaert, 2006). Micro-narratives, therefore, tend to be highly specific not only to cultural and socio-historical contexts, but also to a specific event or experience, making them temporary (O'Donovan, 2006). Indeed, it is this specificity and relativity which may enable and make visible disruptions of normative expectations (Lyotard, 1979 as cited in O'Donovan, 2006). When narrative is understood as both construction and resource, then, the interaction of the micro and macro are illuminated in individuals' interactions and negotiations with discourses and canonical narratives. Furthermore, the use of micro-narratives as a concept reveals how several micro-narratives are often produced in relation to each other, producing a layered or network effect.

2.1.2. Subject positions

Davies and Harré (2001) take up the concept of subject positions by locating it in narrative/discursive work. Like Foucault, Davies and Harré (2001) link the concept of positioning to discourse (discussed above) and the various rights, associated with a particular discourse, which are conferred upon subjects. The concept of rights relates to what speakers may say or do as well as the expectations placed upon them by virtue of having been positioned in a particular way (Davies & Harré, 2001; Harré, Moghaddam, Cairnie, Rothbart & Sabat, 2009). Thus, positioning theory looks at "normative constraints and opportunities for action" found within narratives (Harré et al., 2009, p.6). However, Davies and Harré (2001) depart from Foucault's work by understanding individuals as actively taking up or refusing certain subject positions. Thus, they understand positioning as the process(es) in which people both locate themselves *and* are located by others within conversation as particular subjects or selves (Stanley & Billig, 2004). For Davies and Harré (2001), the process by which one positions oneself during talk is referred to as reflexive positioning and interactive positioning is the process by which one positions others.

Within Taylor and Littleton's (2006) narrative-discursive approach, when constructing a narrative, speakers construct particular selves; subject positions which are instantiated within narratives and discursive resources (Reynolds & Taylor, 2005). Thus, the approach differs from theoretical frameworks where subjectivities or identities ae viewed as unitary, stable and pre-discursive. Like Davies and Harré (2001), these subject positions may be taken up or resisted depending on the possibilities for favourable positioning (Taylor, 2010). As such, Taylor (2005, 2010) discusses subject positions as an on-going and iterative process involving a series of negotiations where individuals "both speak and are spoken by discourse" (Taylor, 2010, p.47). A narrative-discursive approach, then, is particularly cognisant of how, in constructing a narrative account of an event and experience thereof, normative discourses may limit the opportunities presented to individuals to position themselves in positive or socially desirable/acceptable ways, which requires negotiation on the part of the speaker. Despite the constraints placed upon speakers, speakers do deviate from dominant shared meanings and understandings, as well as from their own previously-told narratives. These deviations from normative understandings may be understood as a more nuanced and fleshed out conceptualisation of resistance which Foucault spoke minimally about (I attend to this in the following section on power). And there are consequences attached to conforming or deviating from socially and culturally shared meanings (Taylor & Littleton, 2006; Taylor, 2010). Thus, deviations from these shared meanings, as well as from previous tellings, are conceived within

a narrative-discursive approach as moments of trouble[7]: inconsistencies or slippages which speakers may repair by taking up different subject positions or by using a different discursive resource which may offer up more (socially and/or culturally) favourable positions (Graham, 2014; Morison & Macleod, 2013; Taylor & Littleton, 2006).

While individuals may actively position themselves in particular ways, this process is constrained by ways in which speakers may be already positioned at the outset of an interaction, that is, prior to the co-construction of a narrative or micro-narrative, and how this might also require negotiation (Taylor & Littleton, 2006; Taylor, 2010). For example, before the interview, participants might already have positioned me in particular ways, depending on the interview setting, previous interactions with healthcare services and staff, or previous experiences with researchers. Speakers are also constrained by the possibilities, made by/within discursive resources, for constructing socially desirable selves (Taylor, 2010).

In contrast to Davies and Harré (2001) and Taylor and Littleton (2006), for Foucault (1972) individuals are ultimately produced as particular kinds of subjects through and in discourse. However, Foucauldian post-structural understandings of discourse and subject positions are useful in highlighting how constrained subject positioning is. By drawing on these different but complementary understandings of subject positions, and integrating them within Taylor and Littleton's narrative-discursive approach, the result is an analysis which can look at how discourses and narratives may produce normative subjects and how individuals, even when negotiating positive subject positions, may rely on and are constrained by societal notions of what is socially acceptable.

In the next section, I discuss Foucault's conceptualisation of power and its various operations as a useful framework for understanding narrated experiences of the PTOP healthcare encounter.

2.2.Power

In analysing how subjects come to be formed and how they are governed, Foucault's work speaks to multiple forms of power that operate. These forms of power include sovereign or authoritarian power, disciplinary power, bio-power, pastoral power and the power that operates in and through confessionary practices. Later in his writings, Foucault also spoke about the

[7] I am not using 'trouble' in the Butlerian sense but instead follow Taylor and Littleton's (2006) conceptualisation.

kind of power that is exercised in liberal regimes where individuals' conduct is governed by calling forth the liberal, rational subject who is endowed with certain freedoms, rights and responsibilities to govern themselves. These forms of power will be addressed in this section as they may operate in ways to shape health service providers' conduct within the PTOP healthcare encounter, as well as the ways in which healthcare providers may (seek to) shape womxn's conduct both within the PTOP healthcare context and thereafter. Before speaking to these multiple forms of power, it is important to delineate what I understand the term 'power' to mean.

For Foucault, power is action upon action. A power relation is therefore defined as that which exists between individuals who equally recognise and acknowledge the ability of the other to act. It is exercised by acting upon another's actions, structuring or shaping the other's field of possibilities towards a particular result or action (Foucault, 2000). When power is no longer thought of as something that acts upon people, and is instead understood as acting upon action, power can then be conceived anew. Power "is exercised through networks, and individuals do not simply circulate in those networks; they are in a position to both submit to and exercise this power" (Foucault, 2003, p.29). What is being said here is that power is not something that is wielded by some individuals over others but is transmitted throughout, circulating and passing through individuals in their relations with others, making some actions possible and others impossible. Power, in other words, cannot be given or taken away; all of us, in some way or another, are imbricated in networks of power which require constant negotiation. Consequentially, there are no spaces in which power relations do not exist, no means of existing outside of power. Power is therefore inescapable (Foucault, 1980).

While Foucault described a power that is dynamic and unstable, being as it is relational, and acting as it does upon actions, he also recognised that power relations solidify (Foucault, 2000). Over a period of time, power relations may crystallise in particular patterns, which he referred to as "general conditions of domination" (Foucault, 1980, p.142) or oppression. This domination is never fixed or homogenous because power is multiple, dispersed and localised. Thus, Foucault (1980, p.147) argues: "one should not assume a massive and primal condition of domination, a binary structure with 'dominators' on one side and 'dominated' on the other, but rather a multiform production of relations". Furthermore, Foucault made a point of emphasising that there is no power without resistance. Thus, relations of domination, and power relations in general, are not unidirectional. Foucault (1980, p.147) therefore states: "there are no relations of power without resistances; the latter are all the more real and effective

because they are formed right at the point where relations of power are exercised". In other words, resistance is not outside of power but is imbricated in it. Resistance can then be conceived as an exercise of power; resisting the shaping of one's conduct by another. To use an example, power is not solely exercised by mxn over womxn; by "White" mxn and womxn over mxn and womxn from various racial/cultural groups; by researchers over participants; by parents over children and so forth. These relations of power exist simultaneously, sometimes in intersecting ways. Furthermore, in day-to-day practices and relations the inverse also occurs; a womxn requesting an abortion might exercise power over the nurse or social worker counselling her by 'refusing' to hear about other pregnancy resolution options and 'insisting' on having a termination of pregnancy. What is being argued, therefore, is that the formation and sedimentation of patterns of power relations does not mean that power stops being dynamic and unstable. In other words, despite these patterns, power is not exercised in one direction alone (Rouse, 2005). Even within forms of power that may be described as domination, relations of power are still *reciprocal*, to a certain extent (Foucault, 2003). Thus, for Foucault, domination or oppression are not absolute.

Having addressed how I am deploying the word 'power' in this thesis, I now turn to the various forms of power that I have identified, through the literature and by reading participants' interview data, as relevant to experiences of the PTOP healthcare interaction.

2.2.1. Sovereign power

According to Foucault (1976, 1975/1995), sovereign power is the power that is invested in/with the 'king' or sovereign and is bound up with the rule of law, what Foucault termed a juridico-legal model of power. It is thus largely a power that prohibits, that says 'no', a repressive power. Sovereign power governs absolutely, and does so through a force that is visible and excessive, although not without its boundaries. Foucault uses the example of the public execution as a potent symbol and display of sovereign power where the absolute power wielded and exercised by the 'king' is exemplified in "the power of life and death" (1995, p.48). This power over life was the right "to take life or let live" (Foucault, 2003, p.241). Thus, the sovereignty could decide to impose a death sentence as punishment for a crime or could decide to stay the execution, sparing the life of the subject.

By using the example of the public execution, Foucault demonstrates that sovereign power, unlike disciplinary power (to be discussed immediately below), relies on and is in fact constituted and re-constituted in a visible display of force. Through the public execution, the power of the sovereign is enacted on the body of the condemned, which serves as an example

for those witnessing the display of power. Foucault (1995, p.93) thus states: "in a penality employing public torture and execution, example was the answer to the crime; it had, by a sort of twin manifestation, to show the crime and at the same time show the sovereign power that mastered it". And it is this complete mastery over those subjected to it which is not only the aim of sovereign power but is also reproduced in its show of force. As Foucault argues, this *show* of force, this visibility, is a distinct feature of sovereign power: "Traditionally, power was what was seen, what was shown and what was manifested and, paradoxically, found the principle of its force in the movement by which it deployed that force" (Foucault, 1995, p.187). Thus, sovereign power is concerned with referring to and displaying itself, "emitting the signs of its potency…imposing its mark on its subjects" (Foucault, 1995, p.187), to govern the conduct of its subjects, unlike disciplinary power which works to conceal its own operations.

The excessiveness of sovereign power relates to the maximum power (which requires effort, energy and resources) it exerts on its subjects; its "spectacular expression of potency, an 'expenditure', exaggerated and coded" (Foucault, 1995, p.188). Its excessiveness also relates to the unequal power distribution between sovereign and subject which punishment and other displays of force are meant to reinforce and re-establish. Thus, the relation between the sovereign and its subjects is that of a "surplus power possessed by the person of the sovereign…[and] the 'lack of power' with which those subjected to punishment are marked" (Foucault, 1995, p.29).

Although Foucault traces the emergence and operations of disciplinary power which he juxtaposes against a sovereign power that preceded it, Foucault was careful to point out that he was in no way saying that sovereign power disappeared with the emergence of disciplinary power. Indeed, Dean (2002) argues that despite the predominance of liberal forms of government in many parts of the world today, these have not displaced sovereign or authoritarian power: the two are often comfortably exercised in tandem to shape the conduct of individuals. Thus, while liberal government works by producing liberal, autonomous subjects endowed with rights and an obligation to direct their own acts in responsible ways, it sometimes relies on coercive and authoritarian measures to ensure that individuals act accordingly. As Dean (2002) argues, this is achieved by categorising individuals into subjects who are capable or can become capable of self-directing, that is of autonomy, and those deemed incapable of self-governing their conduct in responsible, socially desirable ways. For the latter group, authoritarian intervention, that is the use of coercion, is enabled and justified in order to

act in the best interests of those who are deemed incapable of doing so. The ability to define the 'best interests' of the other is this tied up in the exercise of authoritarian power.

Dean (2002, p.48) makes the example of "those with certain mental and physical illnesses, significant sections of the elderly in liberal democracies…as well as those whose capacities for self-government have been undermined by drugs, alcohol, tobacco and other addictive substances" as categories of people who might be deemed incapable of self-government. In a pre-abortion counselling context, womxn who are judged to have failed to prevent an unintended pregnancy and are consequently requesting an abortion, and particularly those who have made repeated requests for a TOP, may be categorised as incapable of self-governing in responsible ways, thus justifying authoritarian intervention (such as a coercive imposition of long-acting reversible contraceptives (LARCs)) in order to secure their and society's best interests on their behalf. Similarly, authoritarian intervention, in the form of counselling that directs against abortion, may be enabled and justified in the case of adolescent womxn deemed too immature to appreciate the 'long-term traumatic consequences of abortion'. Certainly, with regard to the South African public healthcare context, recent research by Feltham-King (2016) has shown the patterned exercising of sovereign/authoritarian power by healthcare providers. In the next section, I turn to disciplinary power which Foucault analysed at length, tracing its emergence and various operations.

2.2.2. Disciplinary power

Foucault' contends that modern society (and post-modern society increasingly so) are characterised by the appearance of disciplinary power, which he discusses at length in *Discipline and punish* (1975/1995). Disciplinary power, whose principal function is to train, is a power which moulds, shapes, and guides the conduct of individuals without necessarily acting directly upon the body as sovereign power does through physical punishment. Thus, Foucault (1995, p.102) states that the focus of power shifted to "the 'mind' as a surface of inscription for power, with semiology as its tool: the submission of bodies through the control of ideas". Disciplinary power is thus a means through which individual bodies are disciplined or governed. In one sense, disciplinary power operates through knowledge/discourse which is required for power to be exercised. Thus, discourse/knowledge and power exist in a kind of feedback loop. Knowledge produces the power to act on or shape the actions of others. Put differently, "knowledge is a power over others, the power to define others" (Sarup, 1993, p.67). This ability to *define* others is an ability to compare and judge against an ideal and subsequently categorise those who conform to the ideal and those who do not. The result is the production

of subjects. Thus, Foucault (1995, p.170) argues that "discipline 'makes' individuals". And this formation of subjects depends on the mechanisms of observation or surveillance, measurement and normalisation.

By observing and measuring individuals, individuals become knowable. The knowledge gained through surveillance and examination are integral to the project/technique of normalisation. This is because the production of knowledge enables the establishment of a norm against which individuals may be judged, a concept Foucault (1984) understood to be the standard, the expectation *and* the average. That is to say, through surveillance and measurement, the norm is produced as the behaviour/activity in which most of the population are and *should* be engaged. Through this process of normalisation, hierarchical observation acts to hierarchise subjects, based on their conduct, into 'good'/'normal' and 'bad'/abnormal' etc. Through disciplinary power then, deviations from the norm are made visible and knowable so that they may become the target of discipline, of correction. Foucault (1995, p.178) expresses it thus: "What is specific to the disciplinary penality is non-observance, that which does not measure up to the rule, that departs from it". Applying this to the present study, for example, requests for womxn's reasons for TOP, which the Western Cape Department of Health's (2000) TOP Policy, Guidelines and Protocols document requires of abortion providers, make womxn knowable as sexually responsible or irresponsible subjects, depending on whether they indicate that they were using (appropriate) contraceptives at the time. This knowledge may then be used within the counselling session to inform practices aimed at governing the future conduct of womxn requesting an abortion.

Normalisation is also produced through discourse itself (Foucault, 1980). Important to the maintenance of discipline is the internalisation of surveillance and vigilance such that the subject monitors, and perhaps moderates, his or her own behaviour according to ideas about what is ‘normal’, ideas contained within discourse (Macleod & Durrheim, 2002). Because of this process, certain practices are normalised and constructed as desirable, while others are discouraged. For example, as will be discussed in a later section, Foucault (1978) describes a discursive process in which certain sexual practices, sex with the sole aim of reproduction, are valorised at the expense of others. Within a PTOP healthcare context, the normalisation of sex-for-planned-procreation may shape pre-abortion counselling such that an abortion request may be seen as evidence of a deviation from the norm. Alternatively, a discourse of the imperative of (appropriate) family planning may enable or justify an abortion request.

Power is not only operated by using the knowledge gained from practices of surveillance and examination (such as the pre-abortion counselling session example used above), but also by deploying certain discourse/knowledges that have come to be accepted as 'truths'. For example, that womxn's biological capacity for motherhood means that womxn *should* have children, which implies that 'good' womxn are mothers and childlessness is only acceptable, excusable, when involuntary (Morison, 2011). Another example is that reproduction is only proper and responsible within a heterosexual, marital relationship, or that planned and well-spaced births are 'good' for children's development.

In his later works on governmentality, Foucault specified an adaptation of disciplinary power which he argued operated in liberal and neo-liberal forms of government. According to Foucault (2008, p.2), of the "different modalities and possible ways that exist for guiding men (sic), directing their conduct, constraining their actions and reactions", liberal means of government use the same principles of guiding populations by individualising them and calling upon subjects to self-govern. However, unlike disciplinary power, with liberal forms of government, individualisation and government from a distance are intensified through economic principles and rationalities which enable government in the *least* way (expending the least effort and at the least possible cost) but *maximising* the effects of government. The economic principles that are at work in liberal forms of government are practices and appeals for the economy to be left to its own laws and mechanisms, to its natural state (where it would self-regulate) and, thus, the preclusion of state intervention to control it. When diffused beyond the economy, liberal forms of government shape the conduct of individuals through freedom: the governed are free to monitor and judge their own conduct by making informed choices based on calculations of risk, which is constructed as being everywhere and every day, and desirable outcomes or rewards (Foucault, 2008). Thus, individuals are also governed simultaneously through risk. Indeed, this kind of liberal subject whose autonomy must be used in responsible ways is assumed in the CTOP Act.

Within liberal forms of government, a "culture of danger" (Foucault, 2008, p.66) requires the constant negotiation and management of risk, and potential risk, which justifies the government of all, through surveillance, measurement and subsequent interventions. Although free to govern themselves, individuals' actions are guided indirectly through discourses of risk and responsibilisation, and through the creation of rational, responsible subjects who are endowed with the freedom to self-govern and are expected to conduct themselves in rational and responsible ways. Furthermore, for those deemed to make irrational and irresponsible choices,

interventions on the part of the state or state institutions are enabled and justified. In other words, liberal forms of government not only govern through freedom but circumscribe it. Dean (2002) argues this when he points out that liberal forms of government may exist comfortably alongside sovereign or authoritarian forms of power.

Macleod (2006a) demonstrates how liberal forms of government may operate in the reproductive healthcare context. Although Macleod (2006a) applied Foucault's analytics of power specifically to contraceptive counselling, her work has relevance for the PTOP healthcare encounter, particularly as pre-abortion counselling may and often does include contraceptive counselling (Beja & Leal, 2010; Birdsey et al., 2016; Tong et al., 2014). In reproductive health counselling, liberal power may operate in such a way as to circumscribe the health service provider's conduct, to limit direct and coercive intervention in favour of upholding the client's individuality, that is their rights, desires, wishes, goals and needs, and their ability to self-direct. Power is achieved, nonetheless, by requiring the client to self-govern responsibly, through the formation of the responsible subject who is encouraged to know, master and care for themselves in very particular ways (Dean, 1994; Macleod, 2006a; Rose, 1996). For example, Macleod (2006a) demonstrates how healthcare providers discussed their role as one of providing instruction and information with the expectation that the young womxn being given contraceptive counselling would use this information to self-govern responsibly. Healthcare providers also described their contraceptive counselling practices as precluding judgments about the young womxn's behaviour and instead emphasised the need to be neutral (Macleod, 2006).

In describing disciplinary power, Foucault (1978, 1980, 1991, 2000) thus speaks of a power that acts in subtle ways. It is a power that does not depend on the use of violence or force for it to be exercised, relying as it does on knowledge of others that is obtained through surveillance, examination and processes of normalisation. While violence may be used as a tool, it is not a *necessary* condition for the operation of power at a micro level (between individuals) nor is it necessary at a macro level (that is, the governance of populations).

Disciplinary power is thus unlike the judicial power ‘held’ by the sovereign or state. It is a power that is more pervasive, more diffused. Importantly, Foucault argues that the emergence of disciplinary power does not mean that sovereign power, or the power of legislation and right, has been surpassed or replaced. Instead, both forms exist as “the general mechanisms of power” (Foucault, 2003, p.39) that shape our post-modern society. Indeed, as Foucault (2003)

elaborates in his work *Society must be defended*, the difference in these two powers is such that they may prohibit and permit different things. For example, abortion in South Africa is permitted through the CTOP Act. However, the stigma surrounding abortion, the views regarding abortion held by health service providers and the way in which abortion is socially regulated by health service providers (who act as gate-keepers to the service), conveys a strong and contradictory societal message (see later discussion). Indeed, stigma around and views on abortion are products of normalisation: that is, the idea that abortion disrupts the motherhood imperative and is therefore abnormal (Kumar, Hessini & Mitchell, 2009). That abortion is socially unacceptable in South Africa (Patel & Myeni, 2008) despite it being legally permissible, can be explained by way of this 'new', disciplinary power which operates through knowledge and discourse (abortion stigma may of course be explained through other forms of power).

Below, I discuss pastoral power and confessionary practices as forms of power which seek to know and direct the conduct of individuals. As I will show, these forms of power are relevant to the PTOP healthcare encounter as healthcare providers may be conceived as being tasked with the responsibility to care for the reproductive health and well-being of those who use their services.

2.2.3. Pastoral power and confessionary practices

In the previous section, I spoke to disciplinary power as a mechanism through which an individual's conduct is structured through surveillance, measurement and a process of normalisation. I now discuss a kind of power which, Foucault argues, serves to govern individuals in a different, *less* subtle or indirect way, particularly when compared to the liberal forms of government discussed above.

As with other forms of power, pastoral power operates through individualising and totalising mechanisms and techniques which rely on and necessitate knowledge of both individuals and populations. As such, it is part of the matrix of powers which, according to Foucault, came to govern individuals and populations through dividing practices in which "the subject is either divided inside himself [sic] or divided from others" (1982, p.778). Through knowledge, individuals are produced into subjects, such as "the mad and the sane, the sick and the healthy, the criminals and the good boys" (1982, p.779), or, in the context of abortion and abortion counselling specifically; the responsible and reckless sexual subject, the acceptable and irrational abortion request, the good and abnormal womxn. Pastoral power differs from other kinds of power in that it takes the well-being and moral salvation of the 'flock' or population as

its objective and directs the conduct of individuals to ensure their moral salvation or well-being (Foucault, 1982). Macleod (2006a) describes what she calls pastorship, or pastoral care as a relation of power wherein the pastoral agent, for example the health service provider, is held responsible for directing the conduct of those in their care, and does so through empathy and a detailed knowing of their clients. The pastoral agent directs the conduct of those in their care through various techniques, including passing judgment on what is 'good'/'bad', 'right'/'wrong', warning, chastisement and shame, and providing comfort.

Foucault traces pastoral power from when it was firmly located within the Christian Church to its diffusion and operation in spaces outside of the Church and Christianity, spaces such as the State. In its previous form, pastoral power, according to Foucault (1982), was a relation between pastors and their flock wherein pastors had the task of ensuring the salvation, in the next life, of those (both individually and collectively) under their care. In its more modern forms, which have not replaced the former but have rather diffused its effects, pastoral power has become about safe-guarding salvation in *this* world, with salvation taking on different meanings. Foucault (1982, p.784) discusses examples of "health, well-being (that is, sufficient wealth, standard of living), security, protection against accidents". In this form, pastoral power may be exerted by the state or institutions and organisations and serves to produce two kinds of knowledge: the first is quantitative in nature and concerns the population as a whole while the second is analytical, concerning the individual. Such a power, Foucault argued, necessarily relied on an intimate knowledge of the individual: it relied on the individual's willingness to confess about themselves and their actions anything that would jeopardise their salvation. It was a power thus linked, inextricably so, with "a production of truth- the truth of the individual himself [sic]" (Foucault, 1982, p.783). For Foucault (1978), then, confessionary practices are tied up with or implicated in pastoral power. It is to this that I now turn.

In the *History of sexuality Vol.1* (1978), Foucault traces the development of a "singularly confessing society" (p.58). He thus argues that the confession as a practice (that is, both common and routine) is centred around the production of truth in western(ised) societies. Its origins lie in the Christian Church where individuals were required to divulge truths about themselves, about behaviours, activities, practices engaged and not engaged in, which belied wrong-doing and transgression. Since then, confessionary practices have become a technique of power (alongside observation and measurement) which has diffused into various institutions and spaces. These institutions and spaces include: courtrooms and police stations; teachers' and

principals' offices; healthcare providers' consultation rooms in hospitals and clinics, and more specifically, the pre-abortion counselling session.

As Foucault (1978) argues, contrary to notions that confession and truth yield freedom from constraint, confessionary practices have power effects in that they bring individuals *to* power and not *away* from it; the confession creates subjects and brings them under the gaze and surveillance of power. By confessing, then, the confessor opens themselves up to having their conduct shaped and structured. Within this power relation, the person listening to the confession exercises power first by calling for the confession, stipulating and dictating that it be made, and then by evaluating and measuring it, interpreting its truth, and subsequently acting on what has been confessed─ for example to punish, chastise, judge, console, empathise, give guidance. Furthermore, the power exercised through confessionary practices is such that the confession "cannot come from above…through the sovereign will of the master, but rather from below, as an obligatory act of speech" (Foucault, 1978, p.62). However, as suggested above, it is a power that is not strictly negative as it enables the production of knowable and therefore governable subjects.

Foucault (1978) argues that disciplinary power was further extended when confessionary practices were taken up by and within scientific discourse, specifically in/by the discipline of psychology, at least regarding sex. Through a scientific discourse, sex was constructed as 1) inherently obscure and mysterious to the extent that its full manifestations and repercussions could be concealed from the confessor and 2) as causing disease and illness. This construction of sex, therefore, necessitated two things: firstly, confession needed to be exhaustive, detailed and continuous, and, secondly, the obscurity of sex required its truth to be interpreted, and thus constituted, by an authority or expert. Through scientific discourse, then, the consequences of having or not having sex, in particular ways (with or without contraception, for example), and with particular people, transformed sex from being understood solely in terms of sin or transgression, to being understood also in terms of normality/abnormality and pathology/health. Importantly, a scientific discourse allowed for and justified therapeutic and/or normalising interventions.

Parker's (1998) work on the 'psy-complex' extends Foucault's work on confessionary practices within scientific discourse. The psy-complex is a network of theories and practices (counselling practices) which govern the mind and encourage self-care and self-surveillance through self-reflection. It enables theories about how the mind functions (what is healthy versus abnormal),

how to properly address issues, what the relationship is between client and counsellor (roles, responsibilities, duties etc), and what psychotherapeutic counselling is and what it is meant to do (encourage self-reflection and surveillance in order to self-govern and self-care). Parker (1998) argues that the psy-complex involves two forms of power. The first is the surveillance of populations (who are individualised) as part of disciplinary power, with the mind as both an object and subject of professional knowledge. The second is the intensification and dispersal of the confession, which results in individuals subjecting themselves to surveillance and governance (by those working within and outside the field of psychology, and themselves).

To use an example, abortion counselling encounters may be mobilised as spaces in which womxn must 'confess' behaviours that might jeopardise their health and well-being: having sex without contraception or with incorrect usage of contraception, terminating more than one pregnancy, procreative sex within a context of job instability or unemployment, and 'teenage sex', for example. The knowledge produced in abortion counselling encounters may be both globalising and individualising. For example, where requests for womxn's reasons for having an abortion are elicited and analysed by the healthcare provider within the abortion counselling session, this knowledge may be used by health service providers, who must ensure the health and well-being of the womxn requesting an abortion, to assist womxn in being better contraceptive users or better decision makers. The same would apply to research conducted on womxn's reasons for requesting abortion, at least in the event that the research recommends that healthcare providers take this new knowledge into account and direct womxn's contraceptive and reproductive decision-making.

2.2.4. The clinical gaze

Foucault (1976) in *the Birth of the clinic* not only traces medicine and the production of knowledge on the clinical patient, but also the various conditions that made clinical knowledge possible. Importantly, Foucault (1976) argues that the clinic is not only implicated in but is integral to the exercise of disciplinary power. The clinic, by the time it had emerged as such (as a site in which knowledge was produced and taught), is described by Foucault as having a constant, penetrating, gaze upon the patient. This gaze is a knowing and deciding gaze; through surveillance and examination, the doctor/health service provider reads the body and elicits information from the patient and compares this information against the normalized knowledge gained from individuals over time (culminating in a knowledge of the population), and then decides on the health problem and what intervention is necessary to best 'cure' the problem, which is then executed. The power exercised in and through the clinical gaze is not limited to

seeing, or making visible, the here and now, but is extended to predicting the future: calculating the outcomes and possible risks of decisions and interventions, and imparting these to the patient. Thus, Foucault describes: "it was a gaze that was not content to observe what was self-evident; it must make it possible to outline chances and risks; it was calculating" (1976, p.89).

As a form of disciplinary power, the interaction between healthcare provider and patient is not governed by the authority of a tyrant in which force is used upon the non-consenting. Instead, the interaction is shaped by the authority of a paternal figure who, in caring for the well-being not only of the individual patient but of the population as well, uses their knowledge to will the patient to co-operate/participate in their own care, that is to submit themselves to the disciplinary power wielded by the healthcare provider (Foucault, 1976). Nonetheless, it *is* a relation of power as the medical gaze, through and in the clinic, is the privilege of a doctor: a health service provider who alone exercises the power to make decisions and to intervene. In the “meeting place of doctor and patient” (p.111) it is the doctor who exercises the power to see (to observe and examine) and to know: using the language of science and medicine to see and hear what is communicated both in the silence of the observation and what is spoken by the patient during the interview/consultation. Language, or discourse, as Foucault observes, is implicit in both. The result is that a ‘pure’ gaze is impossible: language is needed both to observe and examine, and to make meaning from and interpret those observations and the findings of the examinations. This deciphering is made possible only through language, albeit one that conceals itself as such: what the patient themselves reveals of their history, and what the constructions of medical and scientific knowledge offer up as ways of reading and making sense of the body and its (dys)functions are made possible through language. Thus, Foucault (1976, p.60) argues that “it is not the gaze itself that has the power of analysis and synthesis, but the synthetic truth of language”. This truth not only constitutes social objects, making them visible in the process. It also fabricates what we know "about the body and the diseases within it" (Feltham-King, 2016, p.42), for example, that womxn have female bodies which have the biological capacity to reproduce.

Shaw (2012), in her extension of Foucault's analysis in *Birth of the Clinic* to pregnancy, argues that the body is configured as a site of knowledge which needs to be accessed. Thus, Shaw states that the "modern medical body is from its inception figured as a site of interior knowledge that must be excavated in order to be made functional; the metaphorical matter on which this operation is performed is female" (Shaw, 2012, pp.112-113). Shaw (2012) goes on to point out that where the medical gaze had been trained to look for signs of illness and disease, the

medicalisation of pregnancy has meant that the medical gaze now also reads the 'female body' for signs of pregnancy. The visibility of the interior of the female body has not only enabled pregnancy to be identified, verified and even constituted; it has also helped to constitute 'womxn' as child-bearer (Shaw, 2012). In other words, the ability to penetrate the 'female body' and make visible the reproductive organs necessary for reproduction has reinforced the configuration of womxn as having the biological duty to reproduce, and therefore as always already a mother.

Part of the effects of the penetrating power of the clinical gaze is that an important subject/personhood has been constituted: the foetal subject (Shaw, 2012). Thus, through examination, the pregnancy (which may not be clearly visible yet) is verified through a scan and the gestation of the pregnancy made known. The foetus also enters the field of the visible: the foetus emerges as an independent body whose development may be depicted and tracked─ its size, its movements, its bodily functions and organs, its human capacity. The clinical gaze's reach into the body of the pregnant womxn has been instrumental in how the foetus and pregnant womxn are constituted and understood. On this subject, Macleod and Howell (2015, p.1) make the following argument: "ultrasonography imagery has entered the political, philosophical, social and moral domains, enabling particular constructions of the foetus (as patient, as person, as citizen), and of the pregnant woman's body (as incubator, as absent, as protective shell)". Furthermore, the clinical gaze invests this knowledge produced and obtained through ultrasonography with the discourse and power of 'fact' and 'truth' by providing "scientific authority to the narratives and discourses attached to the images" (Macleod & Howell, 2015, p.2) produced through ultrasonography. In a pre-abortion counselling context, this knowledge may be used with particular effects: to position the pregnant womxn requesting abortion in particular ways, for example, as obliged to consider and defer to the personhood of the foetus. In other words, the pregnant womxn may be positioned as a caring and protective and therefore 'good' mother.

As Feltham-King (2016) argues, other institutions (such as the family and education), and the assumptions derived from them form an important part of the discursive context of the clinic. These assumptions or knowledges come to bear on the healthcare context in ways which enable healthcare providers to interpret and constitute the 'truth' of what they hear and see in the clinical consultation. Thus, discourses about appropriate motherhood and womxnhood, responsible sexual engagement, and adolescent development may all sit alongside: medical and scientific knowledge (for example, knowledge of the abortion procedure, medicine dosages

and their indications and side effects, and possible complications); contested knowledge linking abortion to PAS and depression, cancer and fertility loss; and foetal personhood, which is coupled and underpinned by the scientific proof rendered by/in the clinical gaze through ultrasonography.

While the PTOP healthcare encounter bears great similarity to the clinic interaction Foucault (1976) theorised about in the *Birth of the Clinic,* there is an important difference. In the PTOP healthcare interaction, the grounds for the meeting between health service provider and patient/client is not a health problem *per se* which needs to be seen, heard (and thus deciphered) by the healthcare provider. It is, instead, a request to have a termination of pregnancy procedure conducted (which might, nevertheless, be precipitated for some womxn by health problems). Nonetheless, interactions in the waiting room space and during the pre-abortion counselling session are likely governed through and by the clinical gaze. Therefore, health service providers may and do (as will be shown in the analysis chapters) carry out observation and examination techniques to determine the 'problem' that necessitates the abortion procedure─ a failure to use contraception adequately or consistently, for example. Thus, in the spoken part of the observation, the interrogation or counselling may include questions as to what the reason for abortion is, the womxn's contraceptive history (whether and how effectively she had been using contraception), reproductive history (whether she has any children and how many) and any illnesses she may have. Foucault's analysis of the clinic and the clinical gaze, thus, provide a very useful way of analysing womxn's and healthcare providers' accounts of their experiences of the PTOP healthcare encounter. Below, I discuss bio-power which, I argue, is another useful lens through which these experiences may be made sense of.

2.2.5. Bio-power

In his work the *History of sexuality* and then later in *Society must be defended*, Foucault speaks about the emergence of another form of power, bio-power. Unlike sovereign power which was invested with "the old power of death" (Foucault, 1978, p.139), bio-power carried with it the right to "make live and to let die" (Foucault, 2003, p.241). Bio-power functions to manage life. In explaining the concept and in delineating the operations of this power, Foucault again focuses on sexuality, stating that "sexuality exists at the point where body and population meet" (Foucault, 2003, p.251). Thus, bio-power operates on two levels: knowledge production on the population (for example through research, surveys, hospital records etc) which is used to shape the conduct of populations on the one hand, and controlling the individual body on the other. What is known about populations enables and justifies interventions on individual bodies. In

this section I discuss bio-power as a useful lens through which abortion consultation/counselling practices, and most importantly, experiences thereof, may be understood.

In a society governed by power which takes varying forms and operates in different ways, bio-power extends the power over life exercised by the state. As such, it operates in tandem with disciplinary power, deepening and widening the management of populations. Whereas disciplinary power individualises populations by making the individual subject visible through surveillance and by creating subjects through normalisation, bio-power "is applied not to man-as-body but the living man [sic], to man-as-living being; ultimately…to man-as-species" (Foucault, 2003, p.242). Thus, bio-power operates at the level of populations which are viewed as organisms collectively "affected by overall processes characteristic of birth, death, production, illness, and so on" (Foucault, 2003, p.243). It is in this sense that bio-power has totalising effects.

Foucault links bio-power, the control over life, to the state's government of populations to ensure that economic productivity is only minimally affected by processes (such as: birth, death, production, illness and so forth) which continuously occur (Foucault, 2003). Bio-politics is thus a preoccupation with calculating, predicting and estimating so as to put measures into place that "optimise a state of life" (Foucault, 2003, p.246). Illness is an example of a biological process which requires large-scale, population-level government intervention, at the level of prevention and treatment, to secure against the loss of productivity and capital that result from it going un-checked. What resulted, according to Foucault, was "the development of a medicine whose main function will now be public hygiene, with institutions to coordinate medical care, centralize power, and normalize knowledge" (Foucault, 2003, p.244).

Bio-power is a useful framework for understanding womxn's and health service providers' accounts of their experiences of the PTOP healthcare encounter. In his work *Society must be defended* (1997/2003) in which he extends his discussion on bio-power, Foucault (1997/2003) argues that in a society governed by the right to make live or let die, 'killing' (which Foucault discusses in its broadest sense) is permitted if it ensures the elimination of some threat to a human population. Given that the abortion debate has been and can be framed as centring on whether life begins at conception (in addition to being inextricably linked to notions and expectations of womxnhood) (Miller, 2014; Pollit, 2015), abortion may be viewed by the state as an extension of its right to make live and let die, that is, if one accepts the foetal personhood

argument. This is so in contexts where termination of pregnancy is criminalised or severely restricted by law. Indeed, very few countries ban abortion outright and will instead allow it in cases where the womxn's life is at risk. Here the state can be said to view the criminalisation of abortion as within its right to make live. Bio-power may also be seen to operate, however, where abortion is granted on other grounds, such as foetal abnormality, pregnancy resulting from rape or incest, socio-economic reasons and so forth. In these cases, the state makes exceptions or allowances for situations where 'life' may be terminated.

Conversely, in contexts where it has been legalised and there is access to abortion services, the state may be exercising its right to ‘let die’ where abortion is permissible for the benefit of the population at large. As a result, in contexts such as South Africa where abortion is legally permissible but structural and socio-cultural barriers to access persist, the pre-abortion counselling session may be viewed as a struggle, between health service providers and womxn attempting to access abortion services, over the right to make live or let die. Certainly, the CTOP Act's stipulation that abortion should not be used as a (legitimate) form of contraception circumscribes womxn's usage of abortion services, with 'repeat abortion' falling outside of what is acceptable. Different knowledges, such as healthcare providers' own experiences and records, public statements made by government officials about the unacceptability of repeat abortion (Chowles, 2013), and research (see Ngene, Ross and Moodley, 2013) which documents that womxn may request abortion due to a non-use of contraception, contraceptive failure or incorrect usage of contraception, obtained at the population level may thus be used to enable and justify controlling individual bodies by imposing long-acting reversible contraceptives (LARCs) on womxn deemed to require state intervention.

As discussed in this section, individuals come to be produced and governed through various forms of power which sometimes work together, interacting and intersecting in various ways. Below, I discuss how power is implicated in the production of sexualities and sexual subjects. As I will show, these discourses of sex and sexuality form part of and enable certain 'truths' about abortion through which experiences of the PTOP healthcare encounter may be understood.

2.3.The production of sexuality

Foucault's knowledge/power nexus is an account of the relationship between power and knowledge. There are two ways in which power and knowledge are interdependently related. In one sense, knowledge, or that which comes to be recognised and held as such, is produced within certain spaces of power for it "is only through the operation of power that truth claims can be made" (Tilley, 1990, p.325). Systems of truth/knowledge are created and upheld in which the authority to speak and to act upon the actions of others is limited to those who operate within these spaces. The spaces Foucault wrote about were formal, disciplined or organised knowledges which are collectively known in contemporary society as 'science' and academia, spaces of knowledge production. Discourses produced within these spaces are legitimised and thus carry the weight of 'truth' and 'fact'. Thus 'truth' is assumed to be the privilege of science while discourse/knowledge "born elsewhere, is automatically, and from the outset, if not actually excluded, disqualified a priori" (Foucault, 2003, p.183). To illustrate the point simply, in an abortion consultation, information or views that are held and passed on by health service providers may be perceived as 'scientific' knowledge and are often valued over the womxn's own knowledge. This knowledge which comprises of her past experiences, of her ability to assess her own capabilities and her circumstances, of her desires and wishes, of what is in the best interest of her significant others, existing children, the potential child and her own interest, is discounted because of the 'lay' space from which it emanates.

As Foucault explains, power is not limited to a restrictive role. Power also says "yes": "it also traverses and produces things, it induces pleasure, forms knowledge, produces discourse" (Foucault, 2000, p.120). Foucault's (1978) *The History of sexuality* is an historical account of the production of discourses on and the 'truth' of sex. That is, it is an account of the relationship between power, sex and discourse. Hence, Foucault (1984, p.314) states: "these discourses on sex did not multiply apart from or against power, but in the very space and as the means of its exercise". In tracing the development of discourses on sex, Foucault (1980, p.187) sought to demonstrate that "[b]etween every point of a social body, between a man and a woman, between the members of a family…there exist relations of power". Rejecting the hypothesis that the period of the eighteenth century onwards was characterised by silence on sex, Foucault (1978) argued the exact opposite: that this period was instead marked by an ever-increasing incitement to speak about sex.

The "transformation of sex into discourse" (Foucault, 1984, p.316) achieved several things: it legalised certain acts and made others illegal or unlawful; it pathologised sexualities and sexual acts that were seen to go against the norm, and prescribed treatments for them; and it defined normal sexual development and identified all the forms of nonconformity (Foucault, 1984). Through the discursive production of sexuality (or the deployment of sexuality), abnormal sexuality appeared. The subjects of this discourse included, among others, "the indifferent mother - or worse, the mother beset by murderous obsessions…[and] the precocious and already exhausted child" (Foucault, 1978, p.110). Integral to this production of sexuality was the family, whose role was to "anchor sexuality and provide it with a permanent support" (Foucault, 1978, p.108). The deployment of alliance, by which Foucault (1978) meant the system of marriage, was integral to the normalisation of sexuality, built, as it was, "around a system of rules defining the permitted and the forbidden, the licit and the illicit" (1978, p.106). Thus, the deployment of alliance is concerned with the maintenance of the social body, and hence its concern with the matter of reproduction, not only in terms of multiplying the population but also in terms of re-producing a normalised sexuality.

According to Foucault (1978), the deployment of sexuality relied on this deployment of alliance for it was made possible by the two main dimensions of the family, the husband-wife axis and the parent-child axis. The interrelatedness of the deployment of sexuality and alliance normalised certain practices within the family. Hence, whether the production of various discourses on sex and the gradual privileging of sexuality within the family were "motivated by one basic concern…to constitute a sexuality that is economically useful and politically conservative" (Foucault, 1978, p.37), the effect was the privileging of a certain kind of sexuality which occurred alongside the production of the abnormal. The family, particularly parents and relatives, was thus tasked with maintaining this privilege.

Accordingly, as Macleod (2003) argues, the linking of the husband-wife and parent-child axes has resulted in the privileging of family formations which retain both these dimensions. Although conjugalised reproduction (Macleod, 2003) remains idealised to a certain extent, the deployment of sexuality and alliance renders the absence of a marital relationship acceptable if reproduction occurs in the context of a stable heterosexual partnership. As a result, within the context of a stable or marital heterosexual relationship, non-contracepted sex-for-planned-procreation is privileged and unintended pregnancy is problematised. Furthermore, the requirement to have children within a stable or marital heterosexual relationship, renders (the

possibility of) infertility (which supposedly is a risk tied to abortion) and termination of pregnancy problematic.

Foucault's (1978) account of the production of sexuality has implications for how womxn who have decided upon abortion choose to narrate the decision as these very same discourses and set of practices might be drawn upon (to be elaborated upon in the analysis chapters). Furthermore, Foucault's (1978, 1982, 2003) writings on bio-power and pastoral power enable an understanding of the power relations that permeate and govern pre-abortion consultations. In the next section I discuss what is to be gained from pairing African feminism with post-structuralism.

3. An African feminist post-structural approach

As mentioned earlier, the present research is guided by an African feminist post-structural approach. Before I delineate what I mean by an 'African feminist post-structural approach', it is important to note that there are multiple approaches to African feminism(s). Indeed, Mekgwe (2008) notes that it is more apt to speak of African *feminisms*. Below, I describe these various approaches and then go on to discuss and argue for an African feminist approach which is informed by a post-structural understanding of gender/sexuality (as well as other social identities) and power.

Before I draw attention to some of the debates in which attempts have been made to conceptualise African feminisms, it is important to at the outset be explicit about whom "African" is, for me, meant to refer here. Kolawole (2002) conceptualises "Africa" in a way which is sufficiently broad. It is thus one I find particularly useful. She clarifies her usage of the term in this way: "Any person…who has the legal citizenship of a nation located on the African continent" (Kolawole, 2002, p.96), thus including those living outside of Africa. I state this here to make my own position clear. I mean not to imply that the writers and theorists I discuss here have used it similarly. Indeed, during this chapter I will show that there is a diversity of viewpoints on who is to be considered 'African' and that such debates have been central to the development of African feminisms.

While feminist writers from the so-called 'Third World' have critiqued mainstream western/global north feminisms for the way in which Third world' womxn and their experiences have been represented and misunderstood in knowledge production (Higginbotham, 1982; Mohanty, 2003), African feminists have specifically called into question the monolithic representation of black African womxn as oppressed victims (Chilisa & Ntseane, 2010). This

rigid representation, it is argued, is the consequence of uncritically applied western/global north feminisms (Chilisa & Ntseane, 2010) where white, middle-class womxn are taken as the referent and then applied, uncritically, to all womxn (Mohanty, 2003). Indeed, this criticism has been the impetus for a turn towards African feminism(s) (Chilisa &Ntseane, 2010; Cornell & van Marle, 2015; Kolawole, 2002) and may be seen as one of the threads joining together the various strands of African feminism.

Another thread that connects the various approaches to African feminism is a commitment to analysing and critiquing gender (Lewis, 2001). Thus, Chilisa and Ntseane (2010), and Cornell and van Marle (2015) speak of African feminism(s) as a contextual and locally-specific approach which takes as its referent and starting point African womxn's experiences. As such, African feminisms highlight those commonalities that are specific to the multiply varied experiences of African womxn from the perspective of, and as articulated by, African womxn. Along with this commitment to produce knowledge that is geographically, culturally and socio-historically specific is a commitment to documenting experiences of oppression and resistance. Hence, Chilisa and Ntseane (2010) state that one of the challenges thus posed to feminist researchers and theorists is to note oppressions and "register [the] small acts of resistance that achieve levels of empowerment" (Chilisa & Ntseane, 2010, p.629). This is but one attempt to demarcate boundaries around what may be called African feminism.

3.1. Approaches to African feminism

Important to discussions around how to conceive of African feminisms are discussions on whom is included/excluded in the signifier "African". As such, Mekgwe (2008, p.21) criticises the silence she observes on this issue, whilst recognising that it can be "both definer and obstacle". This is because being specific about who is included in the term "African" carries implications for who may be represented by the term and limits the scope of African feminisms. There are two aspects to this. In the first, "African" signifies those producing the knowledge. This sets limits on who may legitimately write on/about/with womxn and may therefore call into question the legitimacy of those producing knowledge (Naidu, 2010). In the second, "African" signifies the womxn (and mxn) whose experiences and practices will fall under the scope of African feminism. Thus, some theorists have proposed that "African" refer to those living on the continent of Africa with those part of the diaspora being included or not (see Mekgwe, 2008). Others have fixed "African" to mean only those who are Black African. In both cases, the need to exclude arose from the desire to ensure that one-dimensional

representations of ‘Third World’ and African womxn would not again be repeated (Chilisa & Ntseane, 2010; Mekgwe, 2008).

Approaches to African feminism may be broadly categorised into those which attempt to fix, a priori, (in a Foucauldian post-structuralist sense) and so define Africa feminism around specific concepts and experiences which, it is argued, are relevant to the African context(s), and those which do not. Some of these approaches which fix what is meant by 'African culture(s)' and African experience(s)' eschew the signifier 'feminism' on the basis that it is inextricably tied to western/global north representations of womxn which position African womxn as deficient and oppressed (Blay, 2008). Examples of these approaches include 'Africana Womanism' or 'Womanism' and 'Stiwanism'[8]. Blay (2008) discusses how African Womanism is said to be "grounded in African culture" (p.65). Within Africana Womanism, 'African culture' is characterised in the following ways: gender equality (including flexible gender roles), the centrality of the family, respect for the elderly, respect for womxn, and the importance of motherhood (Blay, 2008). Salo (2001) notes how in some variations of Womanism, African culture is defined as 'distinctly heterosexual' and pronatalist'. As Chilisa and Ntseane (2010) show, however, the fixing of African culture(s) in this way is also adopted by approaches which self-signify as 'African feminist'. Thus, Chilisa and Ntseane (2010) also discuss the importance of mothering and family as specific to the African context.

The above approaches are notable in their attempts to represent African womxn differently, and thus redefine the meaning of 'Africa', by "valuing the everyday experiences of Blackwomen" (Gqola, 2001, p.17). The disadvantage of such an approach, however, is that a priori definitions of what is authentically 'African' and what reflects 'African experience(s), risk entrapment in essentialist understandings of the 'African womxn’s experience' (Mekgwe, 2008). A consequence of this is that African feminism may become monolithic in its representations of African womxn, something which was not only used as a basis of criticism levelled against Western feminism, but also became the impetus for a development of a theory or approach to knowledge production that could be called African feminism. This is echoed by Higginbotham (1982, p.96), a black feminist writing in the US: “In our eagerness to counteract the negative stereotypes, we must not create a different one, which also fails to reflect accurately the varied lives of Black womxn”.

[8] I recognise that this is only *one* interpretation of Africana Womanist, Womanist and Stiwanist approaches. I therefore acknowledge that variations of these approaches may define 'Africa' and 'African womxn' in ways which do not attempt to fix these meanings a priori.

A second consequence is that it may mean that opportunities for dialogue across contexts are missed. In other words, by fixing the importance of mothering, to take an example, as *essentially* African (see Oyewumi, 2001 as cited in Mekgwe, 2008, p.15), what is lost, firstly, is the possible recognition of the significance of mothering among womxn who are variously socially located. In their research on 38 English-speaking American womxn's reasons for obtaining an abortion, Jones et al. (2008) discuss how motherhood figured significantly in the data. Opportunities for dialogue across contexts are thus missed. Secondly, what may also be lost, where this is rigidly applied, are African womxn's experiences where motherhood does not figure as an important concept. Similarly, African womxn's experiences of childlessness, voluntary or not, are then eclipsed, due to being considered as 'un-African'. In a related vein, practices experienced by African womxn, but which are a priori deemed 'un-African', are not only invisibilised but become abnormalised. For example, Macleod, Sigcau and Luwaca (2011) document how in their study, participants worked to construct abortion as against 'African culture', which was homogenously constructed. *Not* presupposing what is and is not (essentially) African in the first place enables an African feminist approach which starts from African womxn's experiences and resists fixing, once and for all, definitions of culture and reality in African contexts. I argue that a post-structural African feminist approach does just that. I discuss this below.

3.2. An African feminist post-structural approach

As the previous discussion already suggests, the African feminist post-structural approach proposed in this thesis, and African feminist approaches in general, has much in common with a post-structural feminist discursive analysis which aims to "subvert the taken-for-granted discourses around ways of being and behaving that run through hegemonic discourses and preserve patriarchal power relations" (Thompson, Rickett & Day, 2017, p. 4). As I will show, an African feminist post-structural approach also shares a concern for how participants and their experiences are theorised and therefore represented. It is also similarly guided by a commitment to represent the experiences of those who have typically been excluded or have been "re-written in the mainstream enterprise of knowledge production" (Thompson et al., 2017, p. 3). An African feminist post-structural approach is, however, particularly attuned to how African womxn are represented and is committed to researching (and producing knowledge about) the experiences of African womxn in ways that recognise the oppressions and resistances in African womxn's experiences. It also is concerned with identifying and

recognising the points of convergence and divergence in and between their experiences to avoid producing a homogenised account of 'the African womxn experience' of any social practice or event.

Following Mekgwe (2008), African feminisms are here conceptualised as a collection of approaches which at the outset enable "the recognition of various and varied 'femininities' where womxn do not easily fall into neat categories" (Mekgwe, 2008, p.21). Instead of fashioning an identity that is "definable against Western feminism(s)" (Mekgwe, 2008, p.21) as some African feminists have done, it is more useful, I argue, to conceive of African feminisms as approaches which are contextually specific whilst registering fluidity, variation, and contradictions (Chilisa & Ntseane, 2010). Such a conception of African feminisms enables us to develop "[a] feminist theory that is neither stagnant nor parochial but crucially, relevant, not to an Africa denoted by prepositional time (post-colonial) but to present-day Africa" (Mekgwe, 2008, p.21) which may nevertheless be shaped by colonial processes.

As this discussion already suggests, researchers and theorists operating in and through African feminist approaches to knowledge must also avoid the trap in which difference and homogeneity are reified and essentialised (Mohanty, 2003). What is needed then, are tools which enable variability and similarity to be made visible. For variability, it must be allowed that womxn who share social locations may not only have experiences different from womxn who are differentially located (along racial identity, age, economic position and so forth), but may also have experiences which are different from each other. The same with similarity. Thus, while social locations do shape subjectivities and experiences in intersecting ways, to rigidly rule out similarity across womxn who are differentially located would result in problematic constructions of particular womxn (Mohanty, 2003). Mohanty (2003) Higginbotham (1982) and Wallace (1982) call attention to the ways in which white feminisms' rigidly-applied expectation of difference among womxn has often problematically constructed black and 'third world' womxn in particular ways: "passive persons being acted upon by oppressive forces" (Higginbotham, 1982, p.96), "faceless masses of welfare mothers and rape victims" (Wallace, 1982, p.10), uneducated, traditional/conservative and economically dependent (Mohanty, 2003). Thus, an approach which flexibly and fluidly retains similarity and difference through a recognition of and focus on the ways in which womxn may be variously constructed, and may variously construct themselves and their experiences, is necessary to avoid the kind of knowledge production that problematically represents and misunderstands (particular) womxn.

Blay (2008) and Tamale (2006, 2011) articulate an approach to African feminism which, I argue, may be read as post-structuralist. Like other approaches to African feminism, some of which have been discussed above, an African feminist post-structural approach is attuned to and works to document and bring an end to African womxn's experiences of imperial/geo-political and gendered oppression (among others). However, it proposes that 'Africa' and 'womxn' are necessarily open signifiers to which we attribute meaning and that these meanings are variable depending on womxn's material conditions and their cultural, socio-historical, political and geographic locations. Thus, Blay (2008, p.67) states that "the designation "woman" is not universal and thus, 'women' "never experience their oppression in the same ways". Multiplicity, variability, and complexity are therefore foregrounded.

Regarding power, an African feminism which is informed by feminist post-structuralism necessarily views power as relational and dynamic. When viewed in this way, power is "negotiated and negotiable, assessed in relative rather than absolute terms, and rightfully framed within cultural, historical, and generational contexts" (Blay, 2008, p.69). In this way, an African feminist post-structuralist approach avoids representing African womxn as monolithically 'oppressed victims' or empowered, both of which are harmful in what the experiences make invisible. Furthermore, power is understood to be bound up in/with normative constructions of gender and sexuality (as well as other social locations). Thus, Tamale (2011, p.16) argues that sexuality and gender "are creatures of culture and society, and both play a central, crucial role in maintaining power relations in our societies". An African feminist post-structural approach therefore explores systems of thought or discourses and the practices they (de)legitimise and (ab)normalise and analyses womxn's experiences from this perspective. In this light, Tamale (2006) highlights the concept of marriagenormativity and mothernormativity. The former refers to the socio-cultural privileging of marital (heterosexual) relations as normative. The latter is a concept which describes the normative privileging of motherhood as an imperative and inevitable goal for womxn (these discourses will be picked up in the literature review and analysis chapters).

Through an African feminist post-structural approach, the way in which womxn (for example) are differentially positioned produces particular and situated knowledges, each of which must be considered, and which require dialogue between the knowledges if a "hegemonic tunnel vision" (Yuval-Davis, 1997, p.19) regarding womxn's experiences is to be avoided. An African feminist post-structural approach is useful in a project that seeks to analyse the narrated pre-abortion counselling experiences of both health service providers and womxn requesting

termination of pregnancy services as they may be differentially positioned. Once situated knowledges have been produced, however, the task becomes: how exactly to create dialogue between these specific experiences (Moore, 1994)? Macleod and Vincent (2014) propose Mohanty's (1999 as cited in Macleod and Vincent, 2014; Macleod, 2006b) concept of a chain of equivalence. Macleod (2006b) explains this notion thusly: despite differences (along race, geographical location and age for example) in womxn's subjectivities, discourses around gender enable womxn to be positioned in similar, though varying, ways.

In the next section, I show how (Foucauldian) post-structural work has been put to work in South African and African research.

3.3. Taking up post-structural knowledge production in South African research

For some African writers, Foucault's work on knowledge and power cannot be used to produce situated knowledges on African experiences because it is borne of an assumed western context and thus lacks relevance or applicability (see Chilisa & Ntseane, 2010; Cornell & van Marle, 2015). On this point, however, Mama (cited in Salo, 2001, p.61) warns that to speak of "Western feminism" in the singular is to ignore those feminisms that have "not only listened to the critiques of African and other so-called third world feminists- they have also re-considered their earlier simplistic paradigms and come up with more complex theories". Kolawole (2002) too acknowledges that we should speak of (Western) feminisms, among which are those which recognise the importance of context and those which ignore it. Furthermore, Ahluwalia (2010) makes the argument that despite presumptions of the western/global north origins of post-structural, postmodern and post-colonial theoretical paradigms, the origins of these traditions may be traced to colonial Africa. For example, Ahluwalia (2010) shows how post-structural work by Foucault and others (for example, Fanon, Derrida and so forth) was produced in and shaped by colonial African realities. In this sense, Foucauldian post-structuralism may be uniquely positioned to speak to the lived realities of womxn living in Africa.

Post-structural work on knowledge and power, and a narrative-discursive approach which visibilises power relations at the micro, interactional level, provide the means of bridging the "specific and the universal, the particular and the comparative" (Moore, 1994, p.80) in womxn's experiences, through a focus on the discourses, discursive practices, and relations of power which enable and/or constrain counselling practices and experiences thereof. By taking these as an analytic point of departure, room is made for an ethical analysis which showcases the various ways in which womxn and healthcare providers are produced and governed in the

PTOP healthcare context. Importantly, a Foucauldian understanding of power as relational and dynamic, while patterned in some ways, further enables a complex representation of African womxn that visibilises the complexity of their experiences and the various conditions (discursive and structural) which produce these experiences.

Indeed, post-structural concepts have been successfully put to work in several studies conducted in Africa and South Africa specifically. For example, Chiweshe (2016) conducted a study in Zimbabwe in which he analysed womxn's narratives of their abortion decision-making processes and juxtaposed these narratives with health service providers' accounts of womxn's abortion decision-making. Using Foucault's work alongside post-colonial feminism, Chiweshe highlights how discourses around culture, shame, stigma, religion and health, as well as inequitable gendered power relations not only shaped womxn's understandings of the necessity of having an abortion but also structured their decision-making towards abortion as the only viable option. In contrast, as Chiweshe (2016) shows, health service providers positioned womxn who have had an abortion/abortions as 'evil', 'selfish' and 'irresponsible'.

Research by Feltham-King (2016) which analysed how teenaged pregnancy was constructed in the antenatal healthcare context (during interactions between healthcare providers and young womxn, and in a range of documents displayed and made available at antenatal clinics), and how teenaged womxn and healthcare providers were managed emphasises the usefulness of using Foucault's work. The study demonstrates how Foucault's analytics of power can be used to speak to and analyse how black, African teenaged womxn come to be problematised and deficiently constructed in post-Apartheid South Africa. Foucault's work has also been utilised in studies on language policy and education (Chetty & Mwepu, 2008), black bodies' experiences of racism in white spaces (Boswell, 2014), how gender is policed in football games on school playgrounds (Mayeza, 2015), and colonial-era depictions of indigenous peoples in South African history textbooks (Seroto, 2015). As this snapshot shows, Foucault can be put to work to highlight the variability and similarity of the discursive conditions of the lives of African peoples and the relations of power which enable and constrain particular realties.

An African feminism, as formulated by Mekgwe (2008), that seeks to produce knowledge that is socio-historically situated, that speaks of an African experience as “a complex tapestry of historical experiences and socio-political realities” (Naidu, 2010, p.26), and that strives to represent this diverse complexity, including the various oppressions and acts of resistance, does share much in common with the post-structural work discussed in this chapter (Kolawole,

2002). Furthermore, I argue that an African feminist approach can enrich and further situate or sensitise post-structural analyses. African feminism can bring a critical reflexivity to the ways in which African womxn in particular have been and are represented in feminist knowledge production. What is also gained from this pairing is an awareness of the socio-cultural locations, referred to by participants, that have shaped the pre-termination of pregnancy counselling experiences of health service providers and womxn requesting abortion.

4. Conclusion

This chapter has served to critically discuss an African feminist post-structural approach as the framework informing this research. As such, it has been necessary to discuss my own understandings of post-structural conceptualisations of discourse/knowledge and power as it relates to sexuality, of which abortion may be a point of intersection for various discourses around sexuality and the forms of power immanent in them. In doing so, I argued that post-structural writers' work on how knowledge has been produced, on sexuality in particular, with power effects of not only creating particular subjects but also of disciplining and regulating those subjects. Tying this particularly to the pre-abortion counselling encounter, I argued that the writings of post-structuralist thinkers on power and knowledge present a useful lens through which to view pre-abortion counselling as a site in which discourses around sexuality may be utilised with particular power effects.

Recognising that pairing African feminism and post-structuralism may be received as problematic by some, I spoke to what is gained in this fusion. I thus argued for the usefulness and applicability of this pairing as lending a cognisance of a particular history of the mis-representations of black, African womxn's experiences and an attention to ethically capturing the complexities of their experiences. I argued that by extending Foucault's work to include the action orientation of a narrative-discursive approach and of positioning theory, the interweaving (micro-macro) that is produced enables a useful and potent retention of African feminism while simultaneously avoiding the trappings of essentialism and homogenisation (Sawicki, 1986).

In the following chapters, I review the body of knowledge that has been produced on abortion in general. In chapter 3 I start of by looking at abortion counselling literature, highlighting the absences and silences in this small body of research. I then go on to discuss research on abortion

experiences. In chapter 4 I begin by looking at the discursive conditions through which abortion and unintended pregnancy are made sense and how they shape experiences of the PTOP healthcare context. Thereafter, I look at research which has been produced on topics relevant to abortion counselling: abortion decision-making and psychological consequences to abortion.

Chapter 3: An overview of knowledge production on abortion counselling and experiences of abortion

1. Introduction

In our review of knowledge on abortion produced in Psychology journals in the period of 1960-2015, my co-authors and I (Macleod, Mavuso, Chiweshe and du Toit (accepted)) found that the foci of research around abortion have varied extensively. During this period, research has been conducted on several issues, including: the incidence of abortion (unsafe abortion specifically), attitudes to abortion, reasons for abortion (including factors leading to the abortion decision), the psychological consequences of abortion, abortion decision-making, and experiences of abortion more generally. While there is a growing body of research on abortion experiences (most notably the experiences of womxn requesting abortion), research on experiences of abortion counselling, specifically, is lacking.

As discussed in the introductory chapter, South African legislation stipulates that non-mandatory counselling prior to and following the termination of pregnancy procedure must be made available to womxn accessing abortion services. In addition to the CTOP Act, and possibly the guidelines and manuals provided by the Western Cape Department of Health and Ipas, pre-abortion counselling takes place within and may therefore be shaped by healthcare and social contexts, as well as research on abortion. Knowledge production which contextualises the pre-TOP healthcare encounter will be discussed in two chapters. In this chapter I discuss abortion counselling: the various theoretical approaches to it and research conducted around it. Thereafter, I review the body of literature on abortion experiences, demonstrating the dearth of research that focuses specifically on counselling experiences more generally, and the pre-TOP healthcare interaction specifically. Then, in the following chapter, I situate the pre-termination of pregnancy encounter within the discursive environment of abortion, including research on the psychological consequences of abortion and abortion decision-making.

2. Abortion counselling

Knowledge about abortion counselling, both theoretical and research-based, is limited though varied (Ely, 2007). What is presently known about abortion counselling can be divided into: (1) perspectives/approaches to abortion counselling and; (2) experiences of abortion

counselling. Ely (2007) distinguishes between 'options counselling' and pre-procedure counselling. In options counselling, as offered by pregnancy crisis centres[9], womxn who have an unintended pregnancy are unsure about what to do about the pregnancy and thus need to be counselled on the options available to them. In pre-procedure (here referred to as pre-abortion) counselling womxn have decided on having an abortion and present at an abortion facility. As Ely (2007) explains, the two differ in the dynamics of the counselling: womxn may have different informational needs and require different kinds of support; and the abortion care worker providing the counselling may play a different role depending on (what they understand about) womxn's needs.

The purpose of options and pre-abortion counselling differ. In options counselling, womxn may need information about termination of pregnancy, adoption, as well as information on the socio-economic support available to them if they decide to parent. Thus, the counsellor may need to find out from womxn their thoughts about the pregnancy and the circumstances surrounding the pregnancy, including the social-economic support (un)available to womxn, to support womxn in deciding about the pregnancy. Pre-abortion counselling is understood to be significantly different to options-counselling (Ely, 2007; Joffe, 2013). It involves three components: (1) obtaining informed consent from the client for the abortion procedure, which includes ascertaining that the womxn has not been coerced into having an abortion; (2) providing information on the technical aspects of the abortion procedure as well as possible complications that may arise; and (3) working through the client's feelings about the termination of pregnancy procedure (Joffe, 2013).

From the literature on abortion counselling, and reproductive counselling more generally (which includes genetic counselling, for example), two inter-related concepts emerge as significant for understanding what counselling is and how it ought to proceed: non-directive counselling and informed consent. However, there is very little clarity or uniformity around what these concepts mean. Thus, different approaches to counselling might take them up in different ways. Below I tackle each of the aspects in turn.

Non-directiveness can be seen as a standard or normative ideal for how healthcare counselling *should* proceed. As Grant (1990) and Petersen (1999) describe, non-directiveness can be located in liberalism where the counsellee is positioned as achieving autonomous decision-

[9] Pregnancy Crisis Centres first appeared in the US and are also found in South Africa. The centres, which do not offer abortion services, take a supposedly 'woman-centred' approach to pregnancy counselling but tend to combine this with a moralistic, anti-abortion stance.

making through the information provided by the counsellor. As a set of liberal counselling practices, non-directiveness circumscribes particular roles for the counsellor and the 'client': the former provides factual information around the risks and possible consequences of a particular decision and in so doing enables the latter to make a responsible, reasonable and informed choice. Through non-directive counselling then, the autonomy of the counsellee is presumed to be upheld and enabled by facilitating the *counsellee's* decision-making. Thus, the counselling aims to respect the autonomous decisions made by the counsellee, decisions which are assumed to take place in a context of a lack of influence, pressure or direction, and which are assumed to be guided by the provision of neutral, factual and non-ideological information.

The issue of informed consent can be understood as an outcome of non-directive counselling and has to do with the matter of avoiding any undue influence by the abortion provider on the womxn's decision (Woodcock, 2011). Traditional discourses of informed consent are positivistic: based on the premise that objective knowledge production that reflects reality is possible, neutral and non-ideological. As such, non-maleficence is understood to centre around the duty to provide accurate information and maintaining neutrality and non-judgment in the delivery of the information provided. In this positivistic sense, ethical counselling is that which involves the provision of accurate information, which is itself assumed to be value-free, and unproblematic when delivered in a neutral/non-judgmental way. That is, ethical counselling is non-directive.

Positivist conceptualisations of informed consent and prevailing notions of non-directiveness fail, however, to acknowledge the harm that can be caused, and the influence that may be exerted, by virtue of receiving *any* information. Thus, Woodcock (2011) discusses how womxn may feel distress upon hearing 'accurate' information that is nonetheless delivered in a 'non-judgmental' way, by virtue of language being value-laden. For example, Woodcock (2011) notes how explicit information about morphological features of the foetus (that at so many weeks it has a heartbeat, for instance) may produce angst in womxn who have hitherto understood that the foetus "is not a person in the sense required to deserve moral consideration" (p.498). Certainly, as Vincent (2011) suggests, where information around the 'risks' of abortion is provided during counselling, this may have ideological effects. In this vein, Woodcock (2011) argues that abortion counselling necessarily takes place against a socio-cultural backdrop wherein "special expectations [are] placed on women to assume nurturing responsibilities for children" (p.499). When decision-making takes place within a bio-medical setting, power relations between the counsellor and counsellee may mean that the counsellee

is unable to contest this truth of 'risk' (Petersen, 1999). Additionally, information around risks usually implies or carries with it expectations about what a reasonable/rational person would do with the information just received (Petersen, 1999).

Woodcock (2011) therefore points out a significant dilemma in abortion counselling which revolves around recognising that harm may be caused, whether the counsellor *intends* to be persuasive or directive, by simply *providing* information. For example, information around foetal development, which draws on a foetal personhood discourse, may work to position the pregnant womxn as a mother and thus produce feelings of guilt and shame over having a procedure which threatens the foetus (Woodcock, 2011). Within this dilemma around harm, then, understandings of what counselling is and how it should proceed, and the ethical obligations required by those counselling womxn, need to extend to and be informed by social constructionist/post-structuralist understandings of knowledge/information and non-maleficence which extend beyond intention to include the *effects* of providing information. This argument is developed later in the thesis.

Another aspect of the informed consent dilemma that needs attention is the assumption, within dominant understandings, that womxn *need* informational assistance from authorities located within and by the bio-medical and/or psy disciplines in order to make a 'true', informed choice. And this positioning of womxn persists despite the multiplicity of ways in which counselling is constructed and the many ideas around how it *should* proceed. This assumption that womxn need informational assistance, however, does not take cognisance of the access to information that some womxn may have, whether via the internet or informally through womxn who have had an abortion/abortions before. Indeed, in the present research, some womxn discussed how their own information-seeking practices were a part of their preparation for the abortion. Of course, assuming that all womxn have equal access to information is just as problematic as assuming that all womxn need the kind of informational assistance that occurs specifically within a medical, hospital/clinical setting.

2.1. Different approaches to abortion counselling

Abortion counselling may be categorised according to the following approaches which will be discussed in turn: feminist counselling, pastoral counselling, and 'head and heart' or psychotherapeutic counselling. It is important to note that while these approaches are discussed separately, in practice their boundaries may be less rigidly drawn.

Ely (2007) describes feminist counselling practices as that which centre on normalising a decision to have an abortion as a normal and appropriate part of fertility regulation or family planning method. By normalising the decision, those providing abortion counselling empower womxn in their decision-making, and simultaneously challenge the stigma around abortion. As research (e.g. Kimport, Foster & Weitz, 2011; Mavuso, 2015) is beginning to show, abortion stigma may significantly shape whether womxn experience their abortion experience in a positive, ambiguous or negative way. According to Ely (2007), explicitly challenging dominant discourses which construct abortion in negative ways, forms part of this normalisation. Other practices involved in feminist counselling include: paying attention to and recognising the various intersecting conditions of womxn's lives which contextualise a decision to have an abortion (the womxn participates in this exercise), and recognising that the personal and political are indeed very often connected so that the political conditions of womxn's lives shape their personal lives.

In contrast, Baloyi (2012) outlines and argues for a different approach to abortion counselling: a pastoral approach to narrative counselling. Within this approach, those counselling womxn on abortion are encouraged to listen to and interpret womxn's varied narratives about their reason(s) for abortion and provide spiritual guidance that may mitigate the negative consequences of abortion. Thus, this approach supposedly borrows from narrative counselling an attention to and prioritisation of how womxn understand their own lives and story their experiences. However, Baloyi (2012) describes an approach which starts off from the premise that abortion is immoral and necessarily leads to emotional and or psychological difficulties which need to be managed with the help of the pastoral counsellor. While many womxn may undoubtedly take up this discourse in that it currently holds a particular force and dominance, starting out from this premise precludes the fact that womxn may view abortion differently. Baloyi (2012) argues that the importance and relevance of pastoral counselling lies in its ability to relate to womxn who have religious beliefs which *may* nevertheless be incompatible with abortion.

While counselling which values womxn's various positions may be important as Ely (2007) argues, pastoral counselling which constructs abortion as sinful/harmful may be extremely limited in serving womxn's needs as it risks perpetuating the emotional difficulty it presumes to be inherent to abortion. Furthermore, as Macleod (2006a) demonstrated when exploring contraceptive counselling practices, pastoral counselling tends to be prescriptive in its approach, with counsellors taking upon themselves the responsibility for producing

responsible, good reproductive citizens and employing such tactics as chastisement and shame in prescribing expected and moral behaviour. Pastoral counselling in this format, therefore, may necessarily be directive and harmful in and of itself.

A third approach to abortion counselling is described by Joffe (2013) as head and heart counselling or psychotherapeutic counselling. This approach to counselling involves attending to womxn's emotions and any possible emotional conflict surrounding the abortion decision, as well as providing technical and procedural information about abortion. Head and heart counselling, like the feminist counselling described by Ely (2007), involves not only recognising womxn's various positions but taking these up in ways that normalise abortion (Joffe, 2013). This kind of counselling would involve acknowledging womxn's own language use and exploring the implications these have for womxn's experiences of abortion. For example, replicating the use of foetal personhood discourses in talking about the foetus as a "baby/child", or moral discourses which construct abortion as "killing" but in ways which still normalise abortion. Likewise, the counsellor would also use terms such as "foetus" and any other terms used by womxn to refer to the foetus, and would similarly follow womxn's language use around the abortion itself. Within the head and heart counselling described by Joffe (2013), the goal for those providing abortion counselling, then, would be to encourage womxn who position themselves through varying discourses to view abortion as justified and necessary. Unlike the feminist approach to counselling, however, the kind of psychotherapeutic counselling described by Joffe (2013) risks the effect of reinforcing the awfulisation of abortion. Thus, taking up womxn's discourses on abortion as immoral/sinful, while acknowledging womxn's own language use and perspectives, may contribute towards and not alleviate emotional difficulty.

Below, I discuss research that has been conducted with a specific and direct focus on experiences of abortion counselling itself. None explore the PTOP healthcare encounter, which is the argument I make in this chapter. However, these studies are extremely useful in highlighting how womxn and healthcare providers have experienced pre-abortion counselling. I start with the studies that have explored womxn's experiences and then turn to those contributing to the production of knowledge on the experiences of healthcare providers.

2.2. Womxn's encounters with abortion counselling

Before I discuss the research in this area, it is important to note that the counselling received by the womxn in the various studies may differ. This therefore requires some caution when making comparisons across studies.

Womxn's experiences with abortion counselling is an under-researched topic in abortion research generally, and abortion experiences more specifically. Research that has been done has had varied results in terms of whether womxn experience the counselling positively or negatively. At the time of writing this chapter, very few studies (Birdsey et al., 2016; Ely, 2007; Moore et al., 2011; Tong et al., 2012) had treated womxn's experiences of abortion counselling as the main problematic of the research. I discuss these here. Thereafter I address studies where womxn's experiences of pre-abortion counselling were not the main focus, but which nevertheless tell us something about how womxn might experience pre-abortion counselling.

Ely (2007) conducted a study on US womxn's experiences of abortion counselling approached from a feminist perspective provided at one abortion clinic. The study used a counselling satisfaction survey requiring Likert-type responses with an open response at the end of the survey where womxn could express themselves on their own terms. The qualitative responses to the open-ended question were analysed as narratives using grounded theory. All of the 104 (out of 200 who completed the survey) patients who answered the open-ended question expressed that the counselling and their interaction with the counsellor were satisfactory. The counsellor was predominantly experienced as kind, helpful, emotionally supportive and non-judgmental. Womxn also valued reassurance, from the healthcare provider counselling them, that their decision was the right one to make and found that this reassurance mitigated the difficulty they experienced in dealing with the experience.

Baron et al., (2015), and Moore et al. (2011) explored womxn's experiences of pre-abortion counselling in Scotland and the US respectively. The context in which the studies were conducted differs: in the UK counselling is voluntary whereas Moore et al.'s (2011) study was conducted in three different states (Washington, Connecticut and Texas) in the US, one of which (Texas) has mandatory counselling. The studies, therefore, provide a useful counterpoint to each other. In Baron et al.'s (2015) study where womxn could choose whether to have counselling[10], only 18 of the 201 womxn who had filled in self-administered surveys actually chose to receive counselling. The majority who did not, reported decision certainty prior to arrival at the facility and thus did not feel counselling to be necessary. In Moore et al.'s (2011)

[10] According to Baron et al. (2015), there are three kinds of counselling which are recommended by the Royal College of Obstetricians and Gynaecologists: 1) implications counselling, where the counsellor talks through the womxn's options and the implications of each course of action; 2) support counselling, where womxn and their partners are given emotional support; and 3) therapeutic counselling which takes place after the abortion and deals with any issues that have arisen from the abortion experience. The study is unclear about whether womxn were told upfront about the kinds of counselling offered and does not specify *which* kinds of counselling were refused or accepted.

study, among the 49 participants who received counselling, 45 were not seeking options counselling, having already made up their minds about having a TOP before presenting at the clinic. While most womxn in Moore et al.'s (2011) study discussed strong emotions in the research interview, they had not expected to emotionally confide in the counsellors and some did not appreciate being prompted to engage in further thinking over the decision. Rather, for some of them their needs centred around procedural information (Moore et al., 2011).

The two studies make a good point for paying attention to what womxn who have received counselling say about their experiences. In Baron et al.'s (2015) study, although all participants who received counselling stated that it went well or 'OK', only 10 out of 18 womxn who received counselling felt that it helped them to reach a decision. Moore et al.'s (2011) study reported that what some womxn seemed to want most from the counselling session was more information about the abortion process. Thus, some participants wanted the counselling session to reassure them about the physical aspects of the TOP (Moore et al., 2011). While some womxn in the study had wanted reassurance about their decision, others thought that the counselling might be useful in assisting other womxn to be sure of their decision but did not find it useful for themselves. Lastly, there was support among the womxn in Moore et al.'s (2011) study for an approach to counselling that considers and caters for womxn's different needs in terms of the kind of information provided and the level or kind of counselling that is conducted.

Studies have also reported very positive experiences of pre-abortion counselling. Vandamme, Wyverkens, Buysse, Vrancken and Brondeel (2013) conducted a study in Belgium where abortion counselling is mandatory. The study aimed to assess womxn's feelings and thoughts prior to and after receiving pre-abortion counselling. Although the 971 participants were anxious about the value and content of the counselling and were certain about their decision, they reported being satisfied with the counselling and reported that the counselling made them even more certain of their decision. In Tong et al.'s (2012) study conducted in Malaysia, 31 womxn were interviewed about their experiences of abortion. Unlike the participants in Moore et al.'s (2011) study, most of the womxn experienced the information provision aspect of the service as satisfactory in its clarity and level of detail. Relatedly, the pre-termination of pregnancy counselling was found to be non-judgmental and non-prejudiced, with the information provided clarifying the womxn's fears, doubts and misinformation (Tong et al., 2012). Participants in Tong et al.'s (2012) study also appreciated the involvement of their partners in the counselling session.

Birdsey et al. (2016) conducted a mixed methods study in KwaZulu Natal province, South Africa, in which they explored womxn's (and healthcare providers' experiences, which I address in the following section on healthcare workers' experiences) of the pre-abortion counselling session. They administered a semi-structured questionnaire (consisting of 11 closed and 2 open-ended questions) to 60 womxn who presented at a district hospital requesting a TOP. Birdsey et al. (2016) report varied results. A third of the womxn found the information provided during the counselling to be insufficient, while over half felt it to be irrelevant to their circumstances. Interestingly, womxn who had decided on abortion *prior* to arriving at the hospital tended to be pleased with the informational aspect of the counselling. All the womxn described the healthcare providers' conduct during the counselling as respectful and guided by a positive attitude. In terms of the format of the counselling, both group and individual counselling was reported, with womxn appearing to have no choice regarding format. Some participants expressed discomfort with the group format, as they had personal and relationship issues surrounding the context of the pregnancy which they felt needed to be addressed in the counselling.

Quantitative studies which evaluate womxn's satisfaction with abortion services yield some useful information on womxn's experience of abortion counselling. Guilbert and Roter (1997) and Devjee et al. (2003) conducted quantitative studies, in Canada and South Africa respectively, where participants received questionnaires. In both studies, most participants were satisfied overall with the services they received, including abortion counselling. In Guilbert and Roter's (1997) study, of the 100 womxn who participated in the study, 56% and 31% were very satisfied and moderately satisfied respectively with the overall abortion service they received. Regarding abortion counselling specifically, womxn expressed satisfaction at being prepared for the procedure and receiving information that allowed them to anticipate what their embodied experience of the abortion procedure would be. They also expressed satisfaction at the supportive attitudes that they perceived from health service providers. Devjee et al.'s (2003) study in contrast focused on contraceptive pre-and post-abortion counselling, which often forms part of abortion counselling, as well as serological screening tests. The study reports that none of the participants attending the level 1 facility[11] received any serological

[11] Hospital services in South Africa are categorised into Level 1, 2 and 3. A 'Level 1 facility' refers to a district hospital, with levels 2 and 3 referring to regional and tertiary hospitals. Cullinan (2006) defines a district hospital as: a facility at which a range of outpatient and inpatient services are offered. It is open 24 hours a day, 7 days a week. The hospital would have between 30 and 200 beds, a 24-hour emergency service and an operating theatre.

screening tests despite 78% of participants stating that they would have opted for HIV testing had it been offered. All participants were offered male condoms by the health service providers although not all womxn accepted them. Whether or not womxn would have preferred other forms of contraceptives, ones whose usage would be in their control, was unfortunately not determined by the study.

The above research on womxn's experiences with abortion counselling is helpful in highlighting the variability of womxn's experiences; these experiences depend on different needs that womxn may have from the counselling. However, greater knowledge on the practices (reportedly) deployed in abortion counselling is useful in contextualising these experiences. Thus, it is important to note that only one of the aforementioned studies (Ely, 2007) focused specifically on an approach to counselling and evaluated womxn's experiences of it. Furthermore, the studies above do not address womxn's experiences of waiting room interactions prior to the counselling which may be significant in shaping how they make sense of and feel about the counselling itself.

2.3. Healthcare providers and abortion counselling

Health service providers' experiences of the counselling aspect of abortion work constitutes an area of abortion knowledge production that is also under-researched. Beynon-Jones' (2013) work on UK abortion providers' counselling practices revealed that health service providers stratify abortion requests according to acceptability. Research on abortion providers' experiences of providing abortion counselling seems to echo this finding. Thus, doctors and nurses in Möller et al.'s (2012) study conducted in Nepal hierarchised womxn's reasons for requesting a TOP: womxn presenting for TOP without any contraceptive knowledge were the most acceptable, followed by womxn whose husbands prevent contraceptive usage. Middle-class educated womxn with access to contraceptives who choose not to practice contraception were the least acceptable and their requests viewed as irrational due to insufficient justification (Möller et al., 2012). This stratification was related to participants' frustration over womxn's use of termination of pregnancy as a family planning method. Like Beynon-Jones (2013) and Möller et al. (2012), in Nicholson et al.'s (2010) study conducted in the UK, nurses reported their own conditions of the acceptability of an abortion request. Among participants, womxn's reasons for requesting a TOP were conditional on whether womxn were using abortion "as contraception", which they viewed as an 'abuse' of the service. Also, difficult to accept were abortion requests following fertility treatments (Nicholson et al., 2010).

In contrast to the above studies, Birdsey et al.'s (2016) study conducted in KwaZulu Natal, South Africa did not report that healthcare providers' hierarchised the acceptability of reasons for abortion. In their study the authors discuss how, during in-depth interviews, the four healthcare providers (all of whom were nurses) demonstrated a limited understanding of the variety of circumstances in which pregnancies occur and which occasion a termination of pregnancy. There was thus agreement among the providers interviewed that womxn who request abortion services were young womxn whose studies would be disrupted by continuation of the pregnancy or womxn living with HIV. Pregnancy resulting from infidelity and pregnancy resulting from rape were discussed as uncommon reasons for requesting a TOP.

In addition to healthcare providers' understandings of womxn's requests for abortion, studies on abortion counselling have also shed light on the content and/or structure of abortion counselling. In Birdsey et al.'s (2016) study discussed above, nurses discussed the following as forming a part of the information provided during counselling: the abortion procedure itself (such as what to bring and how the procedure is done), the risks associated with abortion (it is unclear whether this referred to complications associated with the different abortion methods or contested information around infertility, cancer and the so-called inevitability of psychological trauma), general health education including prevention of sexually transmitted infections and contraceptive methods. Participants in Nguyen et al.'s (2010) study in Vietnam discussed five phases of pre-termination of pregnancy counselling. The phases discussed by the health service providers were: counselling on the adverse effects of having a TOP, which primarily served to discourage 'repeat TOP' and to ensure contraceptive uptake; rapid post-abortion fertility return, used mainly to encourage contraceptive usage post-TOP; contraceptive counselling which involves the correction of erroneous contraceptive beliefs, verification of clients' understanding and willingness regarding contraception and the encouragement of long-term post-abortion contraception; behaviour change and STI/HIV prevention counselling; and sexual and reproductive counselling (Nguyen et al., 2010). Beja and Leal (2010) similarly explored abortion counselling in Portugal. According to participants, pre-abortion counselling involved the following: receiving the womxn and understanding her TOP request; information provision, including legal, clinical and practical information regarding the abortion process; supporting abortion decision-making which involves the client's reflection and discussion on the decision to ensure as little ambivalence as possible; and managing emotional and psychological issues, which include supporting and monitoring the client's emotional state, and discussing future pregnancy plans and screening for psychopathology. Abortion counselling

also addressed contraceptive issues, managing third-party involvement, offering psychological counselling, and offering state support and social counselling (Beja & Leal, 2010).

Lastly, research on abortion counselling has looked at healthcare providers' competency in providing counselling. In Dickson-Tetteh and Billings' (2002) South African study where only midwives were included in the study, competency was shown for 75% of the 96 procedures observed. In addition, in the study 91% of midwives were shown to have competency in information provision regarding the TOP procedure itself and most showed competency in providing information regarding the risk of pregnancy and post-procedure health problems. The study also reported that in the observations of contraceptive counselling at 25 facilities, contraceptives were offered to all womxn post-abortion.

While helpful, such research once again provides a limited understanding of the kind of counselling that is practiced and experienced by healthcare providers. Furthermore, the studies reviewed in this section around abortion counselling did not (sufficiently) consider the role that staff-patient waiting room interactions may have in shaping womxn's abortion counselling experiences. Below, I discuss research that looks at experiences of abortion.

3. Abortion experiences

Research on womxn's and healthcare providers' experiences of abortion encompasses various aspects of abortion. It has come to be a substantially researched area that has been widely investigated, in varying geographic and political regions. Knowledge has been particularly produced in the Scandinavian region (Alex & Hammarström, 2004; Andersson, Christensson & Gemzell-Danielsson, 2014; Halldén, Christensson & Olsson, 2009; Kjelsvik & Gjengedal, 2011) where abortion is legally accessible, with some research also being conducted in contexts where abortion is legally restricted such as parts of Latin America (e.g. Zamberlin, Romero & Ramos, 2012; Ramos, Romero & Aizenberg, 2015), Asia (e.g. Sheehy, Aung & Foster, in press; Vallely, Homiehombo, Kelly-Hanku & Whittaker, 2010) and Africa (e.g. Aniteye & Mayhew, 2011).

Much of the research that exists on experiences of abortion focuses on womxn's experiences of abortion services and the abortion procedure itself (e.g. Andersson et al., 2014; Fisher & Lafarge, 2015; Harries, Gerdts, Momberg & Foster, 2015; Kalyanwala, Jejeebhoy, Zavier & Kumar, 2012; Purcell, 2015; Tong et al., 2012). This has resulted in a neglect of knowledge production around two specific areas related to abortion experiences. The first is health service

providers' experiences of providing abortion services and the second is healthcare workers' and womxn's experiences of the counselling aspect of abortion. In what follows, I review the research on abortion experiences by separating out womxn's experiences from those of health service providers, reflecting the dominant way in which research in this area has been conceptualised and thus conducted. I conclude the section by highlighting the lack of research, at the time of this review, of experiences exploring the PTOP healthcare interaction.

3.1. Exploring womxn's experiences of abortion

Knowledge produced around womxn's experiences of abortion tend to coalesce around the following themes: seeking and accessing abortion in both legally accessible and legally restricted contexts (Harries et al.,2015; Kalyanwala et al., 2012; Prickles, 2013; Ramos et al., 2015; Sheehy et al., in press; Tong et al., 2012; Vallely et al., 2010; Zamberlin et al., 2012); emotional and physical experiences of the procedure itself (Alex & Hammarström, 2004; Andersson et al., 2014; Harries et al., 2015; Ramos et al., 2015; Tong et al., 2012; Zamberlin et al., 2012); interactions with health service providers (Alex & Hammarström, 2004; Fisher & Lafarge, 2015; Purcell et al., 2014; Ramos et al., 2015; Tong et al., 2012) and experiencing the abortion environment (Fisher & Lafarge, 2015; Prickles, 2013; Purcell, 2015).

Below, I start off my review of studies investigating womxn's experiences of abortion by addressing womxn's experiences of seeking and accessing TOP services. Thereafter, I speak to womxn's emotional and physical experiences of the abortion process. Lastly, I look both at studies which have explored womxn's interactions with abortion care staff and those which have investigated womxn's experiences of the abortion facility itself.

3.1.1. Seeking and accessing termination of pregnancy services

Womxn's experiences of seeking abortion vary according to accessibility of the service. According to research on the subject, womxn's experiences of seeking and accessing abortion are shaped by: whether or not there is a delay in pregnancy recognition, whether or not information on abortion is readily available and accessible, (not) having knowledge about where abortions may be done and by whom, the distance to an abortion facility, experiencing or not experiencing delay once an abortion has been requested, whether a request for termination of pregnancy is granted or denied, and whether or not womxn encounter stigma

around abortion (Harries et al., 2015; Kalyanwala et al., 2012; Prickles, 2013; Purcell et al., 2014; Purcell, 2015; Ramos et al., 2015; Tong et al., 2012; Zamberlin et al., 2012). These may make the process of seeking abortion a long and arduous one and negatively shape the abortion experience, or make it a simple, quick and uneventful process and positively shape the abortion experience.

For example, Kalyanwala et al. (2012) conducted a study in India where abortion is legislated via, and is thus accessed as, menstrual regulation. Most participants reported an unsuccessful first attempt at terminating the pregnancy by going to a chemist, nurse or unspecified provider who provided various unspecified mixtures to take orally. Only then did participants go to an NGO clinic where termination of pregnancy services are provided, making the entire process a long and frustrating one (Kalyanwala et al., 2012). Purcell et al. (2014) speaks to the experiences of Scottish womxn seeking second trimester abortion. While some womxn found abortion services in Scotland to be accessible and receptive to their needs, womxn who had to travel to England[12] to access termination of pregnancy experienced the abortion-seeking process as stressful. This was because these womxn had to plan for travel and accommodation costs, consider the prospect of having to inform more people than the womxn would have preferred to initially, and be in an unfamiliar place. Womxn also experienced the abortion seeking process as stigmatising due to the different requirements and treatment when compared to womxn having first trimester abortions.

An important part of the process of seeking an abortion is accessing information about abortion. The research on this aspect of the process suggests that some womxn access information on abortion ─even in contexts where it is legal─ via informal channels, such as the internet, family, friends, neighbours or partners (Andersson et al., 2014; Purcell, et al., 2014; Zamberlin et al., 2012). Accessing abortion information through these informal channels contributed to a sense of a lack of control over the process (Andersson et al., 2014) and to a stressful and emotionally draining abortion experience more generally (Tong et al., 2012; Zamberlin et al., 2012), due to not being able to verify the accuracy of the information which was often incomplete. For some of the womxn in these studies, the use of informal networks was

[12]Ground C in the Abortion Act of 1967 permits abortion for up to 24 weeks gestation because of psychosocial reasons (i.e. pregnancy poses a risk to the physical or mental health of the womxn). However, in Scotland, abortion is not usually provided under Ground C after 18-20 weeks gestation. Therefore, womxn whose pregnancies are beyond 18-20 weeks gestation and who are requiring abortion for psychosocial reasons must travel to England for the procedure of dilation and evacuation. While womxn's local NHS board will cover the cost of the procedure, travel and accommodation costs must be met by womxn themselves.

motivated by not knowing that termination of pregnancy is legal (in Malaysia, where Tong et al. (2012) conducted their study) and where to go to access abortion services. In contrast, participants in a study by Ramos et al. (2015) conducted in Argentina (where abortion is legally restricted) made use of more formal channels such as health services, and abortion service hotlines which would provide relevant information and access to abortion medication.

Delays in the abortion seeking process were reported by womxn in studies by Harries et al. (2015), Prickles (2013) and Purcell et al. (2014). In Purcell et al.'s (2014) study where Scottish womxn had to travel to England for a second trimester procedure, delay resulted from not having known that travel would be necessary and then needing to organise the associated costs. Prickles (2013) describes that in studies conducted in South Africa, delays at various levels have been attributed to: late pregnancy recognition and confirmation; negative responses from others including emotional, cultural and religious pressure and manipulation, and providers' judgemental attitudes; long waiting periods; and a poor referral system. Sometimes delays in accessing an abortion also result from provider opposition or objection, as was reported in the study by Purcell et al. (2014) in which one participant encountered a health service provider who objected to providing the service. Provider opposition or objection was also reported by Harries et al. (2015) and Prickles (2013), in South Africa. Harries et al.'s (2015) study highlights how being denied an abortion may be experienced as upsetting and distressing, particularly for those who are already beyond 20 weeks and for whom pregnancy options narrow considerably as a result.

Below, I discuss womxn's emotional and physical experiences of the abortion process (that is, not strictly limited to the procedure itself) as they have been reported by womxn in research on womxn's experiences.

3.1.2. Emotional and physical experiences of abortion

Although womxn's psychological responses post-abortion and womxn's emotional and physical experiences of abortion sometimes tend to be conflated, I have distinguished between the two in the present study. While there tends to be some overlap, research on womxn's psychological responses post-abortion predominantly focuses on womxn's emotional state (such as grief, loss, sadness; ambiguity; and relief etc) post-abortion as an indication of the effect abortion has had on their psychological well-being. Research on womxn's emotional and physical experiences includes a focus on womxn's emotional state in relation to the whole abortion process (from

seeking out information about abortion to post-procedure) but also incorporates bodily experiences of the abortion procedure. Furthermore, such studies tend to be framed by the need to document womxn's experiences of abortion in the interest of improving them (rather than to restrict abortion access as seen in much of the research on the psychological consequences of abortion).

The dominant narrative on abortion is one in which distress-related emotions such as guilt and regret are normatively expected and are attributed to the abortion event itself (Rocca et al., 2015). Emotions indicating an ambivalent, mixed or largely positive experience tend to be less emphasised, particularly when abortion is constructed as immoral and harmful. Research conducted on womxn's emotional experiences to abortion, however, demonstrates that different womxn experience different emotions during and/or after the abortion process, and that abortion is sometimes experienced as both positive and negative, or as a neither positive nor negative experience. For example, feelings of ambivalence and emptiness, as well as maturity and joy at having experienced the pregnancy, were reported by participants in a study on womxn's abortion experiences in Sweden (Alex & Hammarström, 2004). Most participants in studies conducted by Tong et al. (2012) in Malaysia, Ramos et al. (2015) in Argentina, Vallely et al. (2010) in Papua New Guinea, and Andersson et al. (2014) in Sweden, reported experiencing guilt and remorse, fears and concerns for the foetus, as well as a sense of self-confidence, pride, relief and satisfaction at having resolved what was a tough decision for some (Andersson et al., 2014; Ramos et al., 2015; Tong et al., 2012; Vallely et al., 2010).

Furthermore, as Ramos et al. (2015) note that in their study, womxn who had access to support tended to have more positive emotional experiences compared to those who did not. This finding highlights the importance of contextualising emotional experiences post-abortion. Similarly, context was emphasised in Andersson et al.'s (2014) study where womxn's experiences of suffering seemed to stem from not knowing enough information about the medical abortion procedure and how exactly it works to terminate the pregnancy.

A much-neglected area of research is studies which describe the emotional experiences of womxn who have been denied an abortion. Such studies highlight how this itself can be a highly stressful experience. Where womxn are eventually able to access a TOP, having initially been denied may significantly shape the overall experience. Harries et al. (2015) conducted research in Cape Town, South Africa, as part of a Turnaway multi-country study which sought to document the experiences of womxn who have been denied a termination of pregnancy. Most

of the womxn in the study (a total of eight participants) felt upset and distressed upon being denied an abortion, particularly those who were beyond 20 weeks. After having been denied the procedure, three womxn attempted to access an illegal provider but did not go through with it. Such studies emphasise the importance of researching womxn's varied experiences, and in ways which recognise the important of context.

As with emotional experiences, womxn's physical experiences of abortion vary across and within studies. In Andersson et al.'s (2014) study, for most of the participants physical pain was experienced as worse than the womxn had expected, while some felt the pain to be less than they had expected it to be. Other womxn in the study reported that it was the physical experience of the abortion that they remembered well, such as hearing the foetus drop into the bedpan. In addition to pain, womxn in a study by Alex and Hammarström (2004) experienced nausea and difficulties with heavy bleeding. For womxn in studies reviewed by Zamberlin et al. (2012), where the studies were conducted in areas where abortion is legally restricted, experiences of the abortion took on a different meaning with their experiences centring on considerations of where to take the medical abortion pills, who to have with them during the process, the timing of the process and what to do about existing children.

In the last section on womxn's experiences of abortion, I speak to research that has focused on how womxn have felt and thought about their interactions with healthcare providers and their experiences of being in the facility itself.

3.1.3. Interacting with HSPs and experiencing the abortion environment/facility

When womxn speak to researchers about their experiences of abortion, the kind of interactions and quality of the interactions they have with health service providers tends to be included in their accounts. In research, participants have used both positive and negative terms to characterise their interactions with abortion providers. Negative experiences of staff-client interactions have been reported to include: provider opposition to abortion, judgemental attitudes (Prickles, 2013); a blunt and dismissive manner (Fisher & Lafarge, 2015); and a cold, negative and ignorant attitude which had the effect of bringing about feelings of shame, sadness, loneliness and uncertainty in some womxn (Alex & Hammarström, 2004). Such experiences are contrasted with some womxn's positive interactions with health service providers working in abortion facilities, which I discuss below.

In research conducted by Tong et al. (2012), participants reported a non-judgemental approach used by the abortion providers at the family planning clinics in urban Penang, Malaysia, from which they were recruited. According to the womxn, this was unlike the treatment they had come to expect from health service providers at other health facilities (Tong et al., 2012). In Purcell et al.'s (2014) study conducted in Scotland, some of the 23 participants interviewed had expected a lack of receptiveness from staff concerning their request for a TOP. However, most womxn found this not to be the case as their requests were accepted (as opposed to being denied) by the healthcare staff. Womxn have also positively characterised abortion providers and staff in the following ways: comforting, reassuring and 'there for' participants (Purcell et al., 2014); kind, friendly, empathic (Fisher & Lafarge, 2015); and as providing relevant information, not asking any questions around the abortion decision, and supporting the abortion decision (Alex & Hammarström, 2004; Ramos et al., 2015).

Fisher and Lafarge (2015), Prickles (2013) and Purcell (2015) make contributions to what is known about how womxn experience abortion facilities. In Fisher and Lafarge's (2015) study conducted in England on womxn's experiences of termination of pregnancy for foetal anomaly, participants appreciated the privacy of being in their own room (Fisher & Lafarge, 2015). Contrastingly, a lack of privacy was commonly reported in Prickles' (2013) review of South African research on womxn's experiences of abortion services. In Purcell's (2015) review of studies on womxn's abortion experiences, it was noted that the facility's environment, such as anti-abortion picketers and resultant security measures, and TOP services being in specialist facilities, significantly shaped womxn's experiences of their abortion. In the present study, staff's measures to ensure privacy and confidentiality were pointed out and appreciated by some participants.

In the following section, I address the research that has been conducted on healthcare providers' experiences of providing abortion services. I do so with the view that healthcare providers' past experiences will not only inform their current practices, for example around pre-abortion counselling, but will also shape their present experiences and, in turn, the experiences of the womxn to whom they provide a service.

3.2. Exploring the abortion experiences of health service providers

Research on womxn's own abortion experiences is growing. Healthcare providers' experiences are in contrast under-researched. Studies on abortion providers' experiences of abortion have

focused on: general experiences of providing TOP services (Mercier, Buchbinder, Bryant & Britton, 2015; Möller, Öfverstedt & Siwe, 2012; Nicholson et al., 2010; Prickles, 2013); experiences of providing 'late-term' TOP (Christensen, Christiansen & Petersson, 2013; Mauri et al., 2014) and medical TOP (Lipp & Fothergill, 2009); and clinical experiences (Mizuno, 2011, in press). This research also includes health service providers' experiences of their own abortion counselling practices (Beja & Leal, 2010; Beynon-Jones, 2015; Möller et al., 2012; Nicholson et al., 2010; Nguyen et al., 2010) which have been discussed earlier in this chapter in a section on abortion counselling research. Below, I address research which has contributed to what we know about how healthcare workers have experienced abortion service provision, as this concerns one of the central problematics of my study.

Research on health service providers' experiences of abortion provision are an important knowledge base which, when complementing what we know about womxn's experiences, can be useful in improving abortion services not only for womxn but for abortion providers as well. In identifying, for example, how abortion providers see and experience their work, steps can be taken to encourage and enable abortion providers to positively experience their work. This may, in turn, improve the experiences of womxn who access abortion services.

Möller et al. (2012) conducted research in Nepal on health service providers' experiences of providing abortion. Their analysis of 15 qualitative semi-structured interviews conducted with doctors and nurses spoke to an over-arching theme of "proud, not yet satisfied" (Möller et al., 2012, p.136). Within this theme, participants discussed abortion as important work which helps womxn in need, abortion as the right of all womxn and as necessary for womxn's empowerment, and TOP as contributing to an improvement in womxn's health through a reduction of maternal mortality rates (Möller et al., 2012). In contrast to the experiences described by Möller et al. (2012), Nicholson et al. (2010) report that among their sample of gynaecology nurses working within a public sector, ward-based TOP service in the United Kingdom, participants saw abortion services as part of gynaecology work but experienced a lot of strain, due, in part, to the psychological and emotional aspects of care that they perceive to form a significant part of their work.

Abortion providers' working conditions/environment may shape experiences of their work, with poor working conditions or a demanding working environment leading to negative work experiences. Prickles' (2013) review of South African studies reveals that in South Africa, abortion services are characterised by: a lack of human resources; inadequate provision, in

some public facilities, of suitable procedural equipment; an overburdening and fragmentation of TOP services; sporadic training that is often subject to cancellations; a lack of psychological and emotional support; and a hostile working environment which lead to problems with staff recruitment and retention. In a similar vein, health service providers in Nicholson et al.'s (2010) study reported that a high workload contributed to their feeling of strain. Mercier et al.'s (2015) research conducted in the US explored providers' experiences of providing abortion under the Woman's Right to Know (WRTK) Act which mandates a 24h waiting period before the TOP procedure as well as pre-TOP counselling with state-prescribed information. Participants in the study reported experiencing stress because of needing to determine the logistics of compliance with the Act, increased scrutiny, and fear of the consequences of non-compliance. Significantly, healthcare providers also reported that work stress also stemmed from their perceptions that mandated waiting periods and scripted information around the so-called risks of abortion and foetal development caused stress in their patients (Mercier et al., 2015). These findings by Mercier et al. (2015) point to the need for more research on experiences of pre-abortion counselling practices, as this study seeks to do.

Research by Mizuno (2011, in press) contributes to knowledge on healthcare providers' emotional experiences of providing abortion. The research explores midwives' clinical experiences of providing both child-birth and abortion services in a general hospital maternity unity in Japan. According to Mizuno (2011), participants in the study experienced guilt when having to care for the aborted foetus which some referred to as a "baby". Among participants, there was an expressed inability to care for womxn's varying needs regarding childbirth and post-abortion care as well as some confusion about how to do so. Some midwives expressed difficulty switching between emotions in order to provide emotional support to womxn terminating their pregnancy and to those giving birth (Mizuno, 2011).

Research indicates that particular kinds of involvement in abortion work may shape health service providers' experiences. Christiansen et al. (2013), Mauri et al. (2014) and Lipp and Fothergill (2009) have sought to explore how specific kinds of abortions may be experienced by abortion providers. Focusing on 'late-term' abortions, Christiansen et al. (2013) and Mauri et al. (2014) write about their participants' experiences. Christiansen et al.'s (2013) research reports on the ways midwives in Denmark acknowledged the foetus through rituals and saw the performance of these rituals as part of their roles as abortion providers. Thus, participants spoke of burials and allowing for the viewing and holding of the foetus, picture-taking and the

taking of foot- and hand-prints. Participants also reported experiencing ethical dilemmas and an over-burdening of responsibility when the aborted foetus exhibited signs of life.

In Mauri et al.'s (2014) study conducted in Italy, midwives described positive experiences, such as a manageable workload when working as a team. Participants also described how cooperation and training were a source of support for them. Echoing Christiansen et al.'s (2013) study, participants did, however, speak to their anger and frustration at having to deal with foetuses that showed signs of life, an aspect of abortion work that is specific to 'late-term' TOPs (Mauri et al., 2014). Lastly, Lipp and Fothergill (2009) developed a stress model based on a review of research conducted in the UK on abortion providers' experiences of stress when performing medical abortions. In their model, checking if the uterine contents had been completely expelled after medical abortion, having to suspend judgment when interacting with patients/clients, moral distress and the emotional labour involved in supporting womxn accessing abortion, were all identified as stressors (Lipp and Fothergill, 2009). Some of the moderators identified by Lipp and Fothergill (2009) include education/training as well as personal and professional support.

The research reviewed above on healthcare providers' experiences of providing abortion services showcases the variability of abortion care worker's experiences. Such research is important in shedding light on healthcare providers' experiences. It is also important in helping to think how healthcare providers' experiences of abortion work as stressful, burdensome or emotionally draining, or fulfilling, may shape healthcare providers' interactions with the womxn they service, and thus shape womxn's own experiences. When abortion experiences of womxn and healthcare providers are taken together, and particularly when they are studied alongside each other in a comparative approach, like this study does, the connections between the two sets of experiences are more clearly seen. This makes identifying ways to improve TOP services more generally and the PTOP healthcare interaction specifically, and in turn improve the experiences of both womxn and health service providers, an easier and necessary task.

4. Conclusion

In this chapter, the first of two dedicated to a review of the literature, two areas of abortion literature were discussed: abortion counselling and research on abortion experiences in general. I began this chapter with a section on the theoretical and empirical work around abortion counselling. As I discussed, theoretical knowledge production on abortion counselling outlines different kinds of counselling (for example, options versus pre-procedure counselling), describes informed consent and non-directiveness as two dilemmas which must navigated

during abortion counselling, and distinguishes between different approaches to counselling (feminist, pastoral and psychotherapeutic). Research on abortion counselling is limited with much of it being dedicated to womxn's experiences, and has also studied womxn's and healthcare providers' experiences separately. The difficulty of comparing results across studies notwithstanding, this body of research shows mixed results in how womxn experience abortion counselling. This points not only to that some womxn may not need abortion counselling, but also suggests that those who do require counselling may have different needs from abortion counselling, and that models of abortion counselling may differ as well as the contexts in which the counselling is conducted.

Research around experiences of abortion formed the second part of the chapter. Here I first discussed womxn's experiences seeking and accessing abortion services, womxn's emotional and physical experiences of the abortion procedure, and womxn's experiences of their interactions with abortion healthcare staff. I then moved on to discuss the limited research on healthcare providers' experiences of providing abortion services. Research studies showed that some healthcare providers found abortion provision to be instrumental in womxn's empowerment and their reproductive health, while others experience the work as stressful due to the perceived nature of the work as well as poor working conditions. Studies also showed how some providers stratify womxn's reasons for abortion along degrees of acceptability and rationality, and providers' perceptions of womxn's reasons for using abortion services influenced providers' experiences.

In the next chapter, I discuss the discursive context of abortion. My rationale for doing so is twofold. Firstly, abortion counselling may draw on discourses around womxnhood, sex, parenthood, and abortion which intersect in various ways. And secondly, womxn and healthcare providers will draw on various discourses in giving accounts of their experiences of the PTOP healthcare encounter, and possibly in making sense of abortion itself.

Chapter 4: Situating abortion in its socio-cultural context

1. Introduction

Within the current discursive conditions in which abortion is constructed and (widely) practiced, abortion is a hugely contested procedure that is linked to ideas around whether life begins at conception (Miller, 2013; Pollit, 2015), womxn's sexuality and womxn's role(s) in society. Forming part of the discursive milieu in which the PTOP healthcare encounter takes place are attitudes to abortion, discourses which normalise motherhood and construct abortion as abnormal and/or immoral and the stigma around abortion that results from these constructions. In this section, I discuss these various constructions as they have at times figured in research around womxn's reasons for abortion and have also emerged as influences that shape womxn's experiences of abortion services, including pre-abortion counselling.

2. Attitude research on abortion

Following definitions of attitudes within the field of psychology, attitudes are here understood as evaluative statements or responses about a phenomenon (Wilson, Lindsey & Schooler, 2000). In the first part of this section I review research on participants' attitudes to abortion. In the second part of this section, I discuss studies which, while not researching attitudes per se (at least not in the psychological sense), contribute to an understanding of how healthcare providers' motivations/reasons for providing services or conscientiously objecting to doing so may reflect or be indicative of attitudes to abortion.

Much of the research conducted with the aim of determining attitudes to abortion is quantitative and seeks either to measure the attitudes of specific categories of people or to compare them across various factors such as religiosity (e.g. Patel & Johns, 2009). This kind of research has mostly been conducted in contexts where abortion is legal although the grounds on which a TOP may be obtained vary in the different countries. For example, research has been conducted in the United States (e.g. Shotorbani, Zimmerman, Bell, Ward & Assefi, 2004), Zambia and Nigeria (e.g. Kavanaugh et al., 2013) and South Africa (Patel & Myeni, 2008). Studies where attitudes to abortion have been measured among participants from one social category include the following: studies conducted among university students in general (Patel & Myeni, 2008), as well as medical students specifically (Shotorbani et al., 2004; Wheeler, Zullig, Reeve, Buga & Morroni, 2012); nurses and medical practitioners (e.g. Kade, Kumar, Polis & Schaffer, 2004); and pregnant womxn (e.g. Learman et al., 2005). Comparative attitude research has

included the following: cross-cultural studies with participants from two different study settings such as Japan and the United States (e.g. Sahar & Karasawa, 2005) and Zambia and Nigeria (Kavanaugh et al., 2013).

Recent research on attitudes to abortion reveal that although anti-abortion and pro-choice are viewed as dichotomous positions, attitudes to abortion seem to be less absolute and fixed, as initially suggested, and far more dependent upon various, context-specific factors (Wilson et al., 2000). For example, research conducted in Great Britain[13] among general practitioners found doctors' age to be a factor in beliefs that British abortion legislation should be liberalised (Francome & Freeman, 2000). Thus, doctors younger than 36 and those older than 55 were more likely than those aged 36-55 to agree that British legislation should be liberalised to afford womxn the right to choose, in the first 14 weeks of pregnancy, whether to have an abortion or not. This research also found that gestation of the pregnancy largely determined doctors' attitudes concerning whether the decision to have an abortion should be the womxn's own. Thus, 46% of doctors felt that womxn should have the sole right to choose provided the pregnancy was less than 12 weeks gestation compared to 21% who felt womxn should be allowed to decide by themselves after 12 weeks (Francome & Freeman, 2000). In a similar study conducted in the US among medical students, Shotorbani et al. (2004) found that 70% of the 312 survey respondents supported the legal abortion on various grounds while the remaining participants disagreed with this, suggesting conditional support for abortion provision. Learman et al.'s (2005) study among US pregnant womxn similarly found similar attitudes to abortion. Thus, 59% of the 1080 womxn who participated supported the availability of abortion under any condition while 23% supported abortion availability only in the case of rape or incest. When asked about the circumstances under which they were willing to have an abortion, 72% said they would consider an abortion. Of these, less than 20% said they would do so if the pregnancy interrupted their schooling or career, 50% would consider it only in the first trimester and over 75% said they would have an abortion in the case of foetal anomaly (Learman et al., 2005).

Cross-cultural research on abortion attitudes also highlights the conditional acceptance of abortion. In Sahar and Karasawa's (2005) study comparing the attitudes of Japanese and

[13] Abortion legislation in Great Britain, except for Northern Ireland which has restrictive laws, is such that abortion may be obtained under several conditions. However, the process is such that a womxn requesting a TOP must consult with two doctors to access the service, unlike in South Africa where a TOP may be requested on demand during the first trimester.

American university students, participants' attitudes to abortion were measured by asking participants to rate six causes of unwanted pregnancy on importance, controllability, responsibility, blame, sympathy, anger, and judgments supporting abortion. The six causes for the pregnancy were selected on the basis of assumptions that would be made about the womxn's responsibility for the pregnancy (e.g. not wanting to use birth control versus not being able to afford birth control or pregnancy resulting from rape). The study found that among Japanese and American participants, religiosity was associated with disapproval around abortion. Among Japanese participants, 'traditional family values' influenced a position against abortion while among US participants political conservatism was associated with attitudes which blamed the womxn for her pregnancy and did not support abortion. Kavanaugh et al. (2013) conducted a study in Zambia and Nigeria on mxn and womxn's attitudes to HIV-positive womxn's reproductive decisions. In the study, participants responses to various scenarios presented in vignettes showed support for abortion only when anti-retroviral medication was unavailable with childbearing being favoured in other circumstances. The study also found that womxn in the study were more against abortion for HIV-positive womxn than were mxn, with Zambian mxn being more likely to support abortion across different circumstances.

Research conducted in South Africa has included studies assessing the attitudes of the public and research assessing the attitudes of healthcare workers specifically, with the latter being highly influential in shaping how pre-abortion counselling takes place. Regarding abortion attitudes of the public, Patel and Johns' (2009) research exploring mxle and femxle[14] undergraduate students' attitudes to abortion reported that while participants supported the availability of abortion, participants also believed abortion to be unacceptable and did not support womxn's autonomy in deciding on abortion. Research among Black female university students (Patel & Myeni, 2008) and medical students (Wheeler et al., 2012) has found that womxn's reasons for having an abortion are a significant factor in determining attitudes around the acceptability of abortion. The picture that emerges, therefore, is one in which abortion is an acceptable course of action to take in highly specific, and limited, circumstances (Patel & Myeni, 2008). These circumstances under which abortion is deemed acceptable tend to be restricted to when the womxn's health or life is in danger (Patel & Myeni, 2008; Wheeler et al., 2012), when the womxn has been raped (Patel & Myeni, 2008; Wheeler et al., 2012), in

[14] I have used the terms "mxle" and "femxle" to foreground the fluidity and social construction of 'sex'.

cases of incest (Patel & Myeni, 2008), and when there is a high chance that the foetus will suffer from adverse developmental conditions (Wheeler et al., 2012).

Research conducted specifically among healthcare providers in South Africa has revealed that attitudes to abortion are sometimes influenced by healthcare workers' own interpretations of the circumstances under which abortions should be performed (da Costa & Donald, 2003). These circumstances are restricted to 'medical' reasons for abortion which include the following: the mental health of the pregnant womxn, foetal abnormality, as well as rape and incest (da Costa & Donald, 2003). 'Non-medical' reasons for abortion were considered to fall outside of doctors' obligations (da Costa & Donald, 2003). That 'non-medical' reasons seem to attract judgmental attitudes may be strongly tied to Kelly's (2001) notion of responsibilisation (to be discussed in a later section). Thus, the injunction is to make responsible choices to prevent foreseeable risks, the consequences of which will be experienced not just by the individual but by society at large. Thus, womxn who request abortion for 'non-medical' reasons are judged as having been irresponsible and thus undeserving of abortion.

2.1. Healthcare providers' motivations/reasons for (not) providing TOP

Research into health service providers' experiences of providing termination of pregnancy services, as well as research into health service providers' attitudes to abortion suggest that the practice of unsafe abortion in South Africa and its associated morbidity and mortality is often part of health service providers' motivation for providing TOP services in the first place (Harries et al., 2009; Potgieter & Andrews, 2004). Indeed, research suggests that womxn still rely on illegal abortion providers because of a lack of knowledge of legal services, abortion stigma, and past experiences of punitive treatment by healthcare staff (Harries et al., 2009; Jewkes et al., 2005). This research demonstrates that the practice of unsafe abortion is indeed wide and thus merits significant attention. This research also further suggests that unsafe abortion may therefore play a significant role in shaping health service providers' experiences of providing abortion services, and pre-termination of pregnancy counselling more specifically.

Studies conducted abroad among healthcare workers also revealed that the acceptability of an abortion request depended on the reason being given for abortion. In Beynon-Jones' (2013) study among Scottish abortion providers, for example, avoiding motherhood was constructed as acceptable in very particular circumstances, apart from young womxn who were perceived as too young to parent. Beynon-Jones (2013) demonstrates that among her participants,

requests for abortion were acceptable and rational when: made by womxn who were just starting out their careers; womxn had financial constraints; womxn were in unstable relationships, conceived accidentally or under the influence of alcohol. Particularly interesting about the findings of Beynon-Jones' (2013) study is that requests made based on career goals and accidental conception were seen as acceptable. This is striking given the negative construction, particularly in US anti-abortion politics, of career-driven or womxn-centred motivations for abortion as "giving priority to personal aspirations over motherhood responsibilities" (Jones et al., 2008). Furthermore, given the dominance of responsibilisation and sex-for-procreation discourses which converge to construct womxn who become pregnant accidentally as having been irresponsible and subsequently as using abortion to *avoid* the responsibility of motherhood, as echoed in Larsson et al.'s (2015) study analysing abortion discourses in Ugandan daily newspapers, it is notable that abortion providers in Beynon-Jones' (2013) constructed such requests for termination of pregnancy as 'rational' and acceptable.

Health service providers' reasons for participating in abortions service provision is an under-investigated area of research. In McLemore et al.'s (2015) study with US registered nurses, moral views on abortion as well as practical and theoretical knowledge in relation to abortion provision were considered by participants when deciding whether to provide TOP services or not, with an insufficient knowledge of practical or theoretical aspects resulting in a refusal to provide services. In studies by Potgieter and Andrews (2004) and the World Health Organisation (2010), South African healthcare providers cited their own direct and indirect experiences with the consequences of unsafe abortions, and their role in contributing to womxn's empowerment by preventing deaths and enabling womxn to pursue their goals, as reasons for their involvement in TOP service provision. In addition to drawing on public health and human rights discourses, participants in the study by Potgieter and Andrews (2010) also used a socio-cultural discourse to construct abortion as commensurate with culture and religion as opposed to being *outside* of them.

Lastly, research suggests that acceptance or refusal to provide services may be an important indication of attitudes to abortion. For example, abortion service provision was found, in the US, to be affected by intention to provide TOP services after residency training (Steinauer et al., 2008). In contrast, Harris (2008) focuses on second trimester abortion provision and discusses how it is affected by the negative emotional reactions providers experience when using TOP methods such as dilation and evacuation which are experienced as violent in exposing providers to the products of termination, namely a dismembered foetus with

recognisable body parts. Furthermore, Harris (2008) notes that second trimester abortion service provision is also limited by providers' stigmatisation and social isolation in the work place as well as the inability to talk about their work with colleagues who are *not* involved in abortion.

Within research focusing on healthcare providers' attitudes to abortion service provision, one study has investigated the effect of health service providers' attitudes (Kade et al., 2004) while another explored the issue of conscientious objection specifically (Harries, Cooper, Strebel & Colvin, 2014). In Kade et al.'s (2004) study conducted in Massachusetts, USA, over a third of physicians reported having to postpone abortion services due to a shortage of nurses willing to assist physicians. Furthermore, seven out of 17 physicians reported that nursing shortages resulted in abortions being performed much later with surgical abortions (which carry greater risk) being performed when medical abortions could have been performed. Harries et al. (2014) conducted a study in public and non-governmental health facilities in Cape Town and surrounding peri-urban areas. Interviews with health care providers (doctors and nurses), health care managers and policy-makers revealed that: there was insufficient understanding of the circumstances under which conscientious objection may legally be applied, policies and procedures that would regulate conscientious objection were informal and undocumented and thus rendered ineffective, and there was wide application of conscientious objection by all members of staff in abortion facilities affecting the various stages of abortion service provision. According to Harries et al. (2014), this unregulated practice has resulted in outsourcing to the private sector to improve partially functioning facilities. It has also resulted in the fragmentation of services.

Attitudes to abortion not only influence whether healthcare providers become involved in abortion work, but can also shape how abortion services are carried out. For example, how might an attitude to abortion which views TOP as acceptable only in certain circumstances shape pre-abortion counselling practices and experiences thereof? Attitudes to abortion are in turn made possible by and within discourses around abortion and womxnhood which constitute the 'truth' on abortion. Such discourses may be drawn upon during the pre-abortion counselling. In the following section, I discuss these.

3. Constructing abortion, positioning womxn: abortion stigma

Work around abortion stigma has been useful in illuminating the discourses and attendant normative expectations that underpin and produce abortion stigma. The concept of stigma has been used in relation to abortion to conceptualise both societal reactions to abortion and the effects of these negative reactions on the experiences of womxn who use abortion services, as well as the experiences of health care workers involved in the provision of TOP (Cockrill, Upadhyay, Turan & Foster, 2013; Harris, Debbink, Martin & Hassinger, 2011; Kumar et al., 2009; Kumar, 2013). Kumar et al. (2009, p.628) use Goffman's (1963 as cited in Kumar et al., 2009) definition of stigma to develop one that conceptualises abortion stigma as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them… [by self or others] as inferior to ideals of womanhood". Thus, Kumar et al. (2009) note how, abortion stigma is closely related to and is framed by/within normative and regulatory discourses around womxnhood. These "ideals of womanhood" (Kumar et al., 2009, p.628) or normative discourses (which interlink with religious and moral discourses) link female sexuality to procreation, motherhood, and an innate nurturance of those who are vulnerable, all of which are contradicted by dominant understandings of abortion. As Braam and Hessini (2004) note, motherhood has been, and continues to be, constructed as an essential aspect of a womxn's identity and consequently as a natural process that should not be interfered with. Below, I discuss studies on abortion stigma, focusing first on womxn's experiences and then turning to those of abortion providers.

3.1. Womxn's encounters with stigma: the two-fold nature of stigma

A termination of pregnancy comes to be a transgression of normative ideals: it is understood as "the antithesis of womxn assuming their assigned role in life" (Braam & Hessini, 2004, p.47). In turn, womxn who have a termination of pregnancy are positioned as transgressors (Kumar et al., 2009): selfish (particularly by those who describe themselves as anti-abortion), sinful (Mitchell, Halpern, Kamathi & Owino, 2006), irresponsible and immoral; and finally, as "unfeminine, ungenerous and uncaring" (Gilligan, 1995, p.122).

Kumar (2013) argues for the separation of abortion stigma (described above) and stigma that is less to do with abortion *per se* and is more connected with unintended pregnancy. Her argument for doing so rests on the idea that a failure to discriminate between the two leads to an overburdening of the concept. This in turn makes abortion stigma difficult to investigate, and difficult to eradicate (Kumar, 2013). However, in practice, womxn seeking abortions may

often experience stigma towards unintended pregnancy in addition to abortion-related stigma. Thus, there is significant reason to not only separate the two as distinct forms of stigma, but also to think around the ways in which one draws on or shapes the other. Regarding the present study, stigma around unintended pregnancy and stigma around abortion may have manifested in the problematisation of both.

Levandowski et al. (2012), Shellenberg et al. (2011) and Astbury-Ward, Parry and Carnwell (2012) conducted research which is important in illuminating abortion stigma. In the studies, womxn were found to experience stigma related to their perceived deviation from normative constructions of womxnhood, as well as to their unintended or unplanned pregnancy. Thus, in Levandowski et al.'s (2012) study conducted in Malawi, various stakeholders (including policymakers, educators, healthcare providers and religious leaders) remarked that unplanned, premarital and particularly teenaged pregnancies were much stigmatised. Shellenberg et al.'s (2011) study discusses how male and female participants in Mexico, Nigeria, Pakistan and Peru spoke about the perception in their communities that womxn who undergo abortion are "prostitutes", which simultaneously draws on constructions of womxnhood and constructions of sex-for-planned-procreation. US participants in Shellenberg et al.'s (2011) study demonstrated the stigma around unintended pregnancy by positioning womxn who have had more than one abortion as irresponsible and stupid for repeatedly failing to avoid an unplanned pregnancy (Shellenberg et al., 2011). In Astbury-Ward et al.'s (2012) UK study, womxn reported stigmatisation from healthcare providers specifically. The participants expressed feeling judged as immature, irresponsible and as having loose sexual morals.

Studies on abortion stigma illuminate how womxn's experiences of stigma are also tied to being viewed as evil/sinners (Levandowski et al., 2012), baby killers (Astbury-Ward et al., 2012) and as deserving of divine punishment (Shellenberg et al., 2011). In Shellenberg et al.'s (2011) study, participants believed that a womxn's family members would also be punished for the abortion. Such positions are made possible (in part) by discourses which construct pregnancy termination as an act of killing. For example, anti-abortion, religious, foetal personhood and rights discourses may interact to give personhood to the foetus, which is referred to using words such as "unborn child", "baby" and "infant"; these terms recognise the foetus as a form of life whose sanctity must be preserved, and assert the foetus' right to life (Larsson et al., 2015; Ludlow, 2008; McCullough & Chervenak, 2008; Saurette & Gordon, 2013).

Having more than one abortion has been discussed in abortion research as associated with its own kind of stigma (e.g. Millar, Wadhera & Henshaw, 1997; Rovinsky, 1972; Rowlands, 2007; Stone & Ingham, 2011; Tietze, 1974, 1978). In research, it has been referred to as 'repeat abortion' or 'abortion culture' depending on the context in which it occurs. As I will show, however, 'repeat abortion' may be understood as a re-iteration, albeit in modified form, of 'abortion culture'. Indeed, when used to make sense of abortion and abortion counselling, both may lead to and justify coercing womxn to use contraceptive methods that are deemed socially acceptable.

'Repeat abortion', as it is discussed in research, is often problematised in what Tietze (1974, p.148) describes as a "vague and generalised anxiety" wherein any rate of 'repeat abortion' is constructed as too high. For example, both Hoggart, Phillips, Birch and Koffman (2010) and Stone and Ingham (2011) take care to mention that in discussing experiences and the characteristics of womxn who have more than one abortion respectively, they do not intend to negatively position such womxn. However, having more than one abortion is still implicitly problematised in their efforts to reduce it without much discussion as to *why* 'repeat abortion' may be problematic and should therefore be reduced. Having more than one abortion is therefore constructed as especially unacceptable, revealing the nefarious nature of the acceptability of abortion. Indeed, the phrase 'repeat abortion' is itself loaded as it seems to hark to criminology discourses around repeat offenders, who are constructed as 'worse' than first time offenders.

Womxn who have more than one abortion are positioned as having difficulty using contraception, lacking sufficient (or any) motivation to prevent 'unintended' pregnancies, and/or irresponsibly using termination of pregnancy as a form of contraception or family planning method (Stone & Ingham, 2011). Implicit in this talk around 'repeat abortion' is that womxn who have more than one abortion procedure are positioned as womxn who 'make light' of abortion (presumed to be burdensome morally, psychologically and with regard to health) by having *multiple* abortions. In other words, while womxn who obtain an abortion are constructed as a group separate from womxn who have *never* had an abortion, womxn who procure more than one abortion are seen to constitute a distinct sub-group, and are positioned as even *more* deviant than womxn who only have one abortion in their lifetime.

The problematisation of 'repeat abortion' seems to draw on an 'abortion culture' discourse. The term, 'abortion culture' first coined in reference to countries such as Cuba and former Soviet

countries such as Russia, refers to a discursive and social climate wherein abortion is normalised to the extent that it is regarded as an *acceptable* form of fertility regulation/contraception, alongside other socially acceptable methods of contraception, and is removed from the discursive realm of morality (Agadjanian, 2002; Bélanger & Flynn, 2009; Karpov & Kääriäinen, 2005). 'Abortion culture' is described as extremely permissive on the issue of abortion and as manifesting in problematically high numbers of *legal* abortion. The reliance on abortion as a form of fertility regulation is constructed as widespread, being practised across population demographics (age, socio-economic circumstances, religious belief etc). Notably, some authors (e.g. Agadjanian, 2002) problematise this lowering of abortion to the level of fertility regulation even as they acknowledge that it occurs within a reproductive culture in which abortion is recognised as a reproductive right which *enables* womxn's reproductive freedom. Furthermore, literature on 'abortion culture' often operates within/from the presumption that there are acceptable methods of contraception and that abortion is not one of them, without acknowledging that this is only one, albeit dominant, socially constructed way of viewing contraception/fertility regulation (Bélanger & Flynn, 2009).

As with discussions around 'unintended' pregnancy which take for granted the notion that 'unintended' pregnancies are problematic, problematizing having more than one abortion may slip into public health discourses in which the objective is to control womxn's, and often particular womxn's, fertility. Within public health discourses on abortion, which may tend towards 'population control' approaches, womxn may be positioned as irresponsible "producers of too many [unintended] babies" (Lane, 1994, p.1303) and thus in need of external fertility regulation. As Lane (1994) discusses, population control approaches, in locating reproductive decision-making within state health structures, tend to ignore the expressed desires and needs of individual womxn, prioritise fertility regulation over and above the reproductive rights of individuals (for example, if and when to practice sex, whether or not to use contraception, whether or not to terminate or continue pregnancies), and normalise coercive policies where womxn may be given little informed choice about whether to use contraception or which contraception to use.

Where 'repeat abortion' and/or 'abortion culture' inform understandings of pre-abortion counselling, the effect is two-fold. The first is the positioning of womxn as exploiting abortion services, irresponsible in using abortion unacceptably, and abnormal. The second is understanding the PTOP healthcare encounter as an opportunity for fertility regulation where womxn are encouraged to use (or given little to no choice about whether to use) long-acting

contraceptives such as hormonal injections, implants or the IUD. While these should be available as womxn may indeed desire these kinds of contraceptives for their convenience, when presented coercively it may amount to fertility regulation as a form of population control (Brown, 1987). Rather, womxn who express their desire for contraception post-abortion should be given a wide a range of options and be fully informed about each option.

In comparison to womxn's experiences, healthcare providers' experiences with abortion stigma have been significantly less-researched. Harris et al. (2011) study conducted among health service providers at a US stand-alone abortion clinic is an exception. The study was a pilot study aimed at exploring stigma and determining the effectiveness of a workshop intervention to alleviate healthcare providers' stigma. Like some womxn's experiences of stigma discussed in the research above, in the study, stigma, located both inside and outside the clinic, stemmed from the construction of abortion as the termination of life in which physicians and nurses involved in abortion service provision were positioned as "baby killers" (Harris et al., 2011). Because of the stigma, confiding in others about one's involvement in TOP service provision was described by participants as "coming out". Thus, stigma may dovetail around constructions of morality regarding abortion as termination of life.

The above studies suggest that stigma related to 'unintended' pregnancy may be shown up in responsibilisation discourses. Thus, while it might be useful to separate abortion stigma from stigma associated with 'unplanned' pregnancy, it is important to notice the linkages between the two stigmas in that constructions of womxnhood seem to converge around the imperative of motherhood and expectations of sex where planning for procreation is a key element. Womxn who have pre-abortion counselling may therefore experience negative positioning with regard to being perceived to contradict constructions of womxn-as-mothers *and* constructions of womxn's sexuality as being rooted in procreation. Below, I discuss how a responsibilisation discourse frames abortion and is therefore part of the discursive milieu around abortion. Such a discourse may operate in and through pre-abortion counselling.

4. Responsibilisation and abortion

Foucault's (2003) elaboration on how sexuality "is a matter for discipline and for regularisation" (Foucault, 2003, p.251) by the state offers a useful understanding of stigma that is related specifically to 'unintended' pregnancy. He suggests that sexuality is the intersection between the individual and the population. Within dominant discourses around sexuality, undisciplined sexual practices have negative consequences for both the individual and the

larger population, making such practices of interest to the state. At the level of the individual body, the consequences of unprotected sex may include sexual infections and diseases. At the level of the population, sexuality requires regularisation in the form of large-scale measures because epidemics (such as HIV/AIDS), left unchecked, result in a reduced work force which decreases economic productivity (Foucault, 2003).

Abortion is a relevant example here as it is the point around which motherhood and the expectation that pregnancies are planned intersect. A common finding in research is the idea that 'unintended' pregnancies most likely end in abortion while intended pregnancies are unlikely to (e.g. Ahmed, van Ginneken & Razzaque, 2005; Bankole et al., 2006; DaVanzo, Rahman, Ahmed & Razzaque, 2013). Some authors have even concluded that unintended pregnancy is a major cause of abortion (e.g. Bankole et al., 2006). Furthermore, unintended pregnancy is often constructed, even within research, as a problematic consequence that results from womxn's or (rarely) couples' lack of contraceptive use or their ineffective use of contraception (e.g. Ngene et al., 2013). Within normative discourses around sexuality, where pregnancies are not planned for but are continued to term, the consequences of unintended pregnancies supposedly extend to children whose development will be affected by insufficient resources or inadequate caring and attention (Morison, 2011). At a societal level, the consequences extend further to an over-burdening of the state's resources. Particularly where teenaged 'unplanned' or 'unintended' pregnancies are concerned, in normative public health discourse the consequences of unintended pregnancy also include: riskier and more complicated births which may increase maternal morbidity and mortality; the perpetuation of poverty owing to school drop outs, both of which in turn lead to a strain on the state's resources; and reduced economic productivity in the long term as negative consequences of teenaged unintended pregnancy (Ahmed et al., 2005; Macleod & Durrheim, 2003). Lastly, where termination of pregnancy is legally available, unsafe methods of termination are also framed within a public health discourse in that they result in maternal morbidity and mortality which are not only a huge cost to the individual womxn and her family, but also to the state (Ahmed et al., 2005; Puri, Ingham & Matthews, 2007).

In his paper on the government of youth, Kelly (2001) draws on Foucauldian theory to describe a process of responsibilisation in which certain populations, such as the youth, are constructed as "at risk", and encouraged to self-govern through the taking up of risk management. From this process, responsible citizens, who have a duty and obligation to the state, are produced. As Kelly (2001) describes, these subjects are encouraged to make 'responsible' choices and

decisions (for the benefit of society) and to accept responsibility for the consequences of their actions. Most importantly, subjects are required to take the measures necessary to prevent, in the first place, the risks associated with these actions. Individuals who deviate from this injunction become irresponsible subjects and citizens.

Similarly, research on abortion suggests that womxn, and not mxn, are generally expected to make responsible choices regarding their sexual conduct. Thus, womxn who do not wish to fall pregnant are held responsible by society in general, by the mxn with whom they are involved, as well as by the womxn themselves, for the use of contraceptives (Kimport et al., 2011; Larsson et al., 2015; Purcell et al., 2010; Sathiparsad, 2010; Whittaker, 2002). Among womxn who participated in a study by Kimport et al. (2011), some womxn blamed themselves for failing to use contraception or for not using it consistently enough. Womxn are also subsequently held responsible for the consequences of having fallen pregnant. Hence, questions about what to do about the pregnancy are largely left to womxn (Kimport et al., 2011; Sathiparsad, 2010) who are expected to "bear the consequences…in addition to absorbing criticism for being irresponsible and sexually careless" (Sathiparsad, 2010, p.538). This is demonstrated in research by Whittaker (2002) in which some of the womxn who participated in the study claimed that the decision around whether to terminate a pregnancy or carry it to term *should* be the womxn's responsibility as she would be the one who would give birth and subsequently assume most of the responsibility for child-rearing. Furthermore, research by Chiweshe (2016), Kimport et al. (2011) and Mavuso (2015) show that abandonment by a male partner means that sole responsibility for child-rearing must be considered when deciding what to do about a pregnancy.

From the above studies, then, responsibilisation around unintended pregnancy and abortion draw from dominant gendered discourses, and the inequitable gendered power relations they inscribe, in which both fertility regulation and child-rearing practices are womxn's responsibility. Furthermore, within these inequitable gendered relations of power, the notion of responsibilisation operates so that womxn are called upon to safe-guard against the risks and consequences of undesirable motherhood.

Some of the attitude research reviewed earlier in this section is particularly illuminating in demonstrating that a responsibilisation discourse may operate in ways other than those discussed above. As suggested earlier, individual variance in attitudes towards abortion may rely on evaluations of womxn's role in and thus responsibility for having become pregnant.

Interpreted this way, attitude research may illuminate the dominance and power of responsibilisation discourses. Hence, the termination of pregnancies of womxn judged as not being accountable for the pregnancy, such as victim-survivors of rape, are constructed as unproblematic (Patel & Myeni, 2008; Wheeler et al., 2012). Similarly, termination of pregnancies for womxn whose pregnancies are presumed to have been desired, such as pregnancies terminated for foetal anomaly or where the womxn's physical health or life is in danger (Patel & Myeni, 2008; Wheeler et al., 2012), are also perceived to be justifiable. Key here is that womxn either have an 'understandable' reason for going against normative constructions of womxnhood or are perceived to conform to (while contradicting) these expectations (by having desired the pregnancy, for example).

In the next section, I elaborate on the notion of undesirable motherhood as it operates in such a way as to make some requests for abortion more rational and acceptable than others, thus forming part of the discursive milieu through which abortion is understood both inside and outside the PTOP healthcare encounter.

5. Womxnhood and "peripheral sexualities"

In the *History of Sexuality Vol 1*, Foucault (1978) demonstrates how a discourse on sex not only produced an idea of what is normal, but also what is abnormal. Within a discourse on sex, sexual acts which potentially do not result in procreation (such those between same-sex partners or acts of masturbation) are constructed as perversions, what he termed "peripheral sexualities" (p.42). Motherhood is constructed as both natural and necessary to womxnhood (Braam & Hessini, 2004; Kumar et al., 2009). It has also become a normative expectation for womxn, what Tamale (2006) refers to as mothernormativity, and is constructed as central to the reproduction of human society (Foucault, 1978). However, not all womxn are encouraged to become pregnant and mother children. Thus, discourses around motherhood also produce the idea that certain kinds of mothering are inherently inadequate and socially undesirable owing to the negative consequences that will borne out by the children given birth to and by society at large (Macleod, 2003). Within discourses of motherhood, this kind of mothering is constructed as parenting that should be prevented, primarily through contraceptive use and secondarily through TOP if a pregnancy has already been conceived.

Womxn who are HIV positive (Orner et al., 2011), womxn deemed too young to be mothers, single mothers or womxn in unstable relationships, womxn who are struggling financially or are socio-economically disadvantaged are all womxn who are positioned as inadequate mothers

or, simply exempted from having to be a mother (Macleod, 2003).Below, I home in on young womxn and HIV positive womxn as I discuss how discourses around peripheral sexualities and inadequate mothering may shape the acceptability of abortion and thus shape abortion counselling practices. As I will show in the analysis chapters, these discourses were drawn upon in participants' accounts of their counselling experiences.

Orner et al.'s (2011) study conducted among South African womxn on HIV-positive womxn's abortion decisions show how, in South African contexts, motherhood may be normatively problematised for HIV-positive womxn. In Orner et al.'s (2011) study conducted in Cape Town (in the Western Cape province), participants spoke about how there is little societal support for pregnant womxn living with HIV because of the risk that pregnancy is expected to pose to HIV-positive womxn's health and life, but also because of the perception that the child "would inevitably be infected with HIV and as a consequence the 'sick' and likely motherless child would become somebody else's 'burden'" (Orner et al., 2011, p.785). MacCarthy, Rasanathan, Crawford-Roberts, Dourado & Gruskin's (2014) study conducted among HIV-positive womxn in Brazil found that five of the 25 participants based their contemplation of abortion as a possible solution to the pregnancy solely on their HIV-positive status, particularly around fears of vertical transmission to the foetus. For other participants, abortion was an option due to other reasons (such as socio-economic resources or inequitable gendered power relations) while other womxn had not considered abortion beyond acknowledging the immorality of abortion.

According to Ekstrand, Tyden, Darj and Larsson (2009), Hoggart (2012) and Macleod (2003), public discourses on teenage pregnancy have constructed it as a social problem associated with socio-economic disadvantage (for both the young mother and her child), low levels of education and little prospects for employment, and as an individual problem associated with adverse psychological and health outcomes. Furthermore, negative constructions of teenage mothering, which is often seen as synonymous with single-parenting, include ideas around it being seen as not just socially and personally harmful, but as inherently inadequate and even irresponsible as well (Macleod, 2003). As Macleod (2003) argues, this problematisation of teenaged or young motherhood is premised on the understanding that, in becoming pregnant, she has contravened norms regarding the appropriate age at which to bear children (once married); she thus straddles a divide: her (sexual) actions are those associated with being an adult and yet her age marks her as a child. As Hoggart (2012) discusses, although abortion is stigmatised, this framing of teenage pregnancy as problematic and harmful at multiple levels – at the level of the individual womxn, her offspring should she continue with the pregnancy,

and society at large - *should* mean that a termination of pregnancy is regarded or constructed as an acceptable course of action for teenaged womxn. Instead, as Macleod (2011) notes, young womxn who terminate their pregnancies are seen as deviant in two ways: firstly, by becoming pregnant in the first place, and secondly by terminating the pregnancy.

Important research by Beynon-Jones (2013) on Scottish abortion providers' counselling practices echoes the literature pointing to different expectations of young womxn in relation to motherhood. In her study, Beynon-Jones (2013) interviewed general practitioners, obstetrician-gynaecologists and gynaecology nurses providing abortion services in the National Health Service (public or state-funded) hospital setting in Scotland. In speaking about their pre-abortion counselling practices, participants stratified reproduction according to age, class and parity (number of children) with the effect of constructing a request for TOP as 'acceptable' and 'rational', or 'problematic' and 'irrational' depending on the womxn's age, class or parity. Where abortion was requested by young womxn aged 12 and 13, participants in Beynon-Jones's (2013) study spoke about the obvious need for abortion services while requests from older womxn were deemed problematic and thus requiring justification, due to the normalisation of motherhood for older womxn and the problematisation of motherhood for younger womxn. In terms of parity, for some participants abortion requests from womxn who already had a child or children were deemed acceptable compared to requests made "in the absence of existing children" (Beynon-Jones, 2013, p.516). Lastly, stratification by class worked to normalise motherhood for middle-class womxn whose abortion requests were problematised because the womxn had access to the socio-economic resources needed for pregnancy and child-rearing. In contrast, abortion requests from womxn without access to these resources were deemed acceptable and rational (Beynon-Jones, 2013).

In the next section, I discuss media representation on abortion as forming part of the 'truths' around abortion of which participants in the present study are likely to be aware.

6. Media coverage on abortion

Media coverage on abortion constitutes part of the discursive milieu in which abortion is actively and publicly constructed (Macleod & Feltham-King, 2012), and therefore forms part of the larger discursive context, accessed by both abortion care workers and womxn accessing abortion, in which pre-abortion counselling takes place.

While research on abortion incidence may be useful and important, Purcell et al. (2010) call attention to the ways in which newspaper reporting on abortion incidence figures may

contribute to the perpetuation of abortion stigma. That is, the way in which figures for the incidence of abortion are reported may imply that current figures are high and thus deviate from what normal incidence levels *should* be: *low* (Purcell, 2010). When this is done without explanation, such reporting (seen in research studies as well, see Kalyanwala et al. (2012)) may imply that abortion incidence figures *should* be reduced for their own sake, that is, that abortion *per se* is objectionable, rather than the structural, social and power relations that often underpin abortion decisions, practices and experiences thereof. This can be seen, for example, in some of the research investigating the factors associated with termination of pregnancy where unqualified statements about the need to reduce abortion are sometimes made (see discussion below). Such language can also be seen regarding 'unintended' pregnancy which (seen to be interlinked with abortion, as discussed above) where levels of 'unintended pregnancy' are presented as abnormally high and thus objectionable in and of themselves (see Izugbara, Egesa and Okelo (2015) for an example): in other words, divorced from the structural, social and power relations that might (and not necessarily) *make* an 'unintended' pregnancy problematic.

Larsson et al.'s (2015) analysis of Uganda's two main daily newspapers and Purcell et al.'s (2010) study of British and Scottish newspapers both noted the pervasiveness of moralising discourses in which abortion was associated with womxn's irresponsibility. They also note how mxn's responsibility was not problematised in these texts.

In Purcell et al.'s (2010) analysis of British and Scottish national daily newspapers, womxn who obtained abortions were frequently constructed as "a distinct group, somehow different to normal womxn" (p.1147) who do not terminate their pregnancies. Within most of the 91 articles analysed, childlessness was portrayed as a significant punitive cost associated with terminating a pregnancy, thereby drawing on and reinforcing motherhood as essential to womxn's sense of self and fulfilment.

South African newspaper reporting on abortion is particularly indicative of the discursive context in which abortion, and thus abortion services and the womxn who use them, are understood in the South African context. Macleod and Feltham-King's (2012) study analyses South African newspaper coverage on abortion from 1975 (the era of restrictive legislation on abortion) to 2005 (post legislative reform). They focus specifically on how womxn who access abortion services are referred to and positioned, and how abortion is constructed. In their analysis, the authors discuss how severe restrictions on abortion tended to be argued for when abortion was constructed as immoral/murder and womxn accessing abortion services were

positioned as 'girls' and therefore immature, irrational and incapable of making reproductive decisions, that have long-term consequences (Macleod & Feltham-King, 2012). Contrastingly, constructing abortion as both a harmless act and as an (appropriate) solution to unintended pregnancy, tended to coincide with arguments for the liberalisation of abortion legislation (Macleod & Feltham-King, 2012).

7. Psychological consequences of abortion

Expectations around the psychological consequences of abortion have been used to argue for abortion counselling (see earlier discussion on literature around abortion counselling). They may also, however, inform healthcare providers' understandings of abortion itself, as well as the womxn to whom they provide pre-abortion counselling. These expectations, that abortion has negative psychological consequences, may not only be used as a discursive resource by healthcare providers during pre-abortion counselling sessions, but may also shape healthcare providers' experiences of womxn's conduct in the waiting room and their own experiences of the counselling that follows waiting room interactions. Thus, a discussion on the research that has been conducted on this subject is necessary. As I will show, although expectations of negative psychological consequences post-abortion persist, research conducted on the subject suggests that womxn's responses post-abortion are a lot more variable than is represented within normative expectations.

Information (although contested) on the negative mental health outcomes and of womxn's negative emotional responses following termination of pregnancy often form part of abortion counselling owing to the argument that womxn need access to this information to make informed decisions around whether to terminate a pregnancy or not (Joffe, 2013; Woodcock, 2011). Thus, information on the supposed consequences of abortion is constructed as a risk of having abortion.

In the present study, within both womxn's and healthcare providers' accounts of their experiences of pre-abortion counselling, reference was made to psychological trauma, framed as a risk of having an abortion. As I will show in this section, from the research conducted in this area we now know that womxn's mental health outcomes post-abortion are highly variable. This variability calls into question the purpose of including one-sided and contested information about womxn's *negative* mental health outcomes and emotional responses. Furthermore, given that such information may itself be emotionally difficult for womxn to hear,

as was some womxn's experience in the present study, the implications for womxn in hearing this information, also become significant and are worth serious consideration.

The contention that abortion leads to or causes negative emotional responses and mental health outcomes has in the US "been used to forward parental consent, mandatory ultrasound viewing, and waiting period legislation as well" (Rocca et al., 2015, p.2) as to restrict access to termination of pregnancy services under the veil of protecting womxn from harm. Although the notion that abortion is an event that carries a significant to high risk of mental health problems is a prevalent one, reviews by Charles, Polis, Sridhara & Blum (2008) and Major et al. (2009) suggest that this picture may not be entirely representative of womxn's experiences due the general lack of methodological rigour in the studies reviewed by the authors. Among the methodological problems identified by the authors were: inappropriate comparisons of groups which presumably (but not necessarily) differ in terms of the wantedness of the pregnancy (such as womxn who were never pregnant, womxn who had carried to term and womxn who had miscarried); not controlling for co-occurring risk factors that might have more to do with the pregnancy itself than the abortion; not controlling for pre-existing mental health status; the use of poor measures of mental health; and relying on retrospective, self-reporting data collection methods (Charles et al., 2008; Major et al., 2009). Nonetheless, the psychological consequences of abortion are an extensively researched issue in the field of abortion research (Coleman, Reardon, Strahan & Cougle, 2005; Macleod et al., accepted).

Studies investigating the emotional or psychological consequences of abortion have been conducted in various countries such as the United States of America (Adler, Ozer & Tschann, 2003; Ely et al., 2010; Kimport, Foster & Weitz, 2011; Quinton, Major & Richards, 2001; Rocca et al., 2015; Russo & Denious, 2001), Portugal (Canário et al., 2011; Nazaré, Fonseca & Canavarro, 2012, 2013), France (Rousset, Brulfert, Séjourné, Goutaudier & Chabrol, 2011), New Zealand (Fergusson, Horwood & Ridder, 2006), the United Kingdom (Dykes, Slade & Haywood, 2011; Goodwin & Ogden, 2007), the Netherlands (van Emmerik, Kamphius & Emmelkamp, 2008), Germany (Kersting et al., 2009) and South Africa (Boulind & Edwards, 2008; Faure & Loxton, 2003; Mojapelo-Batka & Schoeman, 2003). These are all countries where termination of pregnancy is legal but under varying conditions[15].

[15] In all the countries listed here TOP is legal in the first trimester of pregnancy. In France, Portugal, the Netherlands, the UK (excluding Northern Ireland) and the US, abortion is available on various ground during this period. Thereafter and until 20 weeks gestation it is performed on grounds of physical and mental health, pregnancy resulting from rape or incest, and foetal malformation (Angloinfo.com, n.d.; Center for

Research in this area tends to be quantitative (e.g. Canário et al., 2011; Ely et al., 2010; Faure & Loxton, 2003; Fergusson et al., 2006; Kersting et al., 2009; Nazaré et al., 2012, 2013; Quinton et al., 2001; Rousset et al., 2011; Russo & Denious, 2001; van Emmerik et al., 2008) and to investigate long-term (from two weeks post-abortion onwards) psychological outcomes following TOP (e.g. Canário et al., 2011; Fergusson et al., 2006; Kersting et al., 2009; Nazaré et al., 2012, 2013; Quinton et al., 2001; Rousset et al., 2011). Studies also investigate mental health outcomes for foetal anomaly specifically (e.g. Kersting et al., 2009; Nazaré et al., 2012, 2013) as well as adolescent mental health outcomes of and emotional responses to abortion (e.g. Coleman, 2006; Ely et al., 2010; Mojapelo-Batka & Schoeman,2003; Quinton et al., 2001). Quantitative studies included in this literature review had sample sizes ranging from 43 to 2525 while the range for qualitative studies was seven to 21 participants.

Undergoing a termination of pregnancy was found to be associated with an increase in a risk of mental health problems by Fergusson et al. (2006). In some studies, participants were found to have moderate to high levels of anxiety and depression (Ely et al., 2010; Faure & Loxton, 2003; Kersting et al., 2009; Rousset et al., 2011), re-experiencing and avoidance (van Emmerik et al., 2008), post-traumatic stress disorder (Kersting et al.,2009; Rousset et al., 2011) and emotional disorder (Canario et al., 2011) immediately following abortion. Three weeks to 14 months after pregnancy termination, 7-19.4% of participants still had elevated levels of mental health problems (Faure & Loxton, 2003; Kersting et al., 2009; van Emmerik, 2008). Rousset et al. (2011) reported that at six weeks, 39% of participants had acute stress scores above 35, which they argue indicates the presence of Post-Traumatic Stress Disorder. For most of the studies which showed negative psychological consequences post-abortion, the mental health problems that were identified decreased significantly for most participants (Boulind & Edwards, 2008; Canario et al., 2011; Faure & Loxton, 2003; Kersting et al., 2009; Rousset et al.,2011; van Emmerik, 2008).

Negative emotions that have been conceptually linked to psychological ill-health post-abortion include: feelings of regret; sadness; guilt, shame and embarrassment; as well as loss and grief.

Reproductive Rights, 2016; Guttmacher Institute, 2016). Some states in the US do not offer abortion services beyond the first trimester (Rocca et al., 2015). In Germany abortion is permitted until 14 weeks once a doctor establishes a risk to the womxn's health posed by the pregnancy or if the pregnancy results from rape or incest. It is performed thereafter until 23 weeks if the womxn is under distress (Diepler, 2012). New Zealand abortion legislation permits abortion up to 20 weeks in cases of foetal impairment, pregnancy resulting from incest and where pregnancy poses a risk to the womxn's health (New Zealand Family Planning, 2016). Waiting or reflection periods are mandated in some US states, as well as in France and the Netherlands (Angloinfo.com, n.d.; Guttmacher Institute, 2016; Ministry of Foreign Affairs, 2011).

These have been reported by participants in various studies (Boulind & Edwards, 2008; Dykes et al., 2011; Goodwin & Ogden, 2007; Mojapelo-Batka & Schoeman, 2003; Nazaré et al., 2012, 2013). In some of these studies, negative emotions have been found to have persisted up to five years post-termination for some womxn (Goodwin & Ogden, 2007) while other womxn have reported that these feelings have given way to acceptance, resolution and adjustment (Boulind & Edwards, 2008; Dykes et al., 2011; Goodwin & Ogden, 2007; Mojapelo-Batka & Schoeman, 2003; Rocca et al., 2015). For some womxn, avoidance of negative emotions in order to carry on with life may later lead to a negative reappraisal of their abortion experience (Goodwin & Ogden, 2007).

Womxn have also described positive abortion experiences. For example, in a qualitative study by Dykes et al. (2011) investigating long-term perceptions of abortion, some womxn discussed their abortion as having led to personal growth and happiness. In two other qualitative studies womxn have also reported the absence of negative emotions altogether, immediately following the procedure as well as some time after (Goodwin & Ogden, 2007; Mojapelo-Batka & Schoeman, 2003).

In their systematic reviews, Charles et al. (2008) and Major et al. (2009) argue that the experience of negative emotions and/or mental health outcomes following a termination of pregnancy may be contextually-based. Hence the authors argue that study findings suggest that: a) womxn may experience negative and/or positive emotional responses following abortion and that this may depend on a variety of factors or variables; b) where they occur, negative emotional responses may not be necessarily pathological; c) mental health problems such as depression, anxiety, and post-traumatic stress disorder tend to decrease over time and that persistent mental health problems are experienced by a minority of womxn; d) a history of mental health problems may itself make some womxn more likely than others to develop mental health problems following an abortion and may thus be an important variable which needs to be controlled for; and e) mental health problems experienced by womxn following abortion are not greater than the mental health problems womxn may experience anyway (Charles et al., 2008; Major et al., 2009).

Recognising the nuances and complexity in the question of whether womxn experience emotional difficulty and/or develop mental health problems post-abortion, qualitative and quantitative research has sought to explore and explain why some womxn and not others have an emotionally trying abortion experience or have negative mental health outcomes. For

example, in research by Kimport et al. (2011) womxn who felt the decision was made by someone else, even when they felt that on their own they would have reached the same decision, reported negative outcomes post-abortion. Womxn whose pregnancies were planned and womxn who had difficulty deciding on abortion were found to be more likely to experience negative emotions and be less satisfied with their decision to terminate the pregnancy (Rocca et al., 2015). In addition, self-blame (Nazaré et al., 2013), a history of experiencing physical and sexual violence (Russo & Denious, 2001), keeping abortion a secret owing to expectations of judgment and/or a lack of support (Boulind & Edwards, 2008; Mojapelo-Batka & Schoeman, 2003) including perceived parental conflict (Quinton et al., 2001), and constructing the foetus as a "child" or "baby" (Goodwin & Ogden, 2007; Mojapelo-Batka & Schoeman, 2003) tended to be reported by womxn who experienced emotional difficulty or negative mental health outcomes. Positive emotional and mental health outcomes were reported by womxn who also reported acceptance of the decision to terminate, (Nazaré et al., 2013), high quality of the couple relationship (Canário et al., 2011; Nazaré et al., 2012, 2013), social support (Canário et al., 2011; Goodwin & Ogden, 2007; Kimport et al., 2011), being in school and/or working at the time of the pregnancy (Rocca et al., 2015), and by womxn who constructed the foetus using terms such as "blood clot", "menstrual blood", "thing" (Mojapelo-Batka & Schoeman, 2003), or "white dot" and "it" (Goodwin & Ogden, 2007).

Research on the psychological consequences of abortion "illustrates variability both in terms of the initial emotional reactions to an abortion and how these reactions change over time" (Goodwin & Ogden, 2007, p.233). Such research is valuable in establishing support mechanisms for womxn who do experience negative emotional responses and develop negative mental health outcomes. It is also an invaluable tool in increasing access to abortion services, particularly where the restriction of access is argued on grounds that abortion is harmful to womxn. The above research demonstrates the nuance and complexity with which research investigating emotional responses and mental health outcomes following termination of pregnancy must be approached and understood. Worth highlighting, also, is how discourses around abortion and foetal personhood may shape womxn's experiences of emotional difficulty or the absence thereof during the PTOP healthcare interaction and after. Thus, such research provides a necessary context for the analysis chapters that will follow later in this document.

In the following section, I discuss research that has been conducted on abortion decision-making. I do so with the view that a) abortion decision-making is often assumed to take place during abortion counselling, necessitating not only the counselling itself, but also particular

kinds of information provision (around the 'options' available to womxn, for example), b) healthcare providers' understandings of womxn's decision-making around abortion (including abortion service providers' understandings of why womxn request abortions) in turn shape what they understand the purpose of the counselling to be, how this purpose is best achieved or carried out and their experience of the PTOP healthcare encounter generally, and c) womxn's own decision-making around abortion may lead them to experience the PTOP healthcare encounter in particular ways.

8. Abortion decision-making

Few studies on abortion decision-making have explored health service providers' reasons for deciding to provide or participate in the provision of termination of pregnancy services (McLemore et al., 2015; Potgieter & Andrews, 2004; WHO, 2010). Most research tends to explore reasons for abortion providers' involvement in abortion work from the perspective of attitudes (discussed earlier in this chapter) as opposed to *decision-making* per se. Thus, abortion decision-making research has largely become synonymous with a focus on womxn.

Literature on abortion counselling suggests that one of the main activities of abortion counselling should be the abortion care provider's discussion with the womxn about the decision to have an abortion. Research around abortion decision-making primarily coalesce around two main areas of focus. In the first area of focus discussed here, research investigates abortion decision-making by exploring womxn's reasons for having an abortion. The second area of focus examines the influence of significant others' (perceived) views and preferences in womxn's decision-making processes. Such research explores power relations in the abortion decision-making process. Research in this area explores the dynamics of decision-making by investigating whether womxn requesting abortion have themselves made the decision or to what extent the decision has been influenced, if not made, by significant others.

8.1. Reasons given for abortion

Research around the decision to have an abortion has demonstrated that reasons for abortion are varying and sometimes multiple. As such, one womxn's reasons for having an abortion may differ from another womxn's, and individual womxn may have more than one reason for having an abortion (Biggs, Gould & Foster, 2013). Kirkman, Rowe, Hardiman, Mallett and Rosenthal (2009) conducted a review of empirical studies which sought to determine reasons for abortion. Most of the studies in the review were conducted in Sweden followed by the US

and then Greece. From the review, the authors found that womxn's reasons for abortion could be categorised as follows: other-focused reasons (where the womxn considered the impact on significant others such as the partner, family members, existing children and so on); womxn-centred reasons (such as wanting to pursue/continue education and employment, as well as health reasons); and material reasons (such as housing and employment/financial concerns). Kirkman et al. (2009) emphasise that in the studies they reviewed, womxn's reasons for abortion were multiple and could be from more than one category. Thus, a womxn could decide to have abortion because continuing the pregnancy would put a strain of the financial and basic resources available for existing children, would adversely affect her health and would disrupt her employment or education.

Research around abortion which focuses on exploring the reasons that occasion a request for an abortion is important. Particularly important are the kinds of qualitative research that allow womxn to generate their own reasons: firstly, because such research is able to "explore the meaning of the diversity of sexual practices for those who practice them" (Sawicki, 1986, p.35), and, secondly, because of the ability of such research to dispel certain myths or challenge dominant constructions of abortion, for example the belief that only young, unmarried, childless womxn end their pregnancies in abortion (Jones et al., 2008). Some of this qualitative research is discussed below.

Studies on womxn's abortion decision-making suggest that the advantages or positive outcomes of abortion for womxn's lives are numerous. Indeed, womxn often place themselves, that is their own desires, goals, aspirations and health, at the centre of their reasoning. The research also shows, however, that these desires, goals, aspirations and even their concerns for their health may be shaped by discourses on appropriate child-bearing/-rearing and thus motherhood. Womxn have expressed being satisfied with the number of existing children, not wanting anymore children or not wanting a child at all (Biggs et al., 2013; Gibson & Hindin, 2008; Kirkman et al., 2009; MacCarthy, Rasanathan et al., 2014; Mavuso, 2015; Rabindranathan, 2003). Research has also shown that, from womxn's point of view, abortion enables womxn to pursue career or study opportunities and be independent and self-sustaining (Biggs et al., 2013; Kirkman et al., 2009; Madiba & Nekhumbe, 2014; Rabindranathan, 2003; Vallely et al., 2010), and to remove themselves from or avoid being locked into inequitable gendered power relations (Chiweshe, 2016; Mavuso, 2015) which may also be violent (Purcell, 2015; Vallely, 2010). Such research has shown that abortion particularly enables the economic independence of young, school-going womxn who may find themselves removed from, or may

have to discontinue, school if the pregnancy is carried to term (Leshabari, Mpangile, Kaaya & Kihwele, 1994). Womxn have also decided on abortion because of: feelings of not being ready for motherhood or being a mother to another child (Hoggart, 2012; Mavuso, 2015); feeling too young or too old to parent a child, both of which carry stigma (Alex & Hammarström, 2004; Gibson & Hindin, 2008; Hoggart, 2012; Leshabari et al., 1994; Madiba & Nekhumbe, 2014; Mavuso, 2015; Rabindranathan, 2003); and needing to consider the state of their own health and the effect that the pregnancy would have on this (Gibson & Hindin, 2008; Jones et al., 2008; Rabindranathan, 2003), a fear experienced by some womxn who are HIV positive (Orner et al., 2011).

When reasons for abortion centre on the needs, preferences or desires of others, womxn most commonly focus on how the existing child/children or potential child will be affected. The concern here is around feeling unable to provide a quality of life for the existing and/or the potential child. This quality of life may be compromised by: the introduction of another child while the existing child/children is/are still quite young and in need of care and attention (Jones et al., 2008; Mavuso, 2015; Rabindranathan, 2003); financial constraints or difficulties (Alex & Hammarström, 2004; Biggs et al., 2013; Jones et al., 2008; Kirkman et al., 2009; MacCarthy et al., 2014; Madiba & Nekhumbe, 2014; Mavuso, 2015; Rabindranathan, 2003); foetal anomaly which may result in a shortened life span or protracted health difficulties for the potential child (Kerns et al., 2012); and ill health as a result of and/or the life-long stigma associated with HIV transmission from the womxn to her potential child, despite ARV medication's improved efficacy in preventing mother-to-child transmission (Orner et al., 2011; MacCarthy et al., 2014; Mavuso, 2015). Womxn have also needed to consider: the male partner's preference for a termination of pregnancy or his refusal to support or take responsibility for the pregnancy and the potential child (MacCarthy et al., 2014; Madiba & Nekhumbe, 2014; Purcell, 2015; Vallely, 2010); and the possibility of parental conflict or the negative reactions of parents in response to the pregnancy (Madiba & Nekhumbe, 2014; Mavuso, 2015).

Research looking at womxn's decision-making has also looked at womxn's motivations for selecting a particular method of termination of pregnancy (medical or surgical) (Kerns et al., 2012; MacQuarrie & Edmeades, 2015). MacQuarrie and Edmeades (2015) reported that participants in their study conducted in Madhya Pradesh, India, selected a surgical abortion procedure when both they and their partners agreed to terminate the pregnancy. Where there was disagreement, womxn would attempt to terminate the pregnancy using unsafe methods as

medical abortion was unavailable at the time of data collection. Kerns et al. (2012) conducted research among American womxn who were terminating their pregnancies due to foetal anomaly. Kerns et al. (2012) found that participants' religious beliefs, attitudes to abortion and coping style influenced their choice of TOP method. Participants who chose to have a medical abortion viewed the surgical dilation and evacuation method as abortion proper and therefore unacceptable for religious and moral reasons while medical abortion was viewed as more akin to labour. Those who selected medical abortion felt that the opportunity to establish contact with the foetus would help with managing grief while those who sought surgical abortion chose it as a self-protective measure to control their experience of loss.

8.2. The abortion decision-making process

Research which approaches abortion decision-making as a process, that is, as involving a series of actions or steps which culminate in the decision to terminate a pregnancy, is limited. Where decision-making is approached in this way, and is not merely equated with the decision itself, it has been conceptualised in different ways. For example, Kebede, Hilden and Middlethon (2012) explored decision-making as an intra-subjective process. In the study, participants, who were young, unmarried Ethiopian womxn living in Addis Ababa and were recruited while receiving treatment for abortion-related complications, constructed narratives in which they morally examined both their situation and available options. In reconstructing the decision-making process, participants drew on the 'tale of the hearts' resource in which decision-making involves 3 subjects: the two hearts who must each present their case for a particular course of action (continuation or termination of the pregnancy) and a moral arbiter who listens to both cases and decides on the best course of action.

Contrastingly, in research conducted in Zimbabwe and South Africa by Chiweshe (2016) and Mavuso (2015) respectively, decision-making was conceptualised as an inherently social process of negotiation involving significant others, whether others were told of the pregnancy and were subsequently involved in the decision-making process. Thus, even among participants who were alone in the decision-making process, negotiation was still required as participants narrated how they navigated their expectations of how significant others would respond as well as normative expectations of conjugalised reproduction and a heterosexual parenting dyad. Participants' decision-making processes were also shaped by structural realities, such as economic difficulties, and generational and gendered power relations which enabled or closed down choice in abortion decision-making (Chiweshe, 2016; Mavuso, 2015).

Research conducted based on the premise that the decision to have an abortion is the product of a dynamic process of interaction between a womxn and others has specifically looked at the question of who gets to make the decision (Whittaker, 2002, Ekstrand, Tydén, Darj & Larsson, 2009). Beyond the womxn's partner, it is important to note that others involved in the decision-making process may refer to significant people in the womxn's life: reproductive health service providers (for example during the pre-abortion counselling session, particularly where womxn are unsure about what to do concerning their pregnancy); as well as the womxn's larger community in which discourses around abortion and sexuality are produced.

Research has also explored the decision-making process as one that occurs between the womxn and her partner, and in doing so has called attention to the power dynamics inherent in this process. Thus, Hardacre (1997, p.103 as cited in Whittaker, 2002, p.15) states the following: "The decision to abort may be a joint decision, but this is by no means always the case. Abortion can be withheld or coerced, it can be undertaken with positive purpose and relief, or with fear and reluctance". This has been explored in various studies which have shown that where womxn desire to continue the pregnancy, abandonment by a male partner on whom the womxn is economically dependent results in abortion being the only option or womxn feeling coerced into deciding to terminate the pregnancy (Madiba & Nekhumbe, 2014; Mavuso, 2015). Some of this research which has highlighted how unstable and inequitable gender relations may shape and constrain the decision-making process, demonstrates that such power relations may be implicated in the circumstances of the pregnancy itself where an undesired pregnancy resulted from womxn being coerced or pressurised into unprotected sex (Mavuso, 2015).

Kumi-Kyereme, Gbagbo and Amo-Adjei's (2014) research conducted in Ghana and MacQuarrie and Edmeades' (2015) study conducted in India demonstrate how womxn's abortion decision-making may also be influenced, although to a lesser extent, by others in their social networks, such as the pregnant womxn's mother, siblings, friends, employer, and extended family such as aunts, uncles, and in-laws. In Kumi-Kyereme et al.'s (2014) mixed methods study, of the 401 womxn who participated, 131 did not consult with anyone before making the decision to have an abortion, while 218 womxn sought their partner's approval, 33 womxn consulted with their mother and the remaining 19 made the abortion decision with friends, siblings, aunts/uncles, employers and mothers-in-law. MacQuarrie and Edmeades (2015) found, from their analysis of a 2002 probability-based survey conducted among a representative sample of 2444 married womxn, that while husbands' fertility preferences had a

strong and independent effect on the decision to have an abortion and the fertility preferences of in-laws was found to be weaker, womxn's own fertility preferences had the strongest effect.

8.2.1. Adolescent/young womxn's decision-making on abortion

Studies investigating adolescent decision-making in relation to abortion mostly revolve around the question of whether minors can make decisions, independently, regarding pregnancy. Indeed, dominant discourses construct adolescent/young womxn as incapable of making mature, responsible decisions about their reproductive lives. In terms of abortion legislation, countries' abortion laws differ in recognising and granting minors the right to autonomous decision-making. Parental notification and consent laws in the US and in parts of Europe rest on the assumption that minors require guidance to make informed decisions and that such guidance can only come from consulting with parents/guardians. This ignores research that shows that minors do sometimes terminate their pregnancy knowing how their parents will respond to the pregnancy but without involving parents in the decision-making process (Ekstrand et al., 2009; Leshabari et al., 1994; Mavuso, 2015). Notably, the CTOP Act recognises the rights of minors to decide, without parental guidance or consent, around whether to continue with a pregnancy. This is in step with the findings of some of the research being conducted around adolescent/young womxn's decision-making on abortion.

The contention that "young womxn are particularly susceptible to their decision being influenced by adults with whom they may be in a relationship of power" (Brady et al., 2008 as cited in Hoggart, 2012, p.537), a contention which fuels much of the research on adolescents' abortion decision-making, may mask that it is power relations and economic dependence, and not age or maturity *per se*, that enables or hinders womxn from making reproductive decisions in line with their own wishes. Indeed, knowledge that minors need assistance in making decisions around abortion is shown up (in the studies discussed below) as *discourse*, a particular construction of adolescence. Thus, various studies have shown that adolescents/young womxn are in fact capable of making mature decisions without parental assistance or involvement.

Several reviews of research around adolescent decision-making on abortion have been conducted. For example, Adler et al.'s (2003) review of studies conducted in the US (where some states require parental consent) around adolescent decision-making on abortion disputes the notion that adolescent decision-making is typically inadequate to the task of deciding what to do about a pregnancy. Adler et al.'s (2003) research suggests that adolescents who are deciding what to do about a pregnancy and are considering abortion tend to display higher

levels of competency in their decision-making compared to pregnant adolescents who are *not* considering abortion at all. Furthermore, across studies, adolescents' decision-making on abortion was largely seen to mirror that of their adult counterparts. Systematic reviews by Ambuel (1995), and Steinberg, Cauffman, Woolard, Graham and Banich (2009) found that not only have studies demonstrated that minors' decision-making capacity is comparable to adults aged 18 to 25 but that judges hearing minors' requests to bypass US parental notification and consent laws have consistently found minors to be capable of independently making the decision to continue with or terminate a pregnancy.

Research has also shown differences between young womxn who involve their parents in the decision-making process and those who do not. When comparing young womxn who do involve their parent(s)/guardian(s) in the decision-making process and those who do not, the latter tend to test higher on scores assessing maturity and competence levels (Butler & Bailey, 2008). They are also more likely to: live independently; have children of their own; have experienced family sexual violence; fear violent parental reactions; or suspect that they will be coerced towards a particular outcome and thus may not benefit from parental involvement (Ambuel, 1995).

The research reviewed above on womxn's cited reasons for deciding on abortion, the decision-making process as a dynamic intra-/interactional one, and young womxn's decision-making in particular, is important as it shows the variable contexts in which womxn's requests for an abortion take place. It also disputes often-held assumptions about womxn's decision-making: for example, that abortion decision-making may simply be reduced to womxn's 'irresponsibility', and adolescents and young womxn need adult/parental assistance to make decisions about their pregnancy or should simply be prevented from accessing abortion services. How healthcare providers understand (young) womxn's decision-making has important implications for how abortion counselling occurs as well as healthcare providers' and womxn's experiences of the PTOP healthcare interaction.

9. Conclusion

Even when abortion is legal and is governed by liberal abortion laws (as is currently the case in South Africa), dominant constructions of abortion, and the ways in which womxn are positioned within them, may operate in and through pre-abortion counselling with significant effects for how pre-abortion counselling is experienced by both womxn and healthcare

providers. For example, when abortion is constructed as immoral/murder, or an (in)appropriate solution to unintended pregnancy, how is pre-abortion counselling understood by healthcare providers? And how might their role in pre-abortion counselling be understood in turn? What counselling practices are then taken-up to achieve the goals of abortion counselling? Womxn's and healthcare providers' experiences of the counselling will inevitably be shaped by these considerations.

To the extent that knowledge that is produced empirically carries with it a stamp of scientific authority, the findings of research studies may circulate within health facilities, informing, if not shaping, abortion providers' work, pre-abortion counselling for example, and their experiences thereof in particular ways. For example, knowledge production on abortion decision-making, and (negative) psychological consequences of abortion may have implications for how counselling should proceed (whether womxn need to be guided through their decision-making during the counselling and whether counselling should be about informing womxn of the risk of psychological trauma) and for how abortion is understood (as benign or harmful to womxn).

Research that is bifocal in exploring both womxn's and health service providers' experiences of abortion counselling is lacking and is especially necessary. This is notwithstanding Prickles' (2013) systematic review of South African research around abortion experiences. In the review (discussed above) an attempt is made to coalesce these research areas which, when investigated, have thus far been explored separately. Certainly, South African research on womxn's and health service providers' experiences of abortion counselling is necessary given the structural problems[16] outlined in Prickles' (2013) review, the fears around directive counselling (see Vincent, 2011) and what is currently known about womxn's abortion experiences in South Africa (see earlier discussions above). Research that explores pre-abortion counselling experiences as they are *told* by womxn accessing abortion and health service providers, and does so from a feminist post-structural point of view, may say something invaluable about how womxn and health service providers make sense of abortion, pre-abortion counselling and the relations of power that run through the events that encompass the PTOP healthcare interaction and shape the experiences thereof. Such research may also then enable serious thinking around the implications of specific abortion counselling practices (at least as

[16] Prickles (2013) discusses a lack of privacy in public healthcare facilities and overburdened functioning facilities which result in rushed care being delivered to womxn seeking abortion services as some of the structural problems which face the public health system.

they are narratively experienced) for abortion counselling service provision, and make important recommendations on how to improve the services both for those who access them and those who provide them.

Chapter 5: Data Collection and Analysis Procedures

1. Introduction

In this study, I analysed womxn's and health service providers' narratives/accounts of their experiences of the PTOP healthcare encounter (interactions in the waiting room and the pre-abortion counselling session). Making use of semi-structured interviews conducted in the style of Schutze's (1977 as cited in Jovchelovitch & Bauer, 2000) narrative interview, personal narratives of these experiences were analysed by fusing Foucauldian concepts with Taylor and Littleton's (2006) narrative-discursive method. Having discussed in chapter 3 how Foucauldian work can be put to work to achieve the aims of an African feminist perspective, in this chapter I explicate the research design: the recruitment and sampling techniques, data collection and analysis methods used (including transcription and translation), as well as the ethics procedures followed throughout the research process. Noting that a use of Foucault's work alongside a narrative-discursive analytic method requires some thinking around how Foucauldian concepts and Taylor and Littleton's (2006) approach may work interactively, I also discuss how a narrative-discursive method is extended by using a Foucauldian understanding of discourse complemented with a conceptualisation of discourse as a discursive resource.

2. A narrative-discursive approach

In their paper entitled "Biographies in talk: A narrative-discursive research approach", authors Taylor and Littleton (2006) explicate a method in which they approach the analysis of narratives from a discursive perspective. The primary focus of this approach is identity as understood from within a discursive perspective. That is, identity is conceptualised as unstable and multiple, being instantiated by and within discursive resources. In analysing identity, or more appropriately perhaps, identity (re)construction, Taylor and Littleton (2006) rely on a dual lens: their analytic method focuses on unique individual, biographical tellings while simultaneously analysing the wider, socio-cultural shared meanings that make these individual tellings possible. In this way, it considers the individual and the social as inseparable. In the present study, however, 'identity' will be substituted for 'experience'. Indeed, others who have used Taylor and Littleton's (2006) have also not used it to analyse 'identity' per se. Thus, Graham (2014) applied Taylor and Littleton's (2006) narrative-discursive approach to her study on young peoples' narratives of high school sexualities and sexuality education. Morison (2011), and Mavuso (2015) both conducted studies on decision-making in which they applied the narrative-discursive approach as an analytical tool. Morison's (2011) was a study on White

Afrikaners' narratives of male involvement in decision-making around whether to have children, while Mavuso (2015) studied womxn's narratives of their decision-making around having an abortion.

Thompson et al. (2017) note how experience has not been incorporated into traditional post-structural discursive approaches, especially those which focus only on discourse. The result of this, according to Saukko (2010, p.299), has been the masking of individual experiences and accounts of agency and resistance that are told, and "render[ing] accounts of women flat and one dimensional". To address this, Thompson et al. (2017) argue for an analysis which understands discourse and experience as connected and complementary, not antithetical, with "experience being inextricably linked to material political conditions" (p.7). While post-structural writers generally accept that discourse (and language) shapes how we understand and experience social practices and events, Saukko (2008, p.203) argues that voiced experiences can provide a "powerful counterpoint to mainstream discourses" and thus play a vital role in shaping discursive processes. This makes an argument for including experience in any post-structural discursive analysis as, through this inclusion of experience, the interaction of micro and macro may be made visible.

The incorporation of experience into post-structural analyses can "shine light on possibilities for being and acting otherwise" (Gavey, 2011 as cited in Thompson et al., 2017, p.5). I argue that the use of a narrative-discursive analysis that is informed by post-structural work on discourse and power, enables possibilities for alternative ways of being, feeling and thinking to be made visible. This visibilisation may be achieved through an exploration of participants' micro-narratives and narratives which are sites where social structures (discourses, canonical narratives and power relations) and individuals meet. By analysing individuals' micro-narrative constructions of their experiences, then, different ways of representing and understanding social practices, events and objects are made visible through voiced experiences. Saukko (2000) does, however, note the dilemma in doing justice to participants' voiced experiences while performing a critical post-structural discursive analysis. I discuss this issue in the reflexivity section of this chapter.

Following Thompson et al. (2017), I understand experience to be constituted in and shaped by discursive resources but as also enabling/constraining the discursive resources one can take up. For example, micro-narratives are localised and specific forms of narrative construction which are shaped by speakers' experiences elicited in response to specific questions. Below I discuss

the tenets which inform Taylor and Littleton's (2006) narrative-discursive method. Thereafter, I discuss its shortcomings and how I have addressed these in this study.

While studies by Reynolds and Taylor (2005) and Taylor and Littleton (2006) have focused on biographical narratives, that is, life stories, narratives have been and can be conceptualised as tellings of an individual's experiences of an event and not just tellings of events themselves. Thus, Miller, Mintz, Hoogstra, Fung & Potts (1992) discuss their work on a particular kind of narrative; "conversational stories of personal experience" (p.48). According to the authors, the study of narrative easily lends itself to an analysis of accounts of experience insofar as narrative is defined not as a telling of a story about a particular something, an event, for example, but as a temporal ordering. Therefore, Miller et al. (1992, p. 49) argue that "both the experiences of the self and the events in a story are organized with respect to time". Indeed, Taylor and Littleton's (2006) own definition of narrative is just as broadly conceptualised and thus their approach may be easily applied to a study on womxn's and health service providers' narrated experiences of pre-abortion counselling.

Narrative, as understood within a narrative-discursive approach, is "a construction, in talk, of sequence or consequence" (Taylor, 2006, p.95) and is thus a kind of temporal ordering of events in a way which creates meaning for individuals. Put differently, within a narrative-discursive approach, narratives are not simply reflective of a speaker's experiences in that "[p]eople do not simply relay information about themselves in their talk" (Reynolds & Taylor, 2005, p.199). Instead, narratives are constitutive of experience in enabling and constraining how a speaker constructs their experience.

The guiding premise of a narrative-discursive approach is that talk is both social and situated (Reynolds & Taylor, 2005; Taylor & Littleton, 2006). At a micro level, the tenet that talk is social refers to the understanding that narratives are co-constructed between individuals or speakers (as is the case in an interview context, for example). This means that within a speaking interaction, the narrative is produced by all those participating in the interaction, in what may be a process of negotiation. At a macro level, talk is social in that individuals make use of socially and culturally available meanings, referred to (in a general sense) as discursive resources, when producing an account, a telling, a narrative of experiences. These shared meanings or discursive resources pre-exist any occasion of talk and are therefore seen, within a narrative-discursive approach, as tools which can be taken up during talk. It is also in this sense that talk is conceptualised as situated or contextualised. Thus, during talk, speakers draw

on discursive resources in constructing a narrative which may be challenged or supported by others within the interaction. Within Taylor and Littleton's (2006) narrative-discursive approach, therefore, talk, and personal narratives, cannot be separated from the discursive resources that both situate, shape and (dis)enable them.

Within approaches which conceptualise narratives as social processes, the argument is made that the relationship between narrative and the context in which it occurs is one in which context has implications for how narratives are produced or constructed. The situatedness of narratives by and within discursive resources has implications for the role of individual speakers in the construction of narrative. As the authors explain, decisions around which narrative to construct and how to construct the narrative are constrained by the speakers' discursive environment (Reynolds & Taylor, 2005; Taylor & Littleton, 2006). As Taylor and Littleton (2006) contend, however, narratives are not only situated within and constrained by the immediate occasion for telling and the wider discursive environments which shape the narratives, but are also situated by a speaker's previous tellings of a particular story. In other words, past narratives come to bear on future narratives as speakers draw on previous tellings to construct a narrative (Taylor & Littleton, 2006). This further constrains the narrative work done by a speaker.

These constraints placed upon speakers mean that when constructing a narrative, decisions about which narrative to construct and how to construct it are shaped by the requirement of consistency. As Taylor and Littleton (2006) contend, during talk speakers are called upon to be consistent with the socially and culturally shared meanings available to them, as well as with their own previously told narratives (Taylor & Littleton, 2006). This aspect of Taylor and Littleton's (2006) approach, that is, the recognition that talk and narrative construction is constrained, is commensurate with Foucault's (1976) ideas on the regularity and systemic nature of discourse which means that it shapes how we write, think and speak about social objects and practices.

In the analytic method I am proposing, experience is thus analysed in relation to narrative and discourse and how participants use them to (re)construct particular experiences as well as the various relations of power which may shape these experiences and the (re)construction thereof (within an interview context). The use of Foucauldian theory around knowledge and power enables an analysis of different formations of (pastoral) power (patterned relations of power between parents and children, and between health care providers and their clients/patients). African feminism enables us to read gender into these processes: the ways in which discourses

around gender enable and constrain womxn's experiences through available subject positions. It also allows a cognisance of racialised and/or classed representations of participants. In analysing womxn's and health service providers' narrative construction, I am also interested in how participants' use of narrative and discourse conforms or runs counter to dominant discourses and narratives, and the ways in which the power relations referred to are similar or dissimilar to those described in Foucault's work. This is much like Morison (2011, p.111) when she states the following: "I, however, am more interested in narrative as a meaning-making device or rhetorical tool in which narrators both interpret and construct various versions of social "reality" and as a political site where meanings are struggled over (Bamberg, 2004)".

A narrative-discursive approach enables the kind of "positioning that is more concerned with self-reflection, self-criticism and agency" (Bamberg, 2004, p.224), a view that, as Wetherell (1989, p.401) puts it, conceptualises positions and their import and implications as "local, highly situated and occasioned" within the interaction in which they occur. Reading Foucauldian work into this approach extends this understanding of subject positioning to include an orientation to how macro-level politics shape and produce particular selves or subjects. For example, how, through the disciplinary technology of normalisation, abortion is constructed as abnormal and womxn are positioned as deviant or transgressors of the norms of 'normal' womxnhood by requesting an abortion. By way of another example, through examination/measurement, the pregnancy and foetus are rendered visible and the womxn requesting an abortion is immediately positioned as a 'good' mother (as protector and nurturer) or 'bad' mother (threat to her child). This fusion of Foucauldian writings into the narrative-discursive approach thus enables an understanding of meaning-making as a *constrained negotiation* by developing more fully the socially and discursively constrained nature of talk, what Wetherell refers to as the "broader forms of intelligibility running though the texture more generally" (1989, p.403).

2.1. Shortcomings of the narrative-discursive approach

Some short-comings or limitations of the narrative-discursive approach have been identified by those who have applied the approach in their own research. Morison (2011) and Graham (2014) speak to this aspect when discussing how they have used the approach. Both authors find the approach to be somewhat limited in the extent to which it considers how micro-level politics (positioning, for example) are shaped by and have implications for wider discursive practices. In other words, as Morison notes, the political nature of talk is under-emphasised. To remedy this, Morison (and later Graham) infuses Butlerian concepts of performativity and

gender trouble into the narrative-discursive analytic approach, resulting in what Morison (2011) proposes as a performative-performance approach to narrative-discursive analysis. The performative-performance approach enables the analyst to identify shifts, within and across narratives, in gender performance (Morison & Macleod, 2013). Through this approach, positioning analysis (used to study the identity claims speakers make within narratives) is extended to look at the ways in which subjects construct themselves in gender-specific ways, that is as *gendered* subjects; as particular kinds of womxn and mxn and how these may converge or diverge with gendered norms. As Morison (2011, p.112) explains, a performative-performance approach also makes possible a focus on power:

> By utilising Butlerian understandings of "trouble" it is possible to make the broader implications of gender trouble and how power comes to bear on an account, as well as the possibilities for resistance, explicit when investigating troubled positions in relation to gender within narratives.

While combining Butlerian theory with Taylor and Littleton's narrative discursive approach is certainly useful in opening up an analytical space for the consideration of gender and power, such an approach appears limited in the opportunity afforded to an analyst to comment on power dynamics beyond those which play out between mxn and womxn, and how these may come to bear on narrative construction. I have thus infused an African feminist post-structural approach into to a narrative-discursive analysis. Through this fusion, an analysis of various forms of power and how they "come to bear on an account" (Morison, 2011, p.112) is enabled.

In the rest of the chapter, I discuss the various methods and procedures used in the research process to enable me to achieve the study's aims and research questions. I begin by addressing the aims and research questions of the study.

3. Study aims and research questions

This present study forms part of a larger study which explores pre-abortion counselling. The partner project collected and analysed audio recordings of the pre-abortion counselling sessions at the three sites used in this study. The present study aimed to explore and compare womxn's and health service providers' talk about their experiences of the PTOP healthcare interaction (waiting room interactions and pre-termination of pregnancy counselling) in the Eastern Cape public sector. The following questions guided the study throughout the various stages of research:

1) How do health service providers describe/speak about their experiences of providing pre-abortion counselling and interacting with womxn in the waiting room? What discursive resources are drawn on and what practices are described?

2) How do womxn describe/speak about their experiences of receiving pre-abortion counselling and interacting with health service providers in the waiting room? What discursive resources are drawn on and what practices are described?

3) How do womxn and health service providers position themselves and the other party in talking about PTOP counselling and waiting room interactions?

4) How do health service providers' and womxn's accounts of the PTOP counselling diverge or converge? And how might these have implications for PTOP counselling service provision?

5) What power relations are referred to or evident in health service providers' and womxn's talk? And what are the implications of these for PTOP counselling service provision?

4. Recruitment and inclusion criteria

As stated above, the aim of the study was to explore and compare accounts of health service providers' and womxn's experiences of waiting room interactions and pre-abortion counselling in public sector abortion facilities in the Eastern Cape. As such, I used a purposive sampling technique as it would ensure the selection of participants appropriate for the purposes of the study. Purposive sampling is understood to be a strategy "in which the study participants strategically selected are those who are best able to meet the informational needs of the study" (Patton, 2002, p.230 as cited in Mayers, Parkes, Green & Turner 2005, p.17). It is a sampling strategy that entails "the deliberate choice of an informant due to the qualities the informant possesses" (Tongco, 2007, p.147) and is especially appropriate for research around participants' experiences (Tongco, 2007). Barbour (2001) thus argues that when used accordingly, the strategy highlights differences between participants (or participants' experiences) which other sampling strategies seek to remove: differences which then need to be discussed during the analysis to take full advantage of the sampling technique. In this study, for example, the divergences and convergences that were of interest to me were primarily the

differences between womxn's and health service providers' renditions of their experiences of the pre-abortion healthcare encounter.

Potential participants in this study had to either: 1) have undergone PTOP counselling and interacted with a health service provider in the waiting room area as part of the abortion service process; or 2) be healthcare workers who participate in pre-abortion counselling service provision and who encounter womxn when they first make a request for an abortion and subsequently in the waiting room area. Further criteria were that potential participants had to be willing and comfortable to speak about their experiences, firstly, of their waiting room interactions with health service providers and other womxn (in the case of womxn receiving PTOP counselling) and with womxn requesting abortion (in the case of health service providers) and, secondly, about their experiences of PTOP counselling. Potential participants were included in this study irrespective of racial identity and age. The rationale for these criteria will now be discussed below.

The rationale behind including womxn of all ages (that is, including minors), was that the CTOP Act affords womxn of all ages the right to access a termination of pregnancy. Although age was not an inclusion/exclusion criterion, participants' ages were recorded. The inclusion of womxn younger than 18 was motivated by a review of the literature. As discussed in the literature review chapters, research conducted among health service providers reports that womxn are sometimes differentially treated based on their age. Thus, in health service providers' accounts of their counselling practices, TOP requests from womxn younger than 18 were viewed as reasonable (Beynon-Jones, 2013; Harries et al., 2009). This is tied to normative ideas around who is expected to be a mother with adolescents being positioned as inadequate mothers. It was therefore expected that age would figure in participants' accounts and narrative constructions.

Participants were recruited from three government funded hospitals (in which abortion services are free of charge) in the Eastern Cape Province. In two of the hospitals, TOPs are performed in a 'Women's Health Clinic' while in the other there is a separate ward for TOPs (and family planning services). The facilities are located in urban and peri-urban environments. All three facilities are located within cities. Of the three facilities, two are located within the same city: one in a large township[17] area (site 1) and the other within the city centre (site 2). The third

[17]'Township' refers to underdeveloped urban living areas that, from the late 19th century until the end of Apartheid, were created and designated for Black, Coloured (mixed raced) and Indian people so they could

facility is located within a different city close to residential and industrial areas (site 3). These facilities were selected based on their patient flow (approximately ten to 20 womxn requesting abortion services per day on average), their relative proximity to the researchers (with the furthest facility being a two and a half hour drive away), their location (urban and peri-urban environments) and the existence of counselling services at the hospital which could be accessed, in addition to other services located outside of the hospital which were identified by the researchers, if participants so desired. This was so that participants who experienced any kind of distress because of the interview discussion could easily access this support.

There was some variance in the procedures followed at the sites, in terms of managing the service on a daily basis. During the course of data collection, at each site the counselling session would be preceded by an ultrasound scan which was done in the TOP clinic by the nurse at site 3 and in a different ward at sites 1 and 2. Following the scan, womxn would receive pre-abortion counselling, which involved contraception counselling, on the day of their arrival. At site 1, during the pre-abortion counselling session womxn would be given a later date, approximately three weeks from their first arrival, for the abortion procedure. At sites 2 and 3, womxn the abortion procedure, which tended to be a medical abortion, would occur on the same day. At site 3, womxn were told about the need to return to the clinic for a follow-up. Whether this was also the practice at sites 1 and 2 was unclear during data collection. At sites 1 and 3, contraceptive counselling was conducted at the end of the counselling session, with the understanding that it would be administered post-procedure. At each site, registered nurses were those who conducted abortion procedures and were the first point of contact for the womxn.

Thirty womxn accessing TOP services agreed to participate in the study. Depending on health service providers' preferences, different strategies were used to recruit womxn accessing TOP services. For example, my co-researcher, Snethemba Mavuso, and I introduced ourselves to the womxn while they were waiting to receive counselling. During this time, we explained the purpose of the research and described what their participation would entail. Whilst the womxn received counselling, we waited in a room that we had been allowed to use for interviewing. Womxn who were interested would approach us and, after informed consent forms were signed, interviews would take place immediately. Alternatively, healthcare workers would

provide labour to adjacent cities and towns whilst not residing in urban areas designated for White people. This specific township was designated for Black people.

send womxn to me after they had received counselling. I would then explain the research as womxn were sent to me. Womxn who agreed to participate were interviewed immediately.

Four healthcare workers involved in TOP service provision agreed to participate in the study. Although a sample size of between 5-10 healthcare providers was hoped for, this proved difficult for two reasons. The first is that abortion facilities in the Eastern Cape public health sector tend to be maintained by one, two or three healthcare providers. For example, at site 3 one nurse provided the counselling and performed the procedures and she agreed to participate in the study. At sites 1 and 2 those recruited were the only ones who agreed to do so. While there is some diversity across the health service providers' interview data, the small sample size is a limitation.

The healthcare providers were approached at the start of the site visit. They were informed about the research - that we wanted to interview womxn and that we were interested in interviewing healthcare providers as well. Health service providers who agreed to participate in the study were interviewed at the hospital at a time of their choosing (at the beginning or end of a work day). Below, I describe the participants in some detail, according to the site from where they were recruited and interviewed.

4.1. Participants

Due to the low number of womxn recruited from site 1 (a total of 4 womxn), most womxn were recruited from sites 2 and 3, with 13 womxn recruited at site 2 and 13 womxn recruited from site 3. The low recruitment at site 1 was due to the staff shortages experienced by the abortion ward as the only person who had been trained in conducting ultrasonography scans had retired and had not yet been replaced. As a result, doctors working at the hospital had to be relied upon to assist in between their other duties. This sometimes meant that womxn would wait until 12pm (having arrived by 7am) before having a scan. Healthcare providers were also unevenly spread with one recruited from site 1, two from site 2 and the other from site 3.

One important way to measure quality in qualitative research is the extent to which the analysis can be transferred across similar populations (Willig, 2008). This necessitates a ‘thick’ description of participants and their circumstances, what Willig (2008, p.151) refers to as “situating the sample”. Such work is particularly imperative in African and transnational feminist work which calls for “attention to the different contexts in which womxn are located” (Amigot & Pujal, 2009, p.662) to avoid homogenising accounts of womxn and their

experiences. I have therefore included tables that provide some information on the participants. The tables record participants by data collection site. As is indicated in the tables, the names presented are pseudonyms. These were selected by participants themselves. I discuss womxn accessing abortion services and healthcare workers in separate sections below.

4.1.1. Womxn accessing TOP services

As can be seen from the tables, participants tended to be mostly similar regarding racial identity: 28 out of 30 participants were Black womxn and the remaining two participants were Coloured and Indian womxn. Most of the participants' ages were between 24 and 35, with only few being younger than 21 and older than 35. This is similar to other research which have been conducted at public health facilities in the Eastern Cape (Mavuso, 2015; Mdleleni-Bookholane, 2007). Mdleleni-Bookholane's (2007) study reported a similar age distribution with most womxn falling in the 21-25, 26-30 and 31-35 age categories and very few womxn below 20 and over 35 (Mdleleni-Bookholane, 2007). In a study I conducted for my master's degree, most participants were Black womxn (two were Coloured womxn) and most womxn were between the ages of 21 and 35.

The tables below contain information on participants' age, occupation, racial identity and the language in which the interview was conducted. The tables have been arranged by site. Discussion of the participants will proceed in the same way.

Table 3: *Womxn's information (site 1)*

Participant no.	**Pseudonym**	**Age**	**Employment status**	**Racial identity**	**Language of interview**
P1	Zintle	24	Studying	Black	English
P2	Thombulelo	28	Unemployed	Black	English + isiXhosa
P3	Lisa	21	Studying	Coloured	isiXhosa + English
P4	Zimkhitha	20	Studying	Black	English

At site 1, participants were recruited and interviewed by Snethemba and I. Four participants were recruited from site 1, which is located in a large township area. As can be seen from the table, participants at site 1 ranged in age from 20 to 28 years of age. Three of the four participants were students while one participant, Thombulelo, was unemployed at the time of the interview but had a job contract starting later that year. One participant, Lisa, is Coloured while the remaining three are Black. The interviews conducted with Thombulelo and Lisa were

conducted in mix of English and isiXhosa while Zintle and Zimkhitha preferred to have the interview conducted in English. Table 5, which presents participant information from site 2, is discussed below.

Table 4: *Womxn's information (site 2)*

Participant no.	**Pseudonym**	**Age**	**Employment status**	**Racial identity**	**Language of interview**
P5	Nziweni	28	Unobtained	Unobtained	isiXhosa
P6	Likhona	Unobtained	Unobtained	Unobtained	isiXhosa
P7	Nikibha	Unobtained	Unobtained	Unobtained	isiXhosa
P8	Lindokuhle	Unobtained	Unobtained	Unobtained	isiXhosa
P9	Nowu	Unobtained	Unobtained	Unobtained	English + isiXhosa
P10	Nandipha	Unobtained	Unobtained	Unobtained	isiXhosa
P11	Mpho	19	Unemployed	Black	English
P12	Sbongiseni	20	Studying	Black	English
P13	Sandisiwe	38	Employed	Black	isiXhosa + English
P14	Sinovuyo	17	Studying	Black	English
P15	Vanessa	34	Unemployed	Indian	English
P16	Sascarlimseko	35	Studying	Black	English
P17	Nokubonga	29	Unemployed	Black	isiXhosa

At site 2, which is located in a city centre in the same city as site 1, interviews for participants P5-P10 were conducted by two psychology honours students (designated as CIs in the data extracts) who were trained by me and another researcher working on a partner project. Most (with exception of Nziweni whose age was recorded) of the information around age, employment status and racial identity for these participants was not recorded by the interviewers, thus the missing information has been coded as 'unobtained' (this is a limitation of the study which will be discussed in the reflexivity section). However, regarding racial identity, it is likely that Nziweni, Likhona, Nikibha, Lindokuhle, Nowu and Nandipha have Black or Coloured racial identities given that these interviews were conducted in isiXhosa (with Nowu's interview having been conducted in both English and IsiXhosa). The remaining interviews (P11-P17) were conducted by me. As Table 5 (above) shows, of those for which there is information, the youngest participant was aged 17 with the oldest aged 38. Three participants were unemployed, and one was employed at the time of their interview. Two participants were studying: Sinovuyo, aged 17, was in high school at the time while Sbongiseni, aged 20, was at university. Except for Vanessa, who is Indian, all the participants are Black. Most of the interviews at this site were conducted in isiXhosa or a mix of both, with the

remaining interviews being conducted in English. Below, I discuss participants who were recruited at site 3. Participant information is presented in Table 6 below.

Table 5: *Womxn's information (site 3)*

Participant No.	Pseudonym	Age	Employment status	Racial identity	Language of interview
P18	Thamie	27	Unemployed	Black	English
P19	Nomonde	29	Employed	Black	English
P20	Yolanda	28	Employed	Black	English + isiXhosa
P21	Zipho	27	Studying	Black	isiXhosa
P22	Asanda	17	Studying	Black	English
P23	Balisa	35	Studying	Black	English + isiXhosa
P24	Asiphe	25	Employed	Black	English + isiXhosa
P25	Nonkosazana	28	Unemployed	Black	isiXhosa + English
P26	Lisakhanya	18	Studying	Black	English + isiXhosa
P27	Thembakazi	39	Employed	Black	English + isiXhosa
P28	Promise Rose	20	Studying	Black	English
P29	Nandipha	21	Studying	Black	isiXhosa + English
P30	Bongiwe	26	Unemployed	Black	isiXhosa + English

At site 3, participants were once again recruited by Snethemba and I. Site 3 is near residential and industrial areas in a different city to sites 1 and 2. Womxn recruited at this site ranged in age from 17 years of age (Asanda) to 39 (Thembakazi). In terms of employment status, four participants were employed, three were unemployed and the remaining five were students at the time of their interview. All participants are Black. Most of these interviews were conducted in a mixture of isiXhosa and English. Below I discuss the healthcare providers who were recruited into the study.

4.1.2. Healthcare workers involved in TOP service provision

Healthcare providers' ages were not recorded as is this was not expected to figure in their interviews or in the interviews of the womxn accessing TOP services; thus, this information is not included in table 7 below. The information that was recorded was participants' racial identity, profession, years of work experience, and the language in which the interview was conducted.

Table 6: *Health service providers' information*

Participant No.	Pseudonym	Racial Identity	Occupation	Work experience in TOP care	Language of interview
P31	Thembi	Black	Nurse	4 months	English
P32	Sam	Coloured	Nurse	4 years	English
P33	Heather	White	Counsellor (NGO)	4 years	English
P34	Chanelle	White	Counsellor (NGO)	3 ½ years	English

Thembi, a Black womxn, was recruited from site 1 (located in a large township area in a city in the Eastern Cape). Sam, a Coloured womxn, was recruited from site 3 (located near residential and industrial areas in a different city to sites 1 and 2). Both Sam and Thembi are nurses. While Sam had been involved in providing TOP services for four years, Thembi had recently been trained and had moved from a different ward. She had been providing TOP services for four months. Both Thembi and Sam were involved in conducting the pre-abortion counselling and performed the abortion procedures. While Thembi shared the duties with her two colleagues (also nurses), at the time of data collection Sam did the work alone due to a colleague being on leave.

Heather and Chanelle are both White womxn and were recruited from site 2 (located in a city centre in the same city as site 1). At the time of their interviews, both volunteered at a Christian-based pregnancy crisis NGO[18] which provided its counselling services free of charge to the hospital. Chanelle has a Psychology Honours degree and Heather has a diploma in Christian Counselling. Unlike Thembi and Sam, Heather and Chanelle were only involved in providing counselling. At site 2, the nurses at the Women's Clinic would conduct the health and contraceptive history-taking part of the pre-abortion counselling while counsellors from the NGO would conduct what they referred to as options counselling. Heather and Chanelle had been involved in pre-abortion counselling for 4 and 3 ½ years respectively. All the interviews were conducted in English, as preferred by the participants.

Having discussed how participants were recruited, I now turn to the data collection method used, which was the semi-structured interview. Thereafter I discuss the ethical considerations

[18] In my interview with Heather, it was explained that the agreement between the hospital and the NGO concerning the provision of counselling services on a volunteer basis came about after Heather submitted a successful proposal to the hospital management. This kind of relationship is not standardised, to my knowledge.

of the study, followed by a section on reflexivity, analysis procedures and finally the steps taken to contribute towards the validation process of the study.

5. Data Collection

In the following section, I describe the methods that were used to collect data for the study. I also describe the procedures followed when utilising these methods of data collection. Where relevant I speak to the ways in which data were influenced by the procedures followed.

5.1. Using observations as a data collection tool

Observations of waiting room interactions were not used as data in and of itself but were rather used as a tool to collect data. Thus, observations conducted by Snethemba and I were used to prompt participants' responses about their experiences of the waiting room interactions between womxn and healthcare providers and interactions among the womxn themselves.

The observations conducted in this study were overt; participants were made aware of the researchers' presence. This was done in two ways: observations of waiting room interactions were included in the informed consent forms, and notices about the observations taking place were put up around the waiting room. Both indicated that there were researchers present and that participants, if they desired, could let the researcher know if they were uncomfortable with having their interactions recorded. Observation occurred in different ways at each of the sites. At site 1, Snethemba and I sat in the waiting room but apart from the womxn (to provide them with some measure of privacy) and took notes on interactions among the clients and those between providers and clients, including whether there were any delays in providing the service and whether this was communicated to the clients etc. At site 2, observation occurred on the first day of recruitment only as the nurse had asked us to sit in a different area outside of the waiting room where she conducted the history-taking part of the consultations which took place as group or individual counselling but with the other womxn present. At site 3, there were two waiting areas. Snethemba and I were permitted to make use of a room which had a large window which faced one of the waiting areas. We could see out as well as be seen by the womxn, health service providers and anyone else who entered the clinic. This not only provided the womxn with some measure of privacy but also enabled us to see quite clearly what was occurring. Included in our observations was how many womxn visited the site and whether they did so alone, whether the womxn engaged with each other at all or kept to themselves, if and how the nurses engaged with them at all in that space (for example, if there was a delay in

the process, whether this was communicated to the womxn), and how the womxn appeared to respond to this engagement. During interviews, these observations were then used to prompt talk about the waiting room interactions and to encourage participants to elaborate on the subject.

5.2. Interviews

Data for the study were collected using semi-structured interviews. Semi-structured interviews are a useful data collection method in qualitative research where the unit of analysis is the individual and the data are participants' narratives of experience (Willig, 2008). This is due to the flexibility of the interview agenda and the use of open-ended questions which can be used to elicit narratives (Jovchelovitch & Bauer, 2000). As is typical in semi-structured interviews, the interviewer has a set of open-ended questions already prepared. However, the interview agenda may be adapted to each interview as and when necessary (Willig, 2008). The interviews were conducted in English and/or isiXhosa in accordance with participants' wishes and were audio-recorded with permission from participants.

As is explained above, there were different participation requirements for womxn undergoing pre-abortion counselling and for health service providers responsible for performing the PTOP counselling. Womxn undergoing PTOP counselling participated in a single interview while health service providers participated two interviews. Separate interview schedules (Appendix 1 and 2) were formulated for both health service providers and womxn undergoing abortion counselling. In constructing the questions for the interview schedules, the challenge was to avoid phrasing the questions in ways which already presumed a very particular narrative. For example, instead of assuming that pregnancy options were in fact discussed (interviews with womxn suggest that this was not always the case), we first established whether this discussion had taken place ('Did the nurse/counsellor speak to you about pregnancy options like adoption and parenting?'). Then we asked how participants experienced this discussion. Regrettably, where participants said that this discussion had not taken place, we did not ask them how they felt or what they thought of this. This would have been helpful in letting us know *more* about whether participants would have found a discussion of pregnancy options valuable (some of the womxn who stated that this discussion did take place constructed micro-narratives around the unhelpfulness of this discussion).

5.2.1. Interviews with womxn about their PTOP healthcare encounter

At all sites, the interviews with the womxn took place at the facility on the same day of the counselling. At site 3, we conducted the interviews after the counselling and sometimes after the medical abortion process had already been initiated (the womxn were given one of their tablets in the consultation room towards the end of the counselling). Interviews lasted on average 15 minutes and tended to be rich in content. Two main themes were covered in this interview: the womxn's own experiences of the way the counselling was conducted (including the content of the abortion counselling) as well as their experiences of the waiting room dynamics between themselves and other womxn requesting abortion as well as between themselves and health service providers. As mentioned above, overt, non-participatory observations (conducted by a Snethemba and I) of waiting room interactions were used as an interview stimulus to elicit narratives around these experiences. Thus, we usually said 'Can you tell us/me more about the waiting room/area, interactions between you all and the healthcare providers/between you all while waiting there?' If what we were asking of the womxn was unclear or if womxn gave brief answers, we then prompted with 'We/I noticed that you were talking to each other in the waiting room. Can you tell us/me about your experience of that?' or 'We/I noticed that no one was talking in the waiting room. Can you tell us/me about your experience of that?'.

Interview questions were posed around the following: the womxn's expectations of the counselling and how these compared to their experiences, their experiences of information provision/sharing during the counselling, discussions around pregnancy options, whether personal information had been solicited/shared during the interview and the experiences thereof, whether there were things the womxn wanted to discuss but did or could not, and experiences of the waiting room. Womxn were also asked what they would tell a friend about their experience, to provide them with an opportunity to describe their experience as a whole, or elaborate on what they already said.

5.2.2. Interviews with health service providers

Health service providers participated in two interviews. These interviews lasted 30 minutes on average and were all conducted in English. They usually took place on the first day, whether at the end of the work day or in between pre-abortion counselling sessions. The first interview was around their experiences of pre-abortion counselling sessions and waiting room interactions. During these interviews, health service providers were asked questions about what they identified to be the purpose of the counselling, their role in relation to that purpose, their

experiences of providing information (including what kinds of information, if any, are provided and under what circumstances), whether and how experiences of providing the counselling might change with the presence of a third party, options counselling and decision-making, as well as their experiences of waiting room dynamics.

During the second interview, healthcare workers were asked to reflect on specific cases seen in the last few says. Specifically, they were asked: 'Which, if any, consultations over the past two days stood out for you? What were the challenges you encountered and what ways did you find to deal with them? What aspects of the counselling went well?' The purpose of these interviews was to assist with the development of a best practices model by collating the responses from each site and to collect grounded narrative that would assist in generating rich data.

Conducting the second interview, in addition to the first interview around their waiting room and pre-abortion counselling experiences in general, proved to be extremely difficult owing to the workload and time constraints of the health service providers. Of the four healthcare providers recruited, interviews around specific cases were only conducted with two health service providers. These interviews lasted between 5mins and 15mins. They were conducted at the end of the second or third day, depending on whether the health service providers had conducted any consultations the previous day or not.

Below, I speak to the procedures followed in analysing the womxns' and healthcare providers' interview data, after which I discuss the ethical principles used to guide the study, as well as any ethical issues that we needed to navigate. This will be followed by a section on the various strategies used in trying to achieve validation of the analysis and findings of this study. The section on validation will include a discussion on reflexivity where I talk to some decisions I made during the research process and their effect on this final product, that is, this thesis. During this discussion on reflexivity I also highlight various power relations and the ways in which they shaped the production of this thesis.

6. Analysis procedures

Data for this study were analysed using Taylor and Littleton's (2006) two-pronged narrative-discursive analytic method. The analysis begins with the transcription of the data during which the analyst begins the process of familiarising him or herself with the data. Thereafter the data are read and re-read iteratively throughout the analytic process. Before I describe the

procedural details of Taylor and Littleton's (2006) analytic method, I will first discuss the transcription and translation process used in this study.

6.1. Transcription and translation

Twin (1997) notes that in research where the audio data need to be translated into another language before analysis proper may begin, questions about the 'accuracy' of the transcribed data, and subsequently the credibility of the analytic argument, may be raised. The need to raise these questions becomes more pertinent where the researcher does the translation work and the data are in a language different to the researcher's own (I will return to this shortly). This concern around accuracy and credibility is in part due to the acknowledgement of grammatical differences between different languages and the implications these differences have for meaning, and in part due to the role played by language and culture in giving meaning to social practices (Temple & Young, 2004). While it is generally agreed upon that the role played by translation in the production of knowledge cannot be denied, there are differences in the arguments made, and in how translation is constructed. These differences, Temple and Young (2004) argue, result from researchers' different ontological and epistemological positions.

Even though concerns around the 'accuracy' of translation encourages thoughtfulness about the implications of translation for not only the data that are produced but also for the analysis of these data, such language use infers certain ontological and epistemological approaches to knowledge production. Discussions of the '(in)accuracy' or '(in)correctness' of a translation must be contextualised within a long-standing tradition in which reality can be objectively perceived and accessed, and in which it is therefore possible to remove any 'biases' in the research process which may 'contaminate' this process and in doing so 'mask' the 'truth' of the phenomenon under study (Temple & Young, 2004). Arguments about 'accuracy' suggest, whether wittingly or otherwise, that there is a single translation that will be vouchsafed by all members of a language group. Thus, to prevent any misinterpretations various techniques are employed to ensure accuracy. Back-translation is one such technique which is widely used in qualitative cross-lingual/cultural research (Chen & Boore, 2009; van Nes, Abma, Jonsson & Deeg, 2010). Described by Chen and Boore (2009), it is a technique in which the data are transcribed verbatim into the source/original language and translated to produce a second transcript in English which is then translated back into the original language. The two versions of the original language transcripts may then be assessed for congruency and the value of the English translation determined. Such techniques are not in and of themselves problematic.

Indeed, these techniques are useful, particularly in research (such as my own) where the focus is on the ways in which experience is narrated and constructed through language. However, the way in which translation (and consequently the techniques themselves) are conceived may have implications for how translation is critically and reflexively addressed in methodological discussions, for example, regarding the role of the translator and/or researcher in the knowledge production process (Edwards, 1998).

Another approach to translation contends that translation is itself an interpretation, as is the analysis of the data (van Nes et al., 2010; Temple & Young, 2004). The final (translated) transcript is therefore but one among several possible interpretations and congruency between members of the same language group may not be achieved (Bradby, 2002). Temple and Young (2004) argue that researchers working from within social constructionist approaches recognise that accuracy of interpretation is unattainable as speakers fluent in the same language may produce different interpretations of the same text. Despite this, owing to the recognition that transcripts (where they are presented to the reader, even in partial form) provide the reader with an opportunity to access and evaluate the data upon which the analysis is based (Nikander, 2008), rigour in translation as well as transparency in the presentation of transcripts is still necessary to ensure credibility or provide a basis from which credibility may be judged (Bucholtz, 2007; Temple & Young, 2004).

6.1.1. Rigour and transparency in translation work

My co-researcher, Snethemba is fluent in isiXhosa, isiZulu and English, while I am fluent in isiZulu and English. Owing to the mutual intelligibility of isiZulu and isiXhosa, we conducted most of the interview ourselves (with some interviews being conducted by psychology honours students at site 2). As result of this mutual intelligibility, back-translation was not used in this study. Indeed, Alberts (2010) notes the similarities between South Africa's four Nguni languages (isiZulu, siSwati, isiXhosa and isiNdebele) to the extent that members of these language groups can understand each other. However, to ensure rigour in the translation process, Xhosa audio data were sent to an independent translator who is fluent in isiXhosa and English. The translator transcribed this data into an English transcript so that I could analyse the data but also created a separate isiXhosa transcript of the data.

Bucholtz (2007) advises transparency regarding the acknowledgement that translation work has occurred. As part of this openness on the part of the researcher, where possible both the original and translated transcripts should be presented to the reader, thereby enabling the reader to access and inspect the data upon which the analysis is based. I have thus included the Xhosa

transcripts of the extracts presented in the analysis chapters as an appendix (Appendix 5) for those readers who wish to have access to the original data. Temple and Young (2004) extend the requirement of transparency to include the researcher's openness about the various decisions and steps taken during the transcription and translation process. For example, the identity of the person doing the translation and whether he/she is best able to speak on behalf of others, as well as what transcription conventions have been used and how they have been used.

As I have already indicated, I transcribed the data myself with the help of a translator. To transcribe the data, Parker's (1992) transcription conventions was used due to the (relatively minimal) level of detail required, often argued to be appropriate when the focus is on the ideological content of talk as opposed to, for example, on the minute workings and structures of interactions such as is the case in conversation analysis (Bucholtz, 2007, Potter & Hepburn, 2005). In accordance with Parker's (1992) conventions, participants' responses were transcribed in large chunks separated by the interviewers' questions with words of assent and encouragement placed in forward slashes (e.g. /mm/). Round brackets have been used to indicate any doubts about the accuracy of the transcribed material (e.g. 'He said I (should not) come') and square brackets to indicate clarificatory information needed to help the reader understand the text. Ellipses in square brackets have been used to indicate any material that has been omitted from the full transcript. An equal sign indicates where speakers' talk overlaps. Pauses are indicated by round brackets which contain a full stop (e.g. (.) for a brief pause) or numbers (e.g. (2) represents a 2 second pause). Extended vowel sounds are indicated by one or more colon but only in the original language (in other words, these fell away when the Xhosa interviews were translated into English). Lastly, words or phrases that were spoken with emphasis have been underlined.

While it has also been argued that including conventions used to notate "the minutia of conversation" (Potter & Hepburn, 2005, p.288) may enable discourse and discursive analysts interested in the ideological content of talk to better speak to and analyse what it is they have set out to analyse, the need to translate data from one language into another impedes this level of transcription, a problem which is rarely recognised and discussed by researchers and theorists writing about transcription (Nikander, 2008). As Nikander (2008, p.226) notes, this often results in some level of compromise on the part of researchers as "translating data extracts is not merely a question of 'adopting' or 'following' a 'transcription technique' but rather includes a range of practical and ideological questions concerning the level of detail chosen".

Thus, in this study, while Parker's convention calls for the notation of silences, extended vowel sounds and emphasised words, gaps between one speaker and the next, the uncertainty of a transcribed word or phrase, and parts of the transcript that have been left out in presented extracts, I made the decision to exclude the notation of extended vowel sounds due to the impossibility of doing so for words that were translated from isiXhosa into English. Additions to Parker's conventions were also made. Firstly, sounds and words of assent/encouragement (etc) were contained in forward slashes to present the transcript in narrative form, and secondly, where words, phrases and exclamations commonly used in isiXhosa/isiZulu were hard to explain or where there was no English equivalent, I have retained these in the final transcript and have instead attempted an explanation in the glossary page. This retention of isiXhosa and English in the final transcript is important as it goes some way to making the translation visible (Nikander, 2008).

6.2. The narrative-discursive analytic process

Taylor and Littleton's (2006) narrative-discursive approach is a two-pronged method involving two interrelated tasks. I have added a third task. In the first task, the analyst searches for patterns across the data set by identifying the various micro-narratives that were constructed by participants. This meant working interview question by interview question and analysing each participant's response to each interview question for whether a micro-narrative was constructed in response to the question. In the second task, the researcher looks at each (micro-)narrative and identifies the discursive resources (discourses and canonical narratives) used and analyses the work done by these discourses within the particular (micro-)narratives. As part of the second task, I have used Davies and Harré's (2001) positioning theory to analyse the subject positions made available within discourses to determine how womxn and health service providers position themselves and each other when constructing their narratives. To analyse the discourses drawn upon and the power relations referred to by the womxn and health service providers, I read the data with the literature and post-structural work in mind. Finally, the third additional task involved an analysis of how health service providers' and womxns' accounts of the information, decision-making and consent aspects of the counselling diverged or converged and the implications that these, as well as the discourses, positionings and power relations, have for abortion service provision. This third task is touched on in the three analysis chapters and is discussed at length in the concluding chapter.

To represent the first, second and third tasks of the narrative-discursive approach I used, I speak in the first analysis chapter to the discourses drawn upon by the participants, but drawing predominantly from the womxns' data (I indicate where healthcare providers also drew upon these discourses), in constructing particular counselling practices and their experiences of them. In the second analysis chapter, I discuss how these discourses were put to work by the womxn in constructing different micro-narratives. I also discuss the power relations referred to by the womxn. The small number of healthcare workers recruited into the study proved to be too small to enable an analysis of the micro-narratives they constructed. Thus, I divide the third chapter into two main parts: the first speaks to the discursive resources (canonical narratives and discourses) drawn upon by the healthcare providers; and the second speaks to how these discursive resources were drawn upon in describing and justifying certain counselling practices. The second part also speaks to how power operated in these practices described and justified by the healthcare providers. Thus, the final analysis chapter is a combination of the three tasks.

Having discussed the analysis procedures used in this study, I now turn to the ethical considerations that were paid attention to in this study. Thereafter, I discuss the various techniques used in the process of validating the analysis and findings of this study. Then I conclude this chapter.

7. Ethical considerations

The proposal for the larger study (of which this study is a part) served at and was approved by the Rhodes University Ethical Standards Committee (RUESC). Upon receiving ethics clearance from the Department of Health, and in some cases from the institutions' ethics committees as well, each site was approached through hospital management and then through the nurses in charge of the hospital's abortion ward or clinic. As this study forms part of a larger study (the details of which have been explained above in this chapter), the recruitment process of this study slotted into that of the partner project. In the partner project, the Snethemba and I met the health service providers involved in abortion service provision. We explained who we were, the purpose of the study and that we had received permission from the

study from management. If the health service provider was interested in participating, they received an informed consent form. Once signed, we explained the recruitment process for the womxn requesting abortion and reached an agreement on the recruitment strategy we would use. The informed consent forms asked participants if they wished to participate by having their counselling session recorded and/or by way of being interviewed about their experiences of the counselling session and waiting room interactions observed by the researcher.

In their paper on the ethics of doing research Dominelli & Holloway (2008) suggest that doing research is inherently a political activity. When conducting research, questions around the reasons for conducting the research (is it necessary and why), who is involved in the research process (those whose names will appear on the final product, research participants, as well as all those who contribute to the research process in some way), how the research is conducted, as well as how it will be used afterwards (and for what purposes) are necessarily raised. These questions are often tackled by institutional ethics review structures before the research can commence. Once the institutional ethics review process has been completed, however, Shaw (2008) argues that researchers should *continuously* be aware of the ethical concerns raised throughout the research process. Indeed, there is some debate around whether to approach ethics as something which is continuously taking place throughout the research process or whether it is sufficient (or even ethical) to treat research ethics as a checklist of guidelines and principles which one must 'tick off' in order to obtain institutional ethics clearance (Shaw, 2008; Dominelli & Holloway, 2008). A combination of the two approaches was used in this study. While ethical principles are important in helping researchers to anticipate ethical concerns and how they might best be managed, and while institutional ethics review structures/processes are necessary in this regard, ethics is *also* about power dynamics within research relationships and is thus necessarily on-going (Dominelli & Holloway, 2008; Yassour-Borochowitz, 2004).

7.1. Ethical principles

In this study, the following guiding ethical principles were used: respect for autonomy; confidentiality, anonymity and privacy; and beneficence and maleficence. Each of these principles serve the purpose of protecting the participant during their involvement in the research. A feminist ethics which focuses on power dynamics and research relationships (Edwards & Mauthner, 2002; Hoskins, 2015) was also drawn upon in this study.

7.1.1. Respect for autonomy of persons

The principle of respect for the autonomy of persons assumes that a research participant is, at the outset, an autonomous being. Meyers (2001) defines autonomy as the ability to act in accordance with one's own desires, goals and wishes. Drawing on Foucault (1995), autonomy can be understood in terms of relations of power which may make it possible, or not, for participants to structure the field of possible action towards one which they desire, that is participation or non-participation in the research study. It may also be understood in terms of how the researcher-participant interaction unfolds. In research contexts, power relations between researchers and participants therefore demand that the researcher upholds and respects participants' autonomy. Informed consent is a way to ensure that the autonomy of participants is maintained.

Israel and Hay (2006) identify twin aspects of informed consent. The first relates to the fullness of information given to participants, information which must be fully understood by the participants. The second relates to the voluntariness of the decision to participate in the research. The relationship between the two is that for ethical consent to be to possible, potential participants must have all the knowledge necessary to freely decide whether to participate. Thus, informed consent requires the researcher to divulge all aspects of the research relevant to participation, namely, "the purpose, demands, risks, inconveniences, discomforts, [benefits] and possible outcomes of the research, including whether and how results might be disseminated" (Israel & Hay, 2006, p.61). The voluntary nature of consent also requires that potential participants understand that they may decide to withdraw their participation at any time (that is, up to the writing up of the thesis), without suffering any negative consequences as a result.

In this study, all womxn and health service providers who were approached were given an informed consent form (Appendix 3 and 4). The consent form was written in English and translated into isiXhosa. The final form that participants received was written in both languages. The cover page explained what the study was about: that we (my co-researcher and I) were interested in womxn's and health service providers' stories about their experiences of a) being and interacting in the waiting room area with womxn and health service providers and b) receiving/providing pre-abortion counselling. It explained the interview procedure, including how long the interview would take and that the womxn could speak in isiXhosa, English or could use both interchangeably; that the interviews would be audio-recorded only

with permission from individual participants (and included a description of the purpose of recording the interviews). In the form, participants were told that the interview would be a non-judgemental, safe space in which participants can share their experiences. The form also stated that the interviewers would provide contact details for available counselling services if participation in the interviews caused distress and participants wanted some psychological support.

When people younger than 18 are included in a study, ethical concerns around ensuring the autonomy of participants include questions of whether minors can give their own consent and/or whether the consent of a parent or guardian is needed. Procedural and ethical requirements of health research where participants are below the age of 18 suggest that consent of a parent or guardian is also required (Strode, Slack & Essack, 2010). However, it is important to note that the CTOP Act recognises the ability and capacity of young womxn below the age of 18 to make reproductive decisions, including the decision about what to do about a pregnancy. Thus, the Act stipulates that while healthcare providers are required to advise minors to consult their parent/guardian, the decision to do so is up to minors themselves. It also stipulates that health service providers are not allowed to prevent minors from accessing abortion services should minors decide *not* to consult with their parents/guardians. According to Mhlanga (2003) the inclusion of this provision in the CTOP Act was motivated by the realisation that for some minors, their pregnancy may result from sexual abuse by their parent/guardian. Requiring parental consent for abortion would thus violate minors' autonomy. Indeed, as discussed in the literature review chapter, research on adolescents and abortion have found that adolescents show great competency in making decisions around pregnancy. Such research has noted the competence particularly of young people who *are* considering abortion (Adler et al., 2003). Furthermore, Foucault's analysis of power shows how the family may be a site of power wherein inequitable parent-child relations may mean that parents, as pastoral agents who also exercise sovereign power, would likely structure their child's decision-making towards a particular outcome or simply enforce a particular outcome.

Guided by this, the consent form included a section for parental consent but asked minors to indicate whether they wanted parental consent and how the parent could be contacted if they did indeed want parental consent. Two participants in this study were below the age of 18- both were 17 years of age. Both indicated that parental consent was *not* required or desired. In accordance with their wishes, their consent to participate in the research was deemed sufficient.

7.1.2. Privacy, confidentiality and anonymity of data

Brinkmann and Kvale (2005) discuss the micro- and macro-ethics of research. Macro-ethics refers to considerations of how the research will impact the lives of participants and their communities once the findings have been disseminated. Micro-ethics refers primarily to how the research participant is treated. One important aspect which perhaps brings the micro- and macro- aspects together is the need to secure participants' privacy, confidentiality and anonymity. Wiles, Crow, Heath and Charles (2008) discuss confidentiality and anonymity as interrelated, with anonymity being one of the means used to ensure participants' confidentiality and privacy. Confidentiality is protected when the researcher and/or interviewer does not disclose information provided by participants without informed consent. As this information includes the content of the interview, researchers need to specify during the informed consent stage with whom the data will be shared so that participants may take this into account when deciding whether to participate.

As such, the consent form stipulated that participants' interviews would only be shared with other researchers working on the project and would also appear in the researchers' publications. Independent contractors who simultaneously listened to the audio data and read the translated transcripts to validate the translation were asked to sign a confidentiality agreement. The form contained information that the data would be stored for a limited time only and that while in use it would be stored on the researchers' laptops as well as in a central, secure, location at the Critical Studies in Sexualities and Reproduction (CSSR) research programme, after which it would be destroyed. Participants were also alerted to the fact that the findings would be shared with hospital managers to allow for an improvement of TOP services if recommended by the researchers. Consent forms for womxn accessing the TOP services included a statement that the womxn's interviews would not be shared with the healthcare providers to ensure that they are able to access the services regardless of what was said about the counselling they had received.

Participants' right to anonymity is upheld when the interview data and findings of the research are presented in ways that ensure individuals cannot be identified (Wiles et al., 2008). The data were anonymised in various ways. Firstly, when signing the informed consent forms, while participants' ages were recorded (for comparative purposes) participants were encouraged to use a pseudonym which they themselves chose. These pseudonyms were then used in the transcripts and subsequently in the extracts which appear in the analytical chapters to follow.

Secondly, when transcribing the data, any personally identifiable information was not included in the transcripts. Thus, names of geographic places, of institutions and organisations, and of people were omitted from participants' narratives. Lastly, while the sites have been described in some detail (in terms of socio-economic indicator, client/patient flow, number of health service providers involved in abortion and abortion counselling service provision), neither the names of the facilities nor their specific geographic location have been included in this thesis.

In addition to the privacy that was ensured through confidentiality (disclosure of information) and anonymity (omission of identifying information), interviews were conducted in a room to ensure that participants' privacy was maintained. This privacy was disrupted on three occasions (twice at site 1 and once at site 2) when a nurse came into the interview room to collect something. To protect the participants' privacy, the interview was paused until the nurse had left.

7.1.3. Beneficence and maleficence

Schlenker and Forsyth (1977) state that the principle of beneficence and maleficence has to do with the tension between knowledge production and the welfare of the participants. Thus, the authors state that the debate around research ethics is in part around what level of minimal harm to participants will/should be tolerated for the sake of 'science' or knowledge production (which may be used for the benefit of communities). Firstly, researchers have a duty to avoid causing harm (even minimal levels) to participants. Where this harm is unavoidable, researchers are tasked with the responsibility to take measures to remedy the harm caused. Secondly, the benefits that stem from the research should ideally outweigh the harm caused. In her paper in which she reflects on the ethics inherent in the researcher-participant relationship, Yassour-Borochowitz (2004) invites researchers to think seriously and critically about whom exactly the study is meant to benefit: the participants themselves and/or their communities, the scientific community, and/or the researchers? This question is being posed more and more as researchers are called upon to be critically reflexive about the researcher-participant relationship (Farrimond, 2013) (see discussion below).

The present study forms part of a larger project around PTOP counselling in the public sector, with the long-term aim of comparing experiences of PTOP counselling service provision in South Africa and in the United Kingdom. The goal of the project is to use the findings of the larger study to develop a best practices model for PTOP counselling which will be shared among the facilities and used to guide and/or improve PTOP counselling service provision. In working towards this, a policy brief (Mavuso, du Toit & Macleod, 2017) has already been

developed based on the findings of this study as well as that of the partner project and is being taken up in the development of National Guidelines on Abortion Provision. Therefore, firstly, in the future womxn who attend these facilities will benefit from the study. The health service providers involved in the study will themselves directly benefit from the study in terms of having access to the best practices model that will be developed using participants' (in this study and in the UK study) narratives of their experiences, as well as the recordings of the actual PTOP consultations. Secondly, for some participants in this present study, the opportunity to speak about their experiences was a rare one. This was true for health service providers who spoke about their experiences of isolation at work because of the stigma around abortion service provision and for womxn who found the non-judgemental, safe space to be extremely useful in a context of a silence around abortion. Thirdly, I, the researcher, have greatly benefitted from the study which is being used for my doctoral degree. Apart from a title, however, I have also benefitted from the skills I have learned and developed during this research process (skills such as sensitive interviewing around a topic that is much stigmatised, managing the ethics related to a project of this nature, developing and expressing my own voice, critical reflexivity and making a coherent argument, among others.).

7.2. A feminist ethics?

In articulating a feminist approach to ethics, Edwards and Mauthner (2002) suggest an approach in which ethics "is about how to deal with conflict, disagreement and ambivalence rather than attempting to eliminate it" (p.25). That is, ethics is inherently about relations of power immanent in the research process (Hoskins, 2015). As the reader will recall, following Foucault (1978, 2000), in this study power is conceptualised as something that is exercised (not possessed or owned) being as it is interweaved into micro- and macro-relations. In the exercising of power, the field of possible actions is structured and shaped towards a desirable action. Thus, a feminist approach to ethics views the researcher-participant relationship as a relation of power. The task is to engage in critical reflexivity about the extent to which both the researcher and participant can shape the other's possibilities for action.

Taking a feminist approach to research ethics, the code of respect for the autonomy of persons becomes problematic in its assumption that participants *can* make decisions in line with their own desires; that participants are able to exercise power and structure the researcher's field of possible actions towards one that is desired by the participant. Thus, for example, questions have been raised (not just by feminist researchers but also by researchers working from within other theoretical frameworks) about the voluntariness of the consent given by participants,

particularly where participation takes place in contexts such as institutional settings (for example, hospitals/clinics etc.) as is the case in the present study (Israel & Hay, 2006; Watts, 2011). Where data are collected within these settings, potential participants who are service users may fear that (non-)participation may affect the quality of health care they receive (Richards & Schwartz, 2002). Where institutional staff are potential participants, permission from institutional management to conduct the research may very well be experienced as an expectation of their participation in the research. In this case, staff may fear repercussions that may affect their work environment if they refuse to participate.

To enable the voluntariness of the consent given, potential participants were given an opportunity to ask any questions they had about the information they had received. This occurred before participants gave their consent and before those who consented were asked to sign the informed consent form (Richards & Schwartz, 2002). Womxn accessing TOP services were also told that participation or non-participation in the research would not affect their health care, that is, they would still receive the services to which they were entitled. Several womxn decided not to participate. For healthcare providers, I made a special effort to emphasise the voluntariness of participating in the study, given the concern that knowing that permission has been obtained from management might be experienced as an obligation to participate. Indeed, at sites 1 and 2, there were healthcare workers who opted to not participate, resulting in the sample of four healthcare providers. Importantly, participants were informed that having decided to participate in the research, they could still decide to withdraw their participation at any time up to write-up and that this decision would be respected. None of the participants decided to do so.

In addition to issues of consent, feminist researchers have also concerned themselves with the politics of representation; that is, how participants' narratives and experiences are represented by the researcher (Hoskins, 2015). When writing up the analysis, the researcher makes decisions about which parts of the data to include as examples and which to exclude. A researcher working from an African feminist approach and drawing from Transnational feminist insights would ask the following question: Have I attempted to represent the diversity or complexity of voices and experiences (particularly voices that have traditionally been silenced)? As a black womxn researching and producing knowledge on the experiences of womxn of colour (here referring to the Black, Coloured and Indian participants in this study), it was important to me that I avoid monolithic representations (either positioning my participants as acted upon or acting upon). I was particularly concerned about empathically

representing the healthcare workers in this study and did not want to position them as 'villainously' acting upon their clients. I found Foucault's analytics of power especially useful in enabling an understanding of health service provider as also acted upon and produced by/within discourses and various formations of power. Thus, for example, Foucault's (1976) work on the clinic as a site of power enables an understanding of how nurses are produced to be responsible for the health and well-being of their clients which includes the duty to decipher 'health problems' through the clinical gaze and intervening where necessary. Through Foucault's (2003) analysis and the work of others (Dean, 1994, 2002) who have elaborated on liberal forms of government, we can see how liberal governance enables and requires nurses to act coercively on behalf of those clients deemed incapable of acting in their own best interests. This enables an analysis of the various operations of discourses and power instead of analysing and evaluating individuals. Input from my supervisor and fellow researchers were extremely useful in paying attention to complexities of participants' experiences.

In the following section, I speak to the validation techniques used in the present study. This section includes a section on reflexivity.

8. Validation

The question of validity regarding 'scientific' research is one of legitimacy (Lather, 1993; Lenzo,1995): what knowledges count as legitimate and how can we (the various readers of various products of knowledge, i.e. dissertations, papers, reports etc) *know* that what we are reading is valid, legitimate, 'good' quality research? Debate around this issue has been extensive with varying viewpoints put forward. Some of the techniques and strategies that have been proposed as contributing to the validation of qualitative research include the following: triangulation, member checking, thick descriptions, reflexivity, saturation, disconfirming evidence, the use of an audit trail, extended field engagement, peer debriefing, and researcher-participant collaboration (Creswell & Miller,2000; Kuper, Reeves & Levinson, 2008). In this study, thick description, reflexivity, saturation and peer debriefing were used. To supplement this, I have also drawn on feminist insights around the notion of transgressive validity. I will discuss each of these in turn and in the following order: thick description, saturation, peer debriefing, and reflexivity (transgressive validity is understood to be a form of reflexivity and will therefore be discussed then).

Lather (1993) argues that in feminist constructionist approaches, authority, the basis from which one can speak or is allowed to speak, is understood to be partial. In other words, authority may be established (but only temporarily) by researchers in/through the explicit

acknowledgement that analysis is only ever an *interpretation*, and only ever one among many others. This means not only acknowledging that the data produced are shaped by the context of the research - the site(s) of data collection as well as participants' various social locations - but also taking time to explicate this context for the reader (Creswell & Miller, 2000). This explication, when described in rich detail, is referred to as thick description and is used as a validation technique in qualitative research (Creswell & Miller, 2000). Creswell and Miller (2000) add that the notion of thick description may also be applied to the description of themes, to which I add discourses and narratives. When producing thick descriptions of narratives or discourses, the reader can see exactly how narratives and discourses have been used in a study, which might differ from how the concepts have been understood and used elsewhere. Doing so enables readers to judge whether the analysis of a particular study is transferable to other contexts. Thus, the concept of transferability is explained by Willig (2008) who states that it is when a study has applicability beyond the immediate context in which the findings were generated. In this study, I have used thick description in describing my participants as fully as possible (whilst safeguarding their rights to privacy, confidentiality and anonymity) and in my detailed description of the discursive resources (discourses and canonical narratives) and micro-narratives analysed.

Saturation refers to the process where the researcher begins a preliminary analysis of the data (e.g. keeping track of the 'themes' that keep emerging) during data collection and uses this to guide the data collection process. When no new 'themes' come up, saturation is said to have been reached and the data collection process can cease (Kuper et al., 2008). In this study, several rounds of data collection were conducted at each site (two rounds at sites 1 and 3 and three rounds at site 2). In terms of the womxn's interview data, data collection at each site stopped when there was sufficient variety of responses. However, for health service providers, saturation proved to be extremely difficult for two reasons. The first is that there were a small number of healthcare providers at each site (for example, at site 3 abortion services were maintained by one provider) and the second is that although we had approached five sites, only three of those gave us permission to conduct the studies. While the data from the four healthcare providers are rich, the small sample size of the healthcare providers is a limitation of the study.

Creswell and Miller (2000, p.29) discuss peer debriefing as "the review of the data and research process by someone who is familiar with the research or the phenomenon". The point of peer debriefing is to challenge to the researcher-writer about: the assumptions entailed in their writing; the coherence of the methods and/or theories used; and challenge the researcher's

interpretations of the data and possible alternative interpretations. Peer debriefing was used in this study in the following ways: my interview schedules were reviewed by a scholar with their own research experience on abortion counselling; my interpretations of the data were reviewed by my supervisor who contributed her own insights; during data analysis sessions I presented my preliminary analysis to other researchers in my research unit; and lastly, my on-going work was presented at work-in-progress colloquia and research retreat held by the CSSR research programme .

8.1.Reflexivity

Critical research assumes that "the knower is part of the matrix of what is known" (Wilkinson, 1986, p.13 as cited in Macleod, 2002, p.19). Starting from this position, when reporting on the research process and the findings of the research, the task is then not to 'sanitise' the research process by removing all traces of the researcher's involvement and the consequences of this involvement, but to "mak[e] visible what is usually overlooked in research" (Parker, 2005, p. 30). This process can be defined as reflexivity. Kuper et al. (2008, p.405) elaborate on the notion of reflexivity by describing it as a process that enhances a researcher's "recognition of their own gender, ethnic background, and social status influence the choices they make about methods, data collection and analysis".

For Lather (1993), reflexivity incorporates 'transgressive validity', wherein researchers imagine and enact discursive practices outside of current normative traditions for practicing and writing up research. Researchers adopting this approach highlight their positionality as a researcher; as someone writing from within a particular paradigm, making particular theoretical assumptions (which may be classed, gendered, and raced in particular ways). What Lather (1993, p.682) proposes is a "politics and epistemology of positionality" which she contrasts directly with a politics of objectivism in which the researcher is implicitly *positioned* as having "a view from nowhere". A view from a specific and specified *somewhere* entails a way of conducting and writing up research in which "explicit incompleteness, tentativeness, the creation of space for others to enter, the joining of partial voices" (Kirkpatrick, 1991 as cited in Lather, 1993, p.682) are encouraged. It also entails the acknowledgement of heterogeneity and similarity (Lather, 1993). In taking up such an approach, it becomes possible to think of different ways in which we researchers may construct authority and authorship when constructing knowledge (Lenzo, 1995). In present study, this has been done by emphasising the construction, tenuousness and partiality of the knowledge I have co-produced here. I have

done this by reflexively engaging with this document as a text, acknowledging and speaking to the role played by others (such as my supervisor, my co-researcher, Snethemba and other researchers studying through the same research unit) in producing this piece of knowledge production, as well as by continually calling attention to the myself as the author-researcher-interviewer who is engaged in the activity of knowledge production.

In the following discussion I speak to my various positionings and the role they played in shaping the research process. Thereafter I speak to what Parker (2005) refers to as the micro-level interactions within research, focusing on the power relations between myself as the researcher and the participants in this study, and between myself, the healthcare providers and psychology honours students whom we relied on for the data collection process of the larger study. I conclude this section by making visible some of the expectations I had going into this research process. Throughout this section on reflexivity, I draw on extracts from a research journal that I kept to aid the reflexivity process.

8.1.1. Positioning the researcher

As I have suggested elsewhere in this chapter, my decision to use an African feminist approach whilst drawing on Transnational feminist critique was motivated by cognisance of the increasing calls for the decolonisation of university spaces. As a Black womxn, (critically) using a framework that not only made visible and drew on the writings of African feminist writers and feminist writers theorising from 'Third World' spaces, but that also enabled a compassionate and ethical representation (that is, non-monolithic) of the womxn (those accessing and providing TOP services) who participated in this study, was important. Given that Foucauldian scholarship could be considered by some as inappropriate and irrelevant for a study researching the experiences of African (designating those with citizenship) womxn, it was also important to think through the contributions which could be made by Foucauldian scholarship and to explicitly address this in the theoretical chapter.

Extract 1

> The interview with the nurse went really well. I think she enjoyed the chance to speak about her experiences. One thing she said stayed with me: she said she wishes that more people would care about the nurses and their experiences instead of focusing on the clients' experiences. I felt guilty as a researcher as my previous research had focused on womxn's experiences of abortion decision-making. And now that I was including the voices of healthcare providers, I didn't want to represent them unjustly. I have been reminding myself to be just as compassionate in how I represent the healthcare providers as I am in my representations of the womxn accessing abortion.

Recognising that this thesis is ultimately my account as a researcher and not my participants, I wanted to make sure that I was capturing the complexities in participants' narratives and accounts of their experiences. As the above extract shows, I was particularly concerned about this when it came to the healthcare providers. The appreciation I was shown by the nurse (Thembi) in this extract highlights the significance of representation: not only how participants are portrayed in analysing their discursive practices, but also the very act of including voices which may have been marginalised. As I discuss in my literature review, much of the research conducted on abortion experiences (and particularly abortion counselling) focuses on the experiences of womxn receiving TOP services. Using an African/Transnational feminist insights, Foucauldian scholarship and a narrative-discursive analytic method have enabled an understanding of participants as both acting upon and acted upon, as produced by/within discursive resources and power relations and as actively negotiating with their discursive environments. This has allowed me to be especially cognisant not only of the power I exercise as a researcher but of *how* I exercise this power. In the next section I speak to some of the relations of power I had to navigate in conducting this research.

8.1.2. Micro-level interactions

While 'researcher' comes with a certain level of authority and privilege, at least in relation to research participants, this is not always the case. The design of the study necessitated co-operation between the researchers (Snethemba and I) and the healthcare providers who were instrumental in the data collection process. This was because we would leave one audio recorder with the nurse/counsellor doing the counselling (we used the other to record interviews) and thus rely on them to record the counselling sessions on our behalf. Occasionally, amid their workload the healthcare providers would forget to record sessions and would thus need to be gently reminded. At other times, because of miscommunication between ourselves and the healthcare providers which would result in a misunderstanding about how many recordings were needed, health service providers would stop recording sessions.

As I mentioned earlier in this chapter, at site 2, two full-time psychology honours students studying through a university that was near the site and who were fluent in isiXhosa and English were paid to conduct some of the interviewers. The workload of the students, and possibly the fact that this was not their project, meant that they struggled to find time to visit the site and conduct the interviews. While the interviews they conducted were rich, they tended to be very brief and not all participants' biographical information was collected, perhaps again reflecting the difficulty of managing a heavy workload. This could also reflect participants' own time

constraints which must also be navigated, and which can place the interviewer under considerable pressure to conclude the interview as quickly as possible. Consequently, opportunities for future comparisons with the present study are limited due to incomplete information for participants recruited at site 2.

When complications in the power relation between healthcare providers and Snethemba and I, and between the psychology honours students and I, I was acutely aware that there were limitations to what I could do to shape the data collection process, particularly because the assistance of the healthcare providers was needed to maintain the privacy of the counselling sessions.

The importance of these interactions described above, and of my experiences of frustration at not being able to fully control the process, lies in their disruption of the privileges that researchers have access to by virtue of their position as 'researchers'. My experience of these disruptions points to my own reliance on these privileges. During an interview with a participant (Promise Rose) my reliance on this privilege as 'researcher' was made apparent to me when the researcher-participant relationship was inverted. At the end of my interview with her, Promise Rose asks if she can interview *me* now that I had interviewed her. Below are two extracts (extracts 2 and 3) from my research journal where I wrote about this interaction.

> **Extract 2**
>
> On the last day of round 1, at the end of my interview with a participant she asked if she could interview me now that I had interviewed her. I was taken completely aback. What I had not expected was to have the tables turned on me, so to speak. And it did feel like that at the time, as if I our positions had been reversed and I was now the participant, slightly anxious due to not knowing what I would be asked. I also, perhaps for the first time, realised how anxiety provoking the word “interview” can be. I now realised that all of the womxn who had accepted being “interviewed” by myself or Snethemba had gone into the encounter being on the back foot. Listening to the recording, I laugh nervously after having agreed to be interviewed. I had no idea what to expect.

> **Extract 3**
>
> As it turned out, she wanted to find out more about *me*, about who the person who had just interviewed her was. In this exchange, some of my social positions, some of which I had not disclosed to her, were revealed. For me, it put into sharp relief, who I had been during my interviewing of her, or the questions she had had about who I had been. I was not just an interviewer (and thus privileged with information/knowledge and the authority this identity brings): I was also someone privileged enough to have climbed the educational ladder to reach a PhD level, someone privileged enough to have a car, young (which she stresses in the exchange), and from Soweto township; all of which intersect with my identity as a black womxn.

In extract 2, my discomfort with and shock at having "the tables turned on me" is apparent. As I discuss in the extract, what became clear to me is that research interviews are a site of power

relations where specific roles are expected of the researcher (elicits the confession) and the participant (is obliged to offer up the confession). As a participant as I was anxious: I had no idea about what Promise Rose was going to ask me. Like many of individuals I have interviewed before, I was "on the back foot". Promise Rose was in control of the interaction and she could take the interview in any direction she wished to. And it was this specifically that made me anxious.

In extract 3 I reflect on the questions Promise Rose had asked me. As is suggested in the extract, the interview had felt like a confession. My various social locations, and how much they distanced me from several of my participants, were elicited by Promise Rose. While I had been allowed to forget about what Collins (1986) calls the 'outsider within' position, this interview "put into sharp relief, who I had been" during the interview: an insider who never fully belongs and thus exists on the edge of belonging. Thus, while, like Promise Rose I was a young Black womxn who had grown up in township, I was also "not just an interviewer (and thus privileged with information/knowledge and the authority this identity brings): I was also someone privileged enough to have climbed the educational ladder to reach a PhD level, someone privileged enough to have a car". My anxiety around this interaction can be analysed in terms of the assumptions I made around insider status being more useful for eliciting participants' 'confessions', thus resulting in my efforts to mask the social distance between myself and my participants. It also can be analysed in terms of the assumptions I made about how research interviews *should* proceed: with me asking the questions and my participants' obligingly responding. Thus, the disruption of this normative expectation was unsettling.

Having discussed some of the decisions I made which shaped the research process, and the power relations which are imbricated in the process of doing research, I now conclude the chapter.

9. Conclusion

The purpose of a methodological discussion within research/academic practices is to make transparent, to the reader, the procedures followed, and decisions taken during the research process. This transparency enables members of research communities to follow the steps outlined to apply the procedures to different or similar contexts to extend knowledge production, or to evaluate and situate the analytical claims made by the researcher. In following the convention of the methodological write-up, I began with a theoretical discussion on how I used Foucauldian scholarship to extend Taylor and Littleton's (2006) narrative-discursive

method. I argued that the use of Foucauldian understandings of discourse and power enables a narrative-discursive method that more fully accounts for how individuals' discursive work or narrative construction is constrained and shaped by prevailing discourses, the subject positions made available within them, and the power relations which shape not only participants experiences of the PTOP healthcare encounter, but particular tellings of these experiences. I then turned to the procedural elements of the study, describing the sampling and recruitment strategies, data collection and analysis methods that were utilised to conduct this research. I also discussed the ethical principles which guided this study, as well as the issues which arose in observing those principles. Lastly, I discussed the strategies used in the process of validating this study, which included a discussion on reflexivity.

Chapter 6: Discourses underpinning pre-abortion counselling talk

1. Introduction

This chapter is the first of three devoted to analytical work. The three chapters are structured in the following way: despite the overlap in the discourses drawn upon by womxn and healthcare workers, the current chapter predominantly draws on womxns' interview data around the discourses they drew on; chapter 7 is dedicated to how these discourses were used by the womxn to construct micro-narratives of their experiences; and in the last analytic chapter (chapter 8) I speak to the discursive resources (canonical narratives and discourses) drawn upon by the healthcare workers in accounting for various pre-abortion counselling practices. During this last analysis chapter, I also speak to the various forms of power (pastoral, liberal and sovereign/authoritarian) referred to by the health service providers in this study.

The current chapter, then, presents the first step of Taylor and Littleton's (2006) two-pronged narrative-discursive approach which I have used to analyse the womxns' and healthcare providers' interview data. As such, in this chapter I discuss the various discourses that participants drew on to construct narratives/accounts of their experiences of waiting room interactions and the pre-abortion counselling session that followed thereafter.

To construct narratives of their experiences, participants drew on (neo-)liberal discourses. Here, womxn described liberal counselling practices wherein they were responsibilised by health service providers, with womxn often responsibilising themselves for having failed to prevent an unintended, but not necessarily unwanted, pregnancy. Drawing on responsibilisation discourses, womxn also constructed the decision to have an abortion as a responsible one in facilitating responsible parenting, given the needs and interests of existing children. Liberal counselling practices described by the womxn included health service providers' emphasis on womxn's 'choice' in deciding about whether to continue with the abortion or not. Womxn also constructed the counselling as non-directive information-giving. In consumer/client-centred discourses, some womxn evaluated the abortion care as a good service, with attendant expectations of what good/bad service provision entails. Within consumer/client-centred discourses, a private/public health care dichotomy emerged wherein private health care was associated with good quality service whereas public health care carried a negative connotation of deficient service. Abortion as risk also featured in womxns' talk.

For some womxn, distinctions between ‘good’ and therefore ‘bad’ service provision relied on a psychotherapy discourse where counselling necessarily involved healing or transformation, or the easing of a burden. Within this discourse, the health service providers’ counselling practices were constructed as ‘real talk’ which, although evoking strong emotions, was positively valued as genuine and truthful.

Through a pronatalist discourse, womxn spoke to the distinctiveness of first-time pregnancy, the imperative of first-time motherhood and the maternal-foetal bond. As part of a pronatalist discourse, healthcare providers spoke to the glorification of parenthood discourse. Womxn not only referred to foetal personhood discourses when relaying health service providers’ talk but sometimes took up this discourse themselves. Lastly, moralisation discourses constructed abortion as im/moral and shameful and, drawing on a religious discourse, sinful as well. Within these moralisation discourses, multiple abortions were particularly problematised.

Post-structural work around disciplinary and sovereign/authoritarian power relations will be drawn on as womxn referred to these kinds of power relations between themselves and abortion care providers. Foucault's analysis of confessionary practices as surveillance and self-surveillance, and their intensification within the disciplines of psychology, will also be drawn on as womxn construct and make use of a psychotherapeutic discourse in making sense of their counselling experiences.

During interviews, participants were asked to speak about their experiences of waiting room and counselling encounters. While speaking about these encounters, they drew on discursive resources that they understood as shaping these encounters. Thus, it is important to keep in mind that at times womxn may have simply referred to discourses used by healthcare providers while at other times womxn took up these discourses themselves.

2. (Neo-)liberal discourses

As discussed in the theoretical chapter, liberal discourses relate to constructions of rational, decision-making individuals, the freedoms they are entitled to and the rights which are to protect these freedoms (Dean, 2002; Rose, 2001). As a form of government, liberalism utilises the disciplinary power techniques of surveillance, measurement and normalisation to direct individuals to self-govern in responsible ways (Foucault, 1978, 1995, 2003). Below I discuss, using extracts from womxns' interview data, these (neo-)liberal discourses and the ways womxn positioned themselves and their abortion care providers through and within them. These discourses are: liberal/non-directive counselling practices, a discourse of

responsibilisation, abortion as risk discourse, and a consumer/client-oriented discourse. Although I draw exclusively from womxns' interview data in this section, it is important to note that these discourses were also used by healthcare providers who spoke of liberal counselling practices (which will be discussed in the third analysis chapter).

2.1. Liberal/non-directive counselling practices

Health care providers' information giving practices were constructed as liberal and non-directive. Although liberalism, as Dean (2002) argues, is an act of government, it is one whose operations mask it as such; hence, its appearance as a *lack* of government. In this study, womxn therefore described health care providers' information sharing around contraception, the abortion procedure and discussion of options (i.e. continuation or termination of pregnancy) as non-directive in that the decision to have an abortion was constructed as theirs to make. Health service providers were positioned as knowledgeable but neutral in imparting useful information.

In extract 1 below, Zipho responds to my question around the way in which the pregnancy options part of the consultation was delivered by the health care provider.

> *Extract 1* [site 3] {womxn} <X>[19]
>
> **I:** (1) e::m then (.) from your experience (.) how did the nurse speak to you when she spoke about the pregnancy options?
>
> **Zipho:** like she explained everything */ja/ ja* she spoke she explained everything she said it's up to me if I do it but she explained (.) nicely/well shame /ok/ mm

By stressing the word "me" in the sentence "she said it's up to me if I do it but she explained nicely/well", Zipho indicates how choice was explicitly emphasised in the counselling. The nurse, in explaining everything about her options, is depicted as imparting necessary information, but is in no way attempting to make the decision for Zipho. Zipho, with information in hand, is left to do that.

In the extracts below (extract 2 and 3) Thamie and Balisa describe liberal, non-directive counselling, this time focusing on the information provided around the termination of pregnancy procedure and possible outcomes thereof. Importantly, the effects (and aims) of liberal counselling, which is to get and enable subjects to self-direct and self-govern, are made visible here.

[19] <X> indicates that the extract was translated from isiXhosa while <E> indicates that English is the original language of the interview.

Extract 2 [site 3] {womxn} <E>

Thamie*:* […] she explained everything /mm/ u::m (2) the advantages /mm/ and the disadvantages /mm/ u::m (1) she:: told me:: about the procedure /mm/ how it's going to be done /mm/ (1) u::m (2) then it was (.) my decision whether I take it in a positive way /*ja*/ o::r (.) I quit /mm/ but then I've decided my decision [laughs] /[laughs]/ the one that I've decided /yes [laughs]/ *ja*

Extract 3 [site 3] {womxn} <E/X>

Balisa: the counselling went well (.) and then I see:: by doing counselling *neh* /mm/ out of my own decision /mm/ it helped me because (.) in such a way that I didn't know that (.) how bad it is to do an abortion it's a bad thing or it's a good thing (.) /mm/ you see it (.) by:: getting counselling it was (.) something that makes me at least (.) powerful /mm/ mm-mm /as if you are reaching a conclusion/ mm to make my own decision /mm/ because in the end (.) I had been thinking a long time not knowing whether I must do it or not do it I wanted to come /mm mm/ but at least I got counselling before I get any medication /mm/ and what I was thinking that (.) you have to do your own decision in the end

In extract 2 above, Thamie tells of how the nurse explained "the advantages and the disadvantages" of the procedure and "how it's going to be done". In doing so, Thami positions the nurse as neutral in telling the balanced and unbiased truth about termination of pregnancy. Like Zipho (in extract 3) Thamie emphasises that the decision to have an abortion was left to her. In Thamie's extract (extract 2) however, we see that another decision has also been left to her and others requesting termination of pregnancy at a public health facility: she can choose to take the information positively, and so proceed with the abortion, or take the information negatively, and "quit". Through this, then, the neutrality and factualness of the information is upheld as *how* the information is received is up to individual womxn. Thus, ultimately, the decision to continue with termination of pregnancy is the womxn's decision. The health service provider's role in the counselling is therefore to make available all the information she has and within liberal counselling discourses, she does so in a non-prescriptive way.

Balisa, in extract 3 above, demonstrates the powerful effect and intention of liberal discourses. She states that by having voluntarily decided to have counselling (at site 3, where this extract is taken from, the nurse providing the abortion care let womxn know that counselling was optional) she benefitted from realising that abortion is not necessarily "a bad thing or it's a good thing" but that "you have to do your own decision in the end". And one effect of liberal counselling, and liberal discourses in general, is that when provided (in a way that emphasises individual freedom to decide) with all the necessary information, individuals may feel empowered to act. Thus, as Balisa states: "counselling it was something that makes me at least

powerful". The implication here is that while individuals are given freedom to make 'rational' and 'responsible' decisions, if they 'stubbornly' refuse direction (which is of course implicit), responsibility for the decision and the outcomes of that decision, is theirs to bear. Below, I turn to liberal discourses which do the explicit work of responsibilising its subjects.

2.2. A discourse of responsibilisation

The concept of risk is important within discourses of responsibilisation. In such discourses, individuals are tasked with the responsibility for avoiding various kinds of risks which pose a threat to individual health, well-being and economic activity and therefore also threaten the population at large in neo-liberal societies (Dean, 2002; Foucault, 2003; Kelly, 2001; Rose, 2001). Where individuals do not responsibly 'choose' to avoid risk, responsibility for the individual and social consequences are theirs to bear. As I will show using the extracts below, dominant constructions of abortion currently entail certain assumptions about what risks should have and have not been avoided or managed for womxn to present at a termination of pregnancy clinic.

In extract 4 below, this responsibilisation was framed in relation to the so-called risks associated with abortion.

> *Extract* 4 [site 2] {womxn} <X>
>
> **Likhona:** = they really then they briefed me they explained everything to me /everything/ and they even said that if I choose to do it (.) I'll be doing it at my own risk /at your own risk/ yes

Several womxn in the study, particularly those who were interviewed at sites 1 and 2, spoke about being informed about the risks of abortion. According to some of the womxn interviewed, deciding to have an abortion was framed by health service providers as a risk that they would have to take. Implied is that the womxn were expected to accept responsibility for having been duly informed and subsequently choosing to have an abortion, despite the risks. Thus, in extract 4 above, Likhona states that: "they briefed me they explained everything to me and they even said that if I choose to do it, I'll be doing it at my own risk".

Sometimes womxn took up this discourse of responsibilisation and positioned themselves as not only responsible for preventing pregnancy, but also as needing to be reminded of this responsibility. Extracts 5 and 6 are examples of this.

Extract 5 [site 2] {womxn} <E>

Sascarlimseko: I felt <u>good</u> (.) *neh* /mm/ because at the same time sometimes you need to <u>understand</u> (.) the situation that we put ourselves into (.) /mm=/ =so (1) it's <u>good</u> to be:: (1) e::h <u>informed</u> /mm/ what is going on /mm/ but then we live by choices (.) /mm/ and eh (.) they also explain that (.) you do by your choice /mm/ mm so (.) I I I felt <u>ok</u> because I was (.) I <u>did</u> (.) have a chance to explain myself /ok/ mm

Extract 6 [site 2] {womxn} <X>

CI: is there anything else you want to speak about or add (.) as we conclude our conversation?

Nziweni: *ja*:: I can say that (.) to do abortion (.) it's not a (.) <u>good</u> thing /mm/ at <u>all</u> /mm/ you see it is not a nice thing this (1) so us womxn (.) or (1) so that we save the souls of our children or so we will not be able to become pregnant (.) we can we prevent (.) we can plan then (.) now with [family] planning we can use condoms /mm/ you see (1) that's what I can say

In extracts 5 and 6 above, Sascarlimseko and Nziweni both take up liberal discourses which place them as accountable for the pregnancy which they intend to terminate. Sascarlimseko responsibilises not only herself but others in her similar situation by stating: "sometimes you need to <u>understand</u> the situation that we put ourselves into". In doing so, she readily accepts ownership of and accountability for the decision to terminate her pregnancy. Importantly, Sascarlimseko also speaks to the usefulness and necessity of pre-abortion counselling which is informative about any risks that come with making a particular *choice,* as she herself explains that we "live by choices".

Having been responsibilised by the counsellor, what is important for Sascarlimseko is that she "had a chance to explain" herself, to account for her decision to terminate the pregnancy, and possibly also account for having been pregnant in the first place. Likewise, when asked at the end of the interview whether she has any final words to say, Nziweni takes up a responsibilisation discourse where abortion is constructed as "not a good thing". As a result, failing to use contraception is constructed as inherently irresponsible. And as Nziweni shows, the responsibility for preventing unintended pregnancy, and therefore abortion, lies with womxn. Thus, she states: "so us womxn or so that we save the souls of our children or so we will not be able to become pregnant we can we prevent we can plan then now with [family] planning we can use condoms". In doing so, Nziweni draws on a religious, foetal personhood and gendered discourse where 'womxn' must exercise pastoral power in safe-guarding the salvation of the souls of their children.

For some womxn in the study, self-responsibilisation was linked to motherhood and the imperative to behave and act in the best interests of one's children. Extract 7 below is an example.

> *Extract 7* [site 3] {womxn} <E/X>
>
> **Yolanda**: […] but the circumstances that I'm under /mm/ you know (1) I've got a twe::nty months toddler /mm/ so:: (.) I can't afford to have /*ja*=/ =you know another child (.) cause she's my responsibility (.) she still (.) needs my you know my attention /yes yes/ so it's one of the reasons that I decided to come here (.) and do it even though it's gonna be hard /*ja*::/ but (.) what can I do

Yolanda (extract 7 above) states that terminating her pregnancy is the responsible thing for her to do as a mother as it will enable her to look after her existing child who is a toddler. Unlike Sascarlimseko above whose accountability is contextualised within the realm of choice, Yolanda's sense of responsibility stems from a lack of choice, a duty and obligation to be a good mother to her children. In doing so, Yolanda draws on what Morison (2011) and Mavuso (2015) refer to as a child-centred discourse wherein the best interests of the child are foregrounded and prioritised above the parent's own. A child-centred discourse is here drawn on so that Yolanda can position herself as a selfless and therefore 'good' mother. Within a pre-abortion counselling context where womxn may be responsibilised for failing to prevent the pregnancy that they wish to terminate, and where abortion is constructed as problematic, self-responsibilisation to justify the decision to terminate is not only understandable but may be an effect of liberal discourses around risk and responsibilisation.

Below I turn to a consumer-/client-oriented discourse which womxn used in evaluating the overall service they received.

2.3. Consumer-/client-oriented discourse

Skålén, Fellesson and Fougère (2006) describe marketing as a form of liberal government wherein organisations and institutions, and their employees, are configured as being customer- or consumer-oriented in not only how they understand themselves but in how they operate. As Skålén et al. (2006) discuss, marketing discourses shifted away from describing how organisations and institutions function to prescribing how they should operate. In service management discourses, understanding and caring for the customer, and paying equal attention to how the service is provided in addition to making sure it is delivered are vital for ensuring customer satisfaction and thus success. While Skålén et al. (2006) focus on how the conduct of employees is governed through service management discourses, as I will show, participants in this study drew on such discourses in their evaluation of the pre-abortion healthcare encounter

as a service provided to them. In doing so, they drew on certain assumptions about what 'good service' is, notions which mostly revolved around expectations of sufficient communication, of empathy, care, and patience from health service providers, as well as efficiency. For some participants, expectations around 'good' and 'bad' service were dichotomised into private/public health care respectively. I refer to this discourse as a consumer-/client-oriented discourse.

While some womxn in the study drew on consumer/client-oriented discourses in response to questions around their expectations coming to the TOP clinic, for other womxn, like Thembakazi below (extract 8) consumer/client-oriented discourses were deployed when answering questions around their experience of their interactions with the abortion care staff. Furthermore, while others spoke to specific pesonal qualities and attributes that make a service provider suitable for interacting with people, others described certain expected behaviours associated with good service provision. Extract 8 (below) is an example.

> *Extract 8* [site 3] {womxn} <E/X>
>
> **CR:** ok (.) ok I understand (.) and now then the interaction with the nurse (.) and you [all] (.) how was it /the nurse/ mm-mm (.) when she interacted with you the time you guys were waiting here?
>
> **Thembakazi:** (1) mm she did not (1) she did not do like (1) I will say like (1) I think the the the [laughs] the nurse is in a pressure of working alone /mm-mm/ so she never gave us the (1) like (1) what will I say (1) she never paid us a lot of attention /o::h/ because (1) she was busy she was trying to do (.) others here she is testing them others do they qualify or not qualify /ok/ and then she left us to do something that we don't know far away she came back (.) she again stood here for a long time and chatted (.) it was then that ok we feel neglected because (.) /o::h=/ =she did not come and say that /o::h/ and then she gave us some forms […] and then we were like 'woh uh (.) she's not even explaining why must we read here' /*ja*/ […] she didn't even <u>stand</u> there even for <u>five</u> minutes and say /mm/ ok guys this what we going to do you going to read this (.) this information I'm giving you is about this and this and this and this /mm/ she just give you the she just gave us the paper then she turned her back away /oka::y/

In extract 8 above, Thembakazi shows how behaviours that are regarded as being part of 'good' service provision are linked to norms around paying attention to clients and providing effective and thorough communication. The absence of these behaviours is not only bad service, but, as Thembakazi implies, is unjust as it contravenes the kind of service *owed* to clients. Hence, Thembakazi states that the nurse "never paid us a lot of attention…then she left us to do something that we don't know far away". As Thembakazi explains, this lack of communication and attention resulted in feelings of neglect. Thembakazi, goes on to explain what *should* have happened to provide a just service: "she didn't even stand there even for five minutes and say

ok guys this what we going to do". That Thembakazi uses the word "even" suggests that what she is describing, constitutes the bare minimum of the kind of service that clients should expect to receive.

While some womxn described their disappointment with the service received and in doing so made explicit and implicit statements about the kind of service they were owed, some also simultaneously expressed their understanding of why the service they had received had been compromised. Thembakazi (extract 8 above) thus prefaces her complaint by acknowledging a possible reason for the poor service: "the nurse is in a pressure of working alone". By doing so, she implies that under certain circumstances, working conditions may put reasonable limitations on the health care worker's ability to provide a 'good service". Considering this however, she goes on to suggest that there is a minimum level of care which should and therefore could have been provided.

For some participants, notions about the kind of care and service they can expect to receive were dichotomised into private and public health care and service provision, with private health care being linked to 'good' service and public health care carrying connotations of 'bad' service provision. Within this dichotomy, the conditions necessary to provide 'good' service (such as access to financial resources needed not only for infrastructure but human resources as well) were masked and were also absent in participants' talk. This had the effect of naturalising the binary between good (private) and bad (public) health care. Most of the participants who drew on and constructed this dichotomy expressed surprise at the level of care and service they experienced at their TOP facility, all of which were located in public/government hospitals. Extract 9 below is one example of the use of this binary.

> *Extract 9* [site 2] {womxn} <E>
>
> **I:** what what (.) can you say more about what you were expecting?
>
> **Vanessa:** I (.) you know I've been to u::h government clinics and hospitals /mm/ and the people generally are very disconnected from the patient /mm/ and they don't care and they are not interested in what's going on with you (.) and they just do their job and you're just a number (.) but here (.) they actually talk to you (.) they listen to your story and they ask you questions and (.) they make you feel like they are here to listen /*ja*/ to understand you (.) so:: um *ja* I expected them to be rude actually /mm/ and very disconnected and unsympathetic and (.) not understanding /mm/ and (.) every single person from (.) that I've met here today is very (.) calm and nice and helpful /mm/ I'm surprised for that people are very helpful /mm/ *ja*:: yus that was nice

In extract 9 above, Vanessa details the kind of service she has come to expect from government health care. Firmly locating her construction of government health care as inadequate within

her own personal experience, she implies that such service is the norm within such institutions. Thus, Vanessa describes: "the people generally are very disconnected from the patient". Connecting with the patient, as she describes, means expressing a genuine interest in and care for the patient. Health care providers who connect with their patients "listen to your story and they ask you questions and (.) they make you feel they are here to listen to understand you". Disconnection is seeing the patient as "just a number", dehumanising the patient. Vanessa goes on to say that she "expected them to be rude actually…and very unsympathetic and (.) not understanding". As Vanessa implies, the way the service is carried out is just as important as the service itself, and the *how* is what elevates the service to more than just doing the job. Unlike other participants, the level of care Vanessa is describing, is constructed as going above and beyond the requirements of the job, as opposed to the job itself.

Vanessa's and others' expectations of 'public health care service' characterised by ill-treatment of patients reflects research conducted elsewhere in South Africa. Such expectations and experiences, which I will show in the next chapter where I discuss womxn's narratives of their experiences of the pre-termination of pregnancy counselling encounter, are in line with research that describes womxn's experiences of public health care services in South Africa. Examples include research by Jewkes et al. (2005) who describe womxn's anticipation of staff rudeness as a barrier preventing them from accessing legal abortion, and Wood and Jewkes (2006) who describe nurses' scolding and harassment of adolescents as a barrier to accessing contraceptive services.

Collectively, the liberal discourses described above figured significantly in womxn's talk around their experiences of the pre-abortion counselling encounter. Such discourses worked to position womxn and health service providers in various ways. Thus, through liberal/non-directive counselling practices womxn positioned the healthcare providers as knowledgeable and as imparting neutral information in a balanced way. By emphasising their clients' choice, womxn also positioned healthcare providers as deferring to and respectful of their clients' wishes and autonomy. Through a responsibilisation discourse, womxn took up the responsible subject position who must be made aware of the consequences of their actions (not preventing an unintended pregnancy) and as responsible, and good mothers by terminating the pregnancy for the sake of their existing children. And through a consumer-oriented discourse, womxn positioned themselves as expert-consumer in knowing the kind of service they are owed. Below I turn to another liberal discourse, a (reproductive) rights discourse but note the absence of this discursive resource in womxn's and healthcare providers' interview talk.

2.4.A (reproductive) rights discourse

In liberal government, individual freedoms are ensured through rights and circumscribed through the responsibilities and duties that are attached to these rights. In a rights framework, the responsibilities of the state are also specified. A rights discourse was evoked once by one participant.

In extract 10 below, Vanessa is responding to my question around whether there was anything she had wanted to ask during the counselling but had not done so.

> *Extract 10* [site 2] {womxn} <E>
>
> **I:** *ja* (1) ok um and then was there (.) anything that you wanted to ask (.) the:: counsellors or say that you didn't get a chance to?
>
> **Vanessa:** no I I:: (.) like I was saying to her at any time can you:: get up and say you don't wanna do this (.) and she said no definitely (1) uh but (.) the way they (.) counsel you and inform you there is (.) you don't have questions cause they are so (.) thorough in the way (.) all the way from contraceptive to:: what next to don't do this again and then what happens if the next time (.) going through the Act [Choice on Termination of Pregnancy Act] (.) or you know uh the:: legal stuff a::nd (.) helping you understand /mm/ their right as well as yours when it comes to having an abortion

Like the several womxn in this study, Vanessa responds to my question by stating that the information provided during the counselling was quite thorough, thus precluding any questions on the part of womxn receiving the counselling. As Vanessa explains, the comprehensive information provision included "going through the Act [Choice on Termination of Pregnancy Act] (.) or you know uh the:: legal stuff a::nd (.) helping you understand /mm/ their right as well as yours when it comes to having an abortion". While the reference to womxn's rights under the CTOP Act is clear here (womxn have the right to an abortion), what is ambiguous and is therefore particularly noteworthy is the inclusion and emphasis on the right of healthcare providers. This is significant because the CTOP Act does not enshrine any rights on the part of the healthcare provider. Although it is ambiguous, what is possibly being referred to is the right to not participate, on grounds of conscientious objection, in abortion provision, a right which is provided for within the South African constitution (as a general right) (Mhlanga, 2003). Thus, the reported reference to healthcare providers' rights under the CTOP Act, when juxtaposed along the right of womxn to access abortion, may have the effect of circumscribing womxn's right to abortion and communicating something about the immorality of abortion which is necessarily implied when conscientious objection is permitted.

Given that the CTOP Act enshrines womxn's right to access legal and safe abortion, it is significant that there was an absence, on both the part of healthcare providers (to be picked up

in chapter 8) and womxn interviewed in this study, of a rights discourse. Where womxn discussed how they were called on to explain their reason for abortion, not one participant stated that they spoke about their right to have an abortion. This echoes a finding by both Chiweshe (2016) and Mavuso (2015) who conducted studies on womxn's narratives of abortion decision-making. While a use of this discourse might effectively justify womxn's abortion request, drawing on this discourse may be untenable within a pre-abortion counselling session as it may be received as a direct challenge to healthcare providers' authority and womxn may feel that their services would have been compromised by drawing on this discourse.

In the next section, I discuss womxn's use of a psychotherapeutic discourse, as described by Parker (1998). This discourse featured as a dominant discourse in making sense of the counselling they received. Womxn sometimes drew on (neo-)liberal notions of counselling which construct counselling as non-directive information-giving which facilitates and enables the womxn's choice. However, this was not always the case. Rather, what emerged is a psychotherapeutic discourse which constructs counselling in particular ways and draws on particular understandings of both the counsellor and counselee. These understandings dovetail with Foucault's (1978) own historical analysis of confessionary practices and the development of the disciplines of psychology and psychiatry.

3. Psychotherapeutic discourse

A psychotherapeutic discourse, as Parker (1998) describes, contains rules for how we are to understand the self, or therapeutic subject, how we are to understand the mind and the ways in which it functions, in both 'healthy' and 'unhealthy' states, and how we are to understand healing. It also prescribes how we are to understand therapy and counselling and the relationship between a counsellor and their counselee within the therapeutic setting. As I will show, Foucault's (1978) work on confessionary practices lends some insight in analysing and understanding this discourse.

When describing their experiences of the pre-abortion counselling session, participants often made statements that constructed what counselling is and is not and would compare their own experience in light of this. As will be seen, womxns' talk revolved primarily around the assumption that therapy or therapeutic talk necessarily involves and indeed relies on the ability of the counsellor or listener to enable the counselee or speaker to genuinely connect with an experience or event in a way that has depth of both emotion and meaning. Counselling was also constructed as a process of problem-solving in which the expertise of the counsellor lies

in helping the womxn to see clearly, using frank, honest and emotionally connecting conversation. Some participants referred to this as 'real talk'.

When asked about how pregnancy resolution options were discussed, or sometimes in response to the initial narrative inducing question around their experience of the counselling, womxn would sometimes make statements about the health care provider's skill at counselling. Extracts 11 and 12 below are examples of this.

> *Extract 11* [site 2] {womxn} <X>
>
> **I:** ok (.) *ja* ok (1) ok (.) in your view (.) how did the nurse speak to you (.) when she was speaking about ways to resolve the pregnancy?
>
> **Nokubonga:** (1) she spoke well /mm/ she spoke well I did not (.) I did not expect that she would speak in that way (.) but then she is person who truly counsels /*ja*/ it shows that she knows how to counsel a person /mm/ who has a problem /mm/ she spoke well
>
> *Extract 12* [site 3] {womxn} <E>
>
> **I:** with the pregnancy (.) how how did you experience <u>that</u> part of the consultation?
>
> **Thamie:** <u>that</u> part of the consultation <u>if</u> I wasn't sure [laughing] what I came here to do (.) I was gonna get out of that room and go home /is it/ [laughs] *ja* /[laughs]/ that's how she she explains like (.) she really gets <u>to</u> your heart whether <u>if</u> you're not sure you would go home /mm/ and tell yourself 'you know what (.) I'm <u>keeping</u> the baby' (1) but I am a stubborn person /[laughs]/ [laughs]

For example, Nokubonga (extract 11 above) speaks about the abortion care provider responsible for conducting the counselling at her facility (site 3) as a "person who truly counsels". Explaining further, she reveals what 'counselling' means to her: "she knows how to counsel a person with a problem". Implied here, is that counselling is about the resolution of some problem, which, as other participants discussed, involves a kind of honest, emotional engagement.

In extract 12, Thamie goes further in constructing a kind of psychotherapeutic counselling where a genuine and meaningful emotional connection is required, and indeed elicited or aided by the counsellor. Thus, Thamie states: "that's how she she explains it like (.) she really gets to your heart". Important here is that what might be argued to be directive or persuasive abortion counselling, possibly resulting (as Thamie herself says) in a decision change, is constructed as normative, and even expert counselling where, as Foucault (1978) discusses, the counsellor helps the client to see and feel what is already in the client's heart/mind but is inaccessible until the moment of counselling.

Parker (1998) describes how psychotherapeutic discourse and psychotherapeutic practices have become such a dominant way of relating to the self and have become so diffused that we all know what '(psycho)therapy' is and what it entails, even if we haven't received therapy. According to Parker (1998) this is partly due to its representation in various forms of media (reality talk shows, and autobiographic books) which are modelled on the confession. Thus, interviews in reality talk shows are often modelled as a kind of confessionary practice where the host asks the guest about a personal experience in their life and the guest is expected to express genuine emotion and make a deep connection to that experience for the host to be satisfied. During this exchange, the host often asks hard-hitting questions meant to elicit an emotional connection in their guest. This has been described as 'real talk'. Extract 13 below speaks to 'real talk' as an aspect of psychotherapeutic counselling.

> *Extract 13* [site 2] {womxn} <X/E>
>
> **I:** mm (1) ok /mm/ u::m (1) and the::n u::m how did you feel about (.) e::m the thing that she told you (.) the way that she gave you the information (1) how was it for you?
>
> **Sandisiwe:** the way that she told me /mm/ it was (2) it was ok she was oka::y it was (1) i::t was (1) it was <u>real</u> talk she wasn't /mm/ (1) what will I say she wasn't (.) she wasn't <u>weak</u> about it she wasn't <u>too</u> strong about it she was just (1) uh <u>clear</u> about what (.) what's gonna happen

As Sandisiwe demonstrates above (extract 13) a necessary tool in this kind of counselling is 'real talk': "she wasn't weak about it she wasn't too strong about it". Described here is the kind of talk that is reminiscent of reality talk shows where the interviewer delivers questions and analyses which, while hard-hitting and emotive, are understood and constructed as not unkind as their intention is to facilitate an authentic, emotional connection and therefore bring about healing or transformation.

Even though 'real talk' is constructed as therapeutic, it is not necessarily a 'good' experience as the healing involves some emotional difficulty. Promise Rose (extract 14) speaks to that below.

> *Extract 14* [site 3] {womxn} <E>
>
> **I:** ok ok (.) u::m (1) then just (.) i- <u>if</u> you were (.) to tell a friend /mm/ about your /experience=/ =experience *ja* /[laughs]/ what would you say [laughs]?
>
> **Promise Rose:** (1) I would say u::m (.) in overall *neh* /mm mm/ I would say the experience (1) was u::m (1) I won't say it's a good experience [laughing] u::m (1) it's a:: (3) it's a *hheyi* I don't know (.) 'k I would say it's (1) informative [laughs] /ok [laughs]/ and it's eye opening /ok/ *ja* it's an eye opening experience (.) like *ja* you get here and then you have to (1) <u>deal</u> with the guilt like it's written <u>in</u> your face not <u>written</u> in your face but (1) you have to <u>deal</u> with it and you face it […]

Promise Rose conveys this psychotherapeutic principle of honestly and frankly dealing with a difficult experience in order to heal. Thus, when asked how she would summarise the experience to a friend, should she choose to do so, she explains: "I won't say it's a good experience". What she does say, is that is "eye-opening": "you get here and then you have to deal with the guilt…and you face it". In this way, the counselling is not constructed as directive, persuasive, or even manipulative, but as simply making visible and tangible what was always already there, and assisting the counselee to deal with it.

Having discussed the processes through which pre-abortion counselling took place (as described by participants), I now turn to the reported content of the counselling: what was discussed and how.

4. The awfulisation of abortion

Participants in this study described what feminist scholars have termed an 'awfulisation of abortion' discourse. Within this discourse, abortion is constructed as an inherently and invariably 'awful' experience. This awfulness has some notable features. The first is that abortion is constructed as traumatic to womxn, with so-called PAS, mental ill-health or emotional duress being part of the trauma of abortion (Hoggart, 2015; Sparrow, 2004; Wahlström, 2013). A second feature is that abortion is constructed as always already medically dangerous and highly risky (Wahlström, 2013), even when conducted legally and safely in healthcare facilities by trained healthcare providers. The third way in which abortion is constructed as 'awful' is that deciding on abortion is constructed as an inherently difficult decision to make. As Lee (2003, p.536) discusses, within this discourse abortion is always a decision that "women agonise about ... that is never reached lightly". As a result, abortion is constructed as "a necessary evil…and never preferable to contraception" (Wahlström, 2013, p.256), precisely because it is constructed as an act of desperation (Lee, 2003).

The extract below is an example of how abortion is constructed as 'awful' through an emphasis on the disadvantages of abortion. Notably, these disadvantages are framed in the bio-medical (thus achieving the status of fact) and liberal language of risk.

> *Extract 15* [site 3] {womxn} <E>
>
> **I**: but can you say a bit more (.) in what <u>way</u> are you saying that if you weren't sure you would just go home (.) <u>how</u> did she?
>
> **Thamie**: well <u>one</u> she tells you that yes it is <u>your</u> decision at the end of the day (.) she's not gonna change your mind /mm/ um but […] in the long run /yes/ it affects you::r (1) your sexua- your <u>sexual</u> life a::nd (.) you might <u>not</u> (.) get pregnant (.) in the future like

it minimises your chances your chances of falling pregnant /ok/ those are the disadvantages (.) now those are the things that would make you tell yourself 'ah (.) I'm going home' /ja/ you see /ja/ because of the disadvantages of it

Importantly, in extract 15 above, we see that despite the health service providers' emphasis that the decision to terminate or continue with the pregnancy belongs to the womxn and the abortion counsellor is positioned as in support of the womxn's decision, the information provided might have the *effect* of dissuading womxn from abortion. Thus, Thamie states that the possibility of infertility and having an adversely affected sex life are "disadvantages": "the things that would make you tell yourself 'ah I'm going home'". In liberal discourses individuals, once thoroughly informed, are given the freedom to decide for themselves with the hope that they will make the responsible decision which, being logical and taken-for-granted, does not need coercion on the part of those attempting to govern populations. However, when healthcare providers draw on the awfulisation of abortion, deciding against abortion emerges as the rational, responsible and only legitimate choice. When the awfulisation of abortion is drawn upon by healthcare providers, the undermining of abortion as a legitimate course of action may certainly be the covert aim.

Extract 16 below is another example of where the awfulisation of abortion is constructed around the 'risks' of abortion. In this extract however, the language reportedly used by the healthcare provider constructs abortion not only as risky, but as physically and mentally damaging.

Extract 16 [site 1] {womxn} <E/X>

Thombulelo: […] they giving us like the (2) I would call it like the terms and conditions of doing it /*ja*/ (1) and u::m (1) at the same time (.) you being told what might happen after /mm/ you done the termination /mm/ like the risks /mm/ and the like u::m (1) the permanent or let's say temporary treatment that you'll be using after (.) /mm/ you done the termination /mm/ u::m (1) when I say temporary it's like if there is any like physical damage /mm/ that e::h (1) *i::-* that eh your womb have experienced /*ja*/ and then u::m (.) they told us that (.) u::h there might be a possibility that you cannot like have babies again /mm/ after doing it /mm/ and u::h they the::y also told us that you can be mentally disturbed (1) after doing it (1) but e::h you can do it under those kinda risks (.) /ok/ *ja*

Thombulelo (extract 16 above), when asked about to speak about her counselling experience in general terms, described the information giving as providing womxn with "the terms and conditions of doing" abortion. Like Thamie outlined in the previous extract, infertility is constructed as a risk of having an abortion: "there might be a possibility that you cannot like have babies again /mm/ after doing it". Other risks of having an abortion include "physical damage" to the womb which may necessitate further treatment, as well as the possibility of

being "mentally disturbed". Thus, included in the risk that is constructed in the awfulisation of abortion is a reference to PAS: 'mental disturbance' which, despite a lack of scientific consensus around this, has become part of the 'truth' of abortion (Major et al., 2009). Likewise, risks of infertility and breast cancer have also been similarly absorbed despite inconclusive evidence (Joffe, 2013).

What is demonstrated in this extract is that in a society governed through risk and responsibility, the freedom of individuals to act and decide for themselves enables institutions to defer accountability for harm to individuals. These individuals then, having been duly informed, must assume sole responsibility for any risks incurred. When it comes to TOP services, abortion may be constructed as physically and psychologically risky in possibly resulting in womb damage, infertility and mental disturbances. Importantly, this is juxtaposed alongside the construction of pregnancy as without risk. Womxn, once informed, must either choose *responsibly* against abortion or *responsibly* accept the over-stated consequences.

Extract 17 below speaks to trauma as a feature of an awfulisation of abortion discourse.

> *Extract 17* [site 1] {womxn} <X/E>
>
> **Lisa:** […] she started by giving me information about this abortion /mm mm mm/ (1) they gave me a date /mm/ they they do not want (.) their thing is (.) they do not want them to do it (.) you come today they do it today /mm/ cause after that when you get out she said you might regret and say no (.) 'I did not want to do this'

Lisa, in extract 17 above, describes how the healthcare providers at site 1 instituted a waiting period between the counselling session and the day of procedure to give womxn a chance to think about their decision. As Lisa explains, this has been implemented out of concern for womxn's psychological well-being, with abortion posing a threat to it. Thus, Lisa states: "they do not want them to do it (.) you come today they do it today /mm/ cause after that when you get out she said you might regret and say no (.) 'I did not want to do this'". Significantly, despite Lisa's use of the word "might" which suggests that regret is a possibility and not a likelihood or certainty, the act of implementing a waiting period as a preventative measure suggests that the trauma is in fact inevitable and that the only way to avoid it is to change one's mind and *not* have the abortion.

In the next extracts (extracts 18 and 19), abortion is constructed as a difficult experience, albeit in different ways.

Extract 18 [site 1] {womxn} <X/E>

Lisa: […] *ja* that is why I came here (.) I thought it's easy /mm/ just like people were saying cause (.) if you can notice people talking things many things and /mm/ you become ok (.) 'it's right this thing it's not difficult it's not'

Extract 19 [site 2] [womxn} <E>

Mpho: […] I don't know (1) just (1) don't (1) don't like (.) this is not a nice (.) process */ja/* so then I'd advise against like anything that will result in (like) (.) like that person being pregnant or anything (.) so then (.) if there are other options and like (1) you know they feel like (.) they cannot take those other options /mm/ to to avoid having an abortion (I think that (.) I think that that would be fine *ja*) (.) but then if they can't (2) it's their choice (.) at the end of the day (1) and (1) that's it (1)

In extract 18 above, Lisa explains that she had been told by other womxn that the process of having a TOP is a simple and easy one. Implied here, is that this has been contradicted by the information given to her by the healthcare provider during the counselling. Because of having had the counselling, Lisa is left expecting a difficult process that is not only risky but necessitates her own direct involvement by watching for expelled products (not shown in the extract- this is discussed in the following chapter). Thus, TOP emerges as an inherently difficult and complicated procedure/process, which, when stated by healthcare providers, may communicate something about abortion itself. Interestingly, the healthcare provider's description contradicts what Lisa has heard from womxn's in their descriptions of their own experiences. Indeed, other womxn in this study similarly spoke about how they had expected a simple, quick and easy process but were being prepared for the opposite.

In extract 19, Mpho has been asked how she would describe her experience to a friend. In her response, Mpho gives advice to her friend. The advice she gives is that her friend should exhaust other options first before resorting to abortion. Thus, Mpho states: " if there are other options and like (1) you know they feel like (.) they cannot take those other options /mm/ to to avoid having an abortion (I think that (.) I think that that would be fine *ja*) (.) but then if they can't (2) it's their choice". Mpho's reason for this advice is that the experience has not been a good one for her: "this is not a nice (.) process". What is significant is that Mpho describes her own individual experience in a way which generalises it as an experience that other womxn would also have. In doing so, abortion is constructed as an inherently awful experience. What is masked, then, is how interactional and content aspects of the counselling encounter may create this awful experience.

In the next section, I discuss moralising discourses (abortion as immoral, abortion as shameful, a foetal personhood discourse and a religious discourse on abortion) which were used as a discursive resource in womxns' interview talk. As I will demonstrate, while at times womxn

attributed this talk to healthcare providers, at other times womxn took up these discourses themselves.

5. Moralising discourse

A dominant feature of participants' talk was discourses which constructed abortion immoral; a wrongful act linked implicitly to the taking of a life. Thus, moralising discourses often, but not necessarily, worked in tandem with the construction of foetal personhood. Sometimes, as will be shown below, womxn drew on a religious discourse to construct abortion as not only immoral, but as sinful as well and therefore going against Christian values. As a result, but also in tandem with these constructions, abortion was further constructed as a necessarily and inherently shameful act or course of action, with womxn being normatively expected, by the abortion care providers in this study, to show remorse and shame. Lastly, constructing abortion as an immoral act, as I will argue, created a hierarchy of relative (un)acceptability among womxn who have abortions, with those who have had more than one abortion being particularly demonised.

5.1. Abortion as immoral

For most womxn in this study, abortion was constructed as an immoral act but nevertheless one that their circumstances dictated. In their talk, womxn would attribute this discourse to the abortion care provider conducting the counselling, while taking it up themselves or simply not disagreeing with it. Nowu, (extract 20 below), is one example.

> *Extract 20* [site 2] {womxn} <E/X>
>
> **CI[20]:** ok (2) I ask you to tell me as much as you want to about how the counselling went and other things that you feel are important to you (.) you can start with whatever you want to start with
>
> **Nowu:** (.) u::m ok I found (.) the counselling very useful (.) in terms of that (.) they told us of the risks of this thing that we did that what they are and (.) we were told of the thing that (1) *i*-contraceptives like in the [inaudible] (.) that which ones should we use and (.) that we should use them (.) because (.) we know that [interruption] we know that the:: the:: (.) the abortion is not right and what not (.) *ja*
>
> **CI:** ok (.) oh how did you feel when it was said that doing abortion is not right?
>
> **Nowu:** u::m we::ll (1) I don't know how I felt actually [laughs] u::m I guess I I don't know (.) i::t it's quite sad neh but then (.) because (.) you don't have a choice (.) ja

When asked to speak about her experience of the counselling she received, Nowu (extract 3 above), states that among the information they were given, they were also told of

[20] CI refers to co-interviewer. This is designated to the two psychology honours students who were trained to collect data at site 2.

"contraceptives…that which ones should we use and (.) that we should use them (.) because (.) we know that abortion is not right". Interestingly, Nowu recalls that the healthcare provider not only constructed abortion as immoral, but did so in a way that takes this 'truth' that abortion is immoral for granted. The health service provider even assumes that it is a shared 'truth': those she is counselling also know that abortion is immoral. When asked how she felt about that statement being made during the counselling, Nowu responds: "it's quite sad neh (.) but then (.) because you don't have a choice". What is implied by Nowu's response is that abortion is indeed wrong. It is the lack of choice in doing something wrong that is saddening.

Sometimes, a discourse of foetal personhood was drawn upon when constructing abortion as immoral. As Macleod and Howell (2015, p.1) discuss, through foetal personhood, the foetus emerges "as patient, as person, as citizen" and therefore as independent of the pregnant womxn. The force of a foetal personhood discourse lies in its co-dependency with gendered discourses which position womxn as always already mothers who, as such, are expected to care for and protect their children. Through foetal personhood discourses, mothering obligations to care for and protect are extended to the foetus. The result is that a womxn wanting or needing to have an abortion is placed in a troubled position as abortion becomes inherently problematised as being detrimental to the foetus. The extract below is an example of a foetal personhood discourse.

> *Extract 21* [site 2] {womxn} <X>
>
> **CI:** when you say things that were spoken by the counsellor that made you scared so you ended up doubting yourself that are you doing this or are you not doing it (.) which are they perhaps (.) and that which perhaps made you say ‘you see now (.) I am scared truly’?
>
> **Nziweni:** (1) u::h things like (.) <u>when</u> you are twelve weeks (.) and <u>above</u> /mm/ twelve weeks /mm/ it is now a person that has a soul /mm/ you see /mm/ so (.) to (.) if it is done there (.) abortion (.) you are given pills to take /mm/ you expel a <u>person</u> a child (.) what is left is blood but the feet are there /mm/ the hands you see them they are there (.) /mm/ then (1) how will you take the pills and expel it when it is still breathing /mm/ u::h you need to wait even for it to pass out you (.) /you are watching everything/ give birth to it (.) yes you are watching everything (.) so other things like that that make you feel painful […]

The example I have used above is indicative of the talk of womxn who were counselled by the Christian NGO counsellors operating through site 2. In the text (extract 4), Nziweni describes the medical abortion procedure and intersperses this description with a discourse of foetal personhood, specifically foetal development. Thus, as Nziweni explains, this is the reason for

her pain and hurt: "it is now a person that has a soul /mm/ you see /mm/ so (.) to (.) if it is done there (.) abortion (.) you are given pills to take /mm/ you expel a person a child". The emphasis Nziweni places on "person", along with her account of feeling pain and hurt, suggests that this information was revelatory and thus shocking. Nziweni goes on to repeat what she was told in the counselling: "what is left is blood but the feet are there /mm/ the hands you see them they are there". In other words, the products of the termination, according to what Nziweni has been told, are recognisably human, in a way that, as it is assumed within such discourses, leaves no doubt as to the life of that which has been expelled.

Indeed, knowledge around foetal development is a powerful tool in creating foetal personhood. As Nziweni demonstrates, such knowledge leads to the creation of a dilemma in which the immorality of abortion, and by implication of the immorality of the womxn undergoing abortion, can be presumed. Thus, Nziweni states: "how will you take the pills and expel it when it is still breathing /mm/ u::h you need to wait even for it to pass out you (.) /you are watching everything/ give birth to it".

The likening of medical abortion to giving birth is interesting and must, I argue, be understood as part of the labour (on the part of the healthcare provider) of constructing foetal personhood. While womxn may describe medical abortion in this way, womxn have also likened abortion to 'normal menstruation' (Tong et al., 2012; Zamberlin et al., 2012) but with heavier bleeding. This choice of words on the part of the *health service provider* is therefore significant because, like abortion, menstruation does not end in a live birth. Furthermore, whether the termination of pregnancy product is recognisable seems to depend on the gestation of the pregnancy. Thus, womxn have also described the termination of pregnancy product as 'blood clots' (Tong et al., 2012). Certainly, as this extract shows, the construction, during pre-abortion counselling, of abortion as 'like birth' may have the effect of producing feelings of emotional difficulty which delegitimises abortion as an option.

When abortion is constructed as immoral, one consequence is that a hierarchy is created between those who have had one abortion (more acceptable), and those who have had more than one abortion (more problematic and therefore less acceptable). Thus, abortion is acceptable if womxn go through the procedure only once. The extract below speaks to this aspect of the moralisation of abortion.

Extract 22 [site 3] {womxn} <E/X>

CR: […] oh okay then *sisi* (.) thank you (.) so then your experience of the information that the nurse provided to you during the counselling (1) how did you feel the time she told you the information (.) during the counselling? (1)

Balisa: like before I did the counselling *neh* /mm/ I told myself I do not care about what is said or is not said but the nurse then told me that (1) like (1) it does not help you to make the same mistake each and every now and again /mm/ your mistakes you care less about them at least [name of site 3] does abortions /mm/ that is not the solution you see /mm/ you have to prevent as a person /mm/ just like she told me that (.) you have to prevent and if you do not prevent (.) how will your problems be able to end /mm/ you see /so the time/ you will continue doing abortion (no matter whatever is said)

In the above extract (extract 22) Balisa is describing a conversation between her and the abortion care provider where Balisa is being warned against having another abortion. Thus, Balisa states: "but the nurse then told me that (1) like (1) it does not help you to make the same mistake each and every now and again /mm/ your mistakes you care less about them [because] at least [name of site 3] does abortions". Womxn who have more than one abortion are thus positioned as stubbornly repeating not only a wrongful act but one that is an inappropriate solution to a bigger problem, presumably unintended pregnancy.

Sometimes, the (un)acceptability of abortion seemed to reference an 'abortion culture' discourse. Within this discourse, having more than one abortion was seen to be indicative of an understanding of abortion as a legitimate form of contraception. An 'abortion culture' discourse constructs abortion as something which cannot be legitimately or appropriately used in this way, that is to prevent pregnancies (Bélanger & Flynn, 2009). The two extracts below are used as examples.

Extract 23 [site 3] {womxn} <E/X>

CR: […] I want to move on to the waiting room experience /mm/ and like how did you find the waiting room (.) being in the waiting room with other womxn /mm/ like how was that experience for you?

Yolanda: it was scary /mm/ because um some of the womxn (.) it's not the first time they've done it /mm/ maybe second or third time /mm/ […]

Extract 24 [site 3] {healthcare provider} <E>

Sam: if you are doing the counselling (.) you can't always (.) believe everything that people say because the one that you counsel (.) probably has said this a million times /mm/ and has been a million times to other clinics as well saying the same thing

In extract 23 above, Yolanda is speaking about waiting room interactions among the womxn. Her response demonstrates the force of a discourse which problematises multiple abortions in such a way that womxn may survey each other's behaviour. In the extract, Yolanda explains, with some surprise, that some of the womxn she encountered in the waiting room are coming

for their "maybe second or third time". Although implied, the emphasis on the "third" suggests how unimaginable, and therefore unusual and possibly unacceptable multiple abortions are. Significantly, in using the word "scary" to describe her experience of this, the unacceptable nature of more than one abortion is reinforced. It also leaves wondering whether Yolanda is signalling her own fear of returning for another abortion. Within this discourse, then, abortion is not a *right*, despite being legislated as such in South Africa, and may be justifiably regulated with womxn who have more than one abortion being positioned as 'exploiters' of the service.

Sam, in extract 24 above, also problematises having more than one abortion. Speaking from the perspective of an abortion provider, Sam seems to be pointing to a 'culture of abortion' in which womxn exploit abortion services by over-using them. That this is constructed negatively, as an unacceptable practice, can be seen from the way she positions womxn who have "been a million times to other clinics" as dishonest, even to the point of manipulation. It is within this discursive context that womxn may be injuncted to be responsible and use contraception: "you have to prevent and if you do not prevent (.) how will your problems be able to end". Abortion is, here, evidence of a problem and so called 'repeat abortion' is problematised.

When abortion is constructed as an immoral thing to do, abortion becomes constructed as a shameful act. Tied to this, womxn accessing TOP services are thus expected to embody this shame. As I will show in the discussion below, this can sometimes become a prerequisite for abortion being acceptable. In other words, womxn who do not embody the shame of abortion are positioned as especially abnormal and/or deviant.

5.2. Abortion as shameful/stigmatised

Sometimes in their interview talk, womxn would implicitly construct abortion as a shameful act. As is the case with the example below, sometimes this happened when womxn were asked to relate to the interviewer how they would describe their pre-abortion counselling encounter to a friend.

> *Extract 25* [site 2] {womxn} <E>
>
> **I:** ok and then u::m what would you tell a friend (.) if you were to tell a friend (.) what would you tell a friend about coming here?
>
> **Mpho:** oh u::m (.) all I'd say is that like she (1) well she shouldn't come here (.) if she has the option to /ok/ becau::se (.) I feel (.) with (.) like because people are different /mm-hm/ and we all react differently to like certain situations so the::n if u::m (.) she came here (.) and she (.) would probably be like (.) overwhelmed by the way like the people like choose (.) (to look at you and) (.) I mean (.) half of the time people are walking past they look into the room /mm/ so then you kind of feel nervous (.) it's like ok (.) 'no this person knows me' (.) like /*ja*/ all those things

In extract 25 above, Mpho explains that she would advise against coming to the abortion facility because stigma around abortion, manifesting in the stares of others walking past the TOP centre in the gynaecology and maternity ward, would make her friend feel overwhelmed. As Mpho goes on to describe, relying on her own experience as she does so: "so then you kind of feel nervous (.) it's like ok (.) 'no this person knows me'". The nervousness Mpho feels and which her friend will feel stems from not wanting to be seen doing something that is regarded as a shameful thing to do. The taken-for-grantedness seen in this extract serves not to disrupt the idea that abortion is shameful, but reinforces and replicates it.

> *Extract 26* [site 2] {womxn} <X/E>
>
> **I:** ok (1) and you said earlier that (.) u::m (1) everyone was fine in terms of the nurses and the counsellors /mm/ you know (.) to talk to them was fine and?
>
> **Sandisiwe:** *ja*:: they were fine (.) an- they answered what I wanted and (.) they showed me where I needed to go /mm/ nobody was (.) being rude and /mm/ or undermining by the fact that I::m actually doing an abortion cause you do have that (.) mentality that ok (.) people are going to be looking at you that way of (.) she is going to do an abortion /mm/ but (.) I didn't get none of that /mm/ u::h (.) I think everyone was (.) was okay (.) it was (1) it wasn't like come it was (.) okay it was an okay situation /ok/ mm

Compared to Mpho (extract 25) above, Sandisiwe (extract 26) is more explicit in her construction of abortion as shameful. In the extract, she responds to a question around her interactions with the nurses and counsellors. She contextualises the lack of rude and undermining behaviour she expected from the staff by describing the "mentality" that leads to these expectations. Thus, she states: "you do have that (.) mentality that ok (.) people are going to be looking at you that way of (.) she is going to do an abortion". By not explaining why someone would look you for having an abortion, Sandisiwe, I argue, draws on a construction of abortion as shameful. Unlike Mpho above, however, Sandisiwe's use of the word "mentality" frames this construction of abortion as shameful as one way of understanding abortion, and even perhaps as an irrational one which is contradicted by interactions with abortion care providers, who, although not welcoming, did not undermine her.

What is significant about the responses of Mpho and Sandisiwe (extracts 25 and 26 respectively) is that both responses construct abortion as shameful through reference to a shaming gaze, that is, a gaze that is meant to shame them for having an abortion. However, their descriptions belie the fact that shaming becomes slippery when it is done in subtle ways, for example, through a gaze. When abortion is constructed as *already* shameful, then, the act of looking, and being seen by others, is always potentially shaming and shameful, whether it is meant to be.

An important effect of discourses which construct abortion as inherently immoral is the expectation of an embodiment of shame. Once abortion is constructed as a wrongful and shameful act, womxn who have had an abortion are expected to act and feel in ways which express, outwardly, a sense of shame assumed to always govern abortion experiences. This expectation of an embodiment of shame is extended to womxn who haven't yet had the procedure. This discourse was used by two health service providers when speaking about their experiences of providing pre-abortion counselling. Specifically, they naturalised the expectation that womxn must embody shame before and after an abortion procedure. The extracts below are an example.

> *Extract 27* [site 1] {healthcare provider} <E>
>
> **Thembi:** they are happy they will sit here be happy (.) chatting (.) like nothing is happening /mm/ that is not what I thought somebody who is coming to do abortion will behave /mm/ you know (.) they they are not a- ashamed (.) they don't see anything wrong /mm/ with what they are doing
>
> *Extract 28* [site 3] {healthcare provider} <E>
>
> **Sam:** […] I don't think I've ever seen someone sad (1) they are on the cell phones they are listening to music (.) they are chatting as if they are not coming to an abortion clinic /mm/ and when they leave they are very happy /mm/ (1) especially when they want they have gotten the service (.) when they come for a check-up (.) they are bright /*ja*/ (1) Friday usually they come for a check-up neh /mm/ then you will see how bright they are /mm/ they've got make-up they've got everything in (1) and everything is in place because they are grateful for the service because (.) you took them out of a dilemma /mm/ that no one else can help them with (1) see (.)

In extract 27 above, Thembi conveys her bafflement at the embodiment of the womxn to whom she provides abortion care, an embodiment which contradicts the 'truth' of abortion as immoral. Thus, she states: "they are happy they will sit here be happy (.) chatting (.) like nothing is happening /mm/ that is not what I thought somebody who is coming to do abortion will behave". Importantly, when Thembi says "like nothing is happening", she is communicating the message that not only is abortion an event worth noting, but it is assumed to be a profound one with *negative* implications for the womxn. We can assume, from Thembi's description of what she was *not* expecting, that womxn who are about to have and have just had an abortion, ought to be sad, remorseful, silently reflecting on what it is they are about to do or have done; they must *embody* shame. For those who do not, it is simply because "they do not see anything wrong with what they are doing", with the implication that abortion *is* necessarily wrong.

Encounters (like Thembi's) with alternative kinds of embodiment around abortion may, if reflected upon, challenge dominant constructions around abortion which expect womxn to embody abortion in particular and monolithic ways. Extract 28 is an example of this. In the

extract, Sam begins by problematising womxn's lack of sadness in their embodiment, which relates not only to the expectation of shame but also indicates an expectation around the awfulisation of abortion. This can be implied in the line: "they are on the cell phones they are listening to music (.) they are chatting as if they are not coming to an abortion clinic". However, as Sam attempts to account for this unexpected behaviour, womxn's embodiment of happiness and an absence of shame is not only normalised but is constructed as rational and understandable, even as expected. Thus, Sam explains how "when they leave they are very happy /mm/ (1) especially when they want they have gotten the service". Ultimately, the womxn's lack of sadness and shame is reframed in a positive way as an expression of gratitude for the resolution of a difficult situation. Thus, Sam states: "because they are grateful for the service because (.) you took them out of a dilemma /mm/ that no one else can help them with". Through this dialogue then, truth of abortion as necessarily shameful or awful begins to be challenged. While Sam's response can be seen as a resistance of the normative discourses on abortion, the juxtaposition of Thembi's and Sam's responses show, however, that work is needed to re-imagine abortion so that experiences that contradict normative expectations are not simply used to reinforce the 'truth' of abortion as immoral and shameful.

Next, I discuss a religious discourse on abortion which constructs abortion as not just immoral, but as sinful and therefore incompatible with religious values and beliefs.

5.3. A religious discourse on abortion

In a religious discourse, abortion is constructed as a sin. The sinfulness of abortion lies in the understanding that it goes against a religious deity who is responsible for the creation of all life forms, including the foetus. A religious discourse on abortion thus draws on a foetal personhood discourse in constructing the foetus as a (sanctified) life. Vanessa's extract (29 below) is one example.

> *Extract 29* [site 2] {womxn} <E>
>
> **I:** mm (1) no I understand that (.) so was it the:: discussion (.) u::m around your options that was making you maybe want to change your mind (.) or was it them (1) which part of the counselling was it=
>
> **Vanessa:** = I think it was just from the whole (1) this is what (.) the procedure is gonna be /ok/ if you you know and then (.) this is what the risks are /mm/ and that (.) what really got to me is when they said God created this (.) and that was (.) the way I was feeling as well that (.) this happened and (.) you know who are you to play God (.) cause that's what you doing (.)

As she states in the extract above, within a religious discourse on abortion which draws on a discourse of foetal personhood, terminating a pregnancy amounts to 'playing God': deciding

who lives and who dies. Abortion is thus simultaneously constructed as an act of murder or killing. Worth noting is that in this extract Vanessa initially describes a religious discourse as being present in the abortion care provider's talk but seems to take up this discourse herself later on in the interview (not shown here). Thus, for her, the distress that was caused by this talk (which made her want to change her mind), is taken for granted and framed within a view that abortion is sinful. Conversely, this extract can be read as

> *Extract 30* [site 3] {womxn} <E/X>
>
> **Yolanda:** […] so:: I will ask them (1) friend just sit down and tell yourself (.) are you doing the right thing or not /mm/ and then you have to also forgive yourself (1) you know (2) and u::h (.) I think (.) you also have to pray (.) yoh before everything (.) you have to pray ask God for guidance (.) /mm/ ask God for strength (.) you know because /mm/ this whole thing needs strength /mm/ to be done yes we laugh right now /yes/ but you see deep down /mm/ it's not nice /mm/ so:: (.) I'd tell them you need to be certain (1) pray (1) and then (.) forgive yourself /mm/ and go for counselling /mm/ (2)

While Vanessa's talk in the previous extract (extract 29) suggests that abortion is a sin of great magnitude, Yolanda (extract 30 above) states that while sinful, abortion is pardonable. Thus, she describes what she would tell a friend of hers about her experience: "sit down and tell yourself (.) are you doing the right thing or not /mm/ and then you have to also forgive yourself". It is implied here that, although inherently sinful, abortion may be the right course of action given an individual's circumstances. However, the immorality of abortion, although a forgivable sin, is such that one needs to "pray [to] ask God for guidance (.) ask God for strength" because abortion is an act that "needs strength", being immoral.

Although most participants constructed abortion as immoral, this construction was challenged by womxn on occasion, albeit rarely. This counter discourse to abortion as immoral was enabled by liberal counselling practices (to be discussed in detail in a separate section) which framed womxns' decision as their choice and therefore not inherently wrong. The extract below (extract 31) is an example.

> *Extract 31* [site 3] {womxn} <E/X>
>
> **I:** so (.) you said she supported you inside the counselling?
>
> **Asiphe:** *ja* (.) it is it supported me (.) explained well and I understood well
>
> **I:** ok ok (.) so she explained (.) she explained well /*ja*/ and you understood it?
>
> **Asiphe:** *ja* and (.) you know (.) the way I had been expecting I was afraid but /mm/ she makes me to feel comfortable and to realise that the decision that I made is not wrong /mm/ because it's my decision /mm/ *ja*

Liberal counselling discursive practices which emphasise individual choice enabled a counter discourse to the moralisation of abortion. By constructing the decision to have an abortion as

an *individual choice*, abortion as an *inherently* moral issue is questioned. Thus, Asiphe, in extract 31 above, states how through (liberal) counselling she realised that: "the decision I made is not wrong because it's my decision". What emerges then is a side-stepping of the immorality of abortion, but not the construction of abortion as a right thing to do. Through a discourse where imposing on individual liberty (by prescribing what the right thing to do is) is undesirable, leaving individual womxn to make their own decisions (and perhaps accept the consequences of their actions) is preferable.

In the following section, I discuss what Meyers (2001) and Morison (2011) describe as pronatalist discourses.

6. Pronatalist discourses

Drawing on Meyer's (2001) work on pronatalism and womxn's autonomy, Morison (2011) describes a pronatalist discourse (which I here refer to as a network of discourses) as constructing procreation as an eventuality for heterosexual couples, with parenthood being idealised as an overwhelmingly or largely beneficial experience, and as an imperative, duty or expectation. Morison (2011) notes that although masked in a pronatalist discourse, biological parenthood is foregrounded and prioritised over adoptive parenthood. Lastly, within a pronatalist discourse, children are constructed as valuable for their own sake; as "emotionally priceless" (Morison, 2011, p.182). What results, according to Morison (2011, p.183) is a kind of "automatic childbearing" wherein childlessness is othered and denigrated.

In this section I draw on Morison's (2011) work and demonstrate that womxn in this study used pronatalist discourses as a discursive resource. Included in my own understanding of pronatalism, however, are discursive nuances where womxn constructed first-time motherhood as particularly obligatory, and the first pregnancy as distinctive which, for the womxn, contextualised their distress over deciding to have an abortion.

6.1. Parenthood as inevitable

Several participants (womxn accessing TOP services and healthcare providers) in this study constructed parenthood as inevitable. In some cases, womxn reported healthcare providers' use of this talk. The extract below is an example.

> *Extract 32* [site 3] {womxn} <E>
>
> **I:** ok but can you say a bit more (.) in what way are you saying that if you weren't sure you would just go home (.) how did she?
>
> **Thamie:** […] in the future like it minimises your chances your chances of falling pregnant /ok/ those are the disadvantages (.) now those are the things that would make

you tell yourself ‘ah (.) I’m going home’ /*ja*/ you see /*ja*/ because of the disadvantages of it /mm/ it minimises you::r chances la- cause she asked me if you were to get married are you married and I said no (.) then she asked me (.) if you were to get married (.) and you your husband wants a baby and you can’t have a baby cause of this /mm/ what would you do (1)

I: that’s a tough question

Thamie: that’s a tough question [laughs] eh but (.) I told her no I would adopt (.) and I would be very open with my husband /mm/ that (.) maybe reason being (.) I can’t fall pregnant (.) it’s because of (.) what I did /mm mm/ honesty helps

In extract 32 above, Thamie describes how the abortion care provider asked Thamie to reflect on the possibility of infertility and what it would mean for Thamie's life with her partner. Thus, Thamie states: "cause she asked me if you were to get married are you married and I said no (.) then she asked me (.) if you were to get married (.) and you your husband wants a baby and you can’t have a baby cause of this what would you do ". The abortion provider's construction of this scenario draws on two taken-for-granted assumptions. The first is the inevitability of conjugalised heterosexual unions, what Tamale (2006) refers to as marriagenormativity. The second is the normalisation of procreation, which, when used to define womxnhood, becomes what Tamale (2006) refers to as mothernormativity. In phrasing the scenario in this way, an illusion of a difficult dilemma that is impossible to solve is created, that is, not being able to produce children within marriage. The inevitability of parenthood in this instance relies on the conjugalisation of reproduction which is an effect of the alignment of the parent-child and husband-wife axes of the family, where procreation is normalised and even required (Macleod, 2003). Within the illusion created by the healthcare provider, the only apparent solution would be to not have an abortion in the first place and thus avoid the guilt and the presumed untenable position that comes with being responsible for denying parenthood to one's husband. Colluding with this construction of procreation as inevitable, natural and desirable, I, the interviewer, comment that it's "a tough question", thereby reinforcing the abortion provider's construction of abortion as inevitable.

Thamie's response to my statement that its "a tough question" shows that pronatalist discourses mask the reality that there are different routes to parenthood, including adoption. What is also masked by pronatalist discourses, is that *biological* parenthood is privileged as the *only* route to parenthood. Thus, Thamie explains: "that’s a tough question [laughs] eh but (.) I told her no I would adopt". Thamie begins by echoing my evaluation of the question put to her by the healthcare provider, but goes on to challenge the privileging of biological parenthood, a response which is unexpected in pronatalist discourses and was certainly unexpected by me as the interviewer. Simultaneously, however, Thamie perhaps reinforces the inevitability of

having children. As I will show later in this section, I was complicit in constructing and upholding pronatalist discourses by simply asking participants how they felt about being told about the risk of infertility, as if it was *inherently* upsetting information.

Extracts 33 and 34 show how pronatalist discourses necessarily involve the construction of childlessness as problematic and undesirable, and that this is taken for granted. In extract 33 below, Nikibha is being asked to tell her story about her experience of the counselling.

> *Extract 33* [site 2] {womxn} <X>
>
> **CI:** ok *sisi* I ask you to tell me that (.) ok (.) I ask you to tell me as much as you want to about how the counselling went […]
>
> **Nikibha:** [laughs] now I was counselled there (.) I was told that (.) one (.) this thing I am going to do (.) it has what is right and not right (.) just because (.) in the end I may not have children (.) secondly perhaps I may get uterine cancer just because it will be (.) because what they will be removing is something [tissue] that's incomplete that's just attached to you (1) so (1)

As Nikibha explains, what stood out for her from the counselling is that doing an abortion "has what is right and not right", advantages and disadvantages. From the way her response is structured, we are to understand that not being able to have children in the future, juxtaposed alongside the possibility of contracting uterine cancer, belongs to what is "not right", what is disadvantageous about terminating a pregnancy.

> *Extract 34* [site 1] {womxn} <X/E>
>
> **I:** […] u::m so e::h now when you came what (.) u::m (.) before you came here */ja/* what were the expectations (1) for the counselling?
>
> **Lisa:** […]when I was still studying (.) when I was studying at high school etcetera/and so on (.) I learnt about abortion (.) abortion is not right */ja/* 'cause abortion (.) you do it now the child leaves but (.) for the future (.) it might be you will not have children */ja/* for the rest of your life (.) or you get married (.) and you don't have children whereas this is something you did */ja/* when you were still at the tertiary or when you were still young

While in extract 33 it is not clear whether Nikibha's use of "right" refers to morality as well as advantages/disadvantages, or pros/cons, Lisa's use of "right" in extract 34 does appear to refer to morality. In the extract, Lisa links the immorality of abortion to the possible risk of future infertility, explaining: "abortion is not right /ja/ cause abortion (.) you do it now the child leaves but (.) for the future (.) it might be you will not have children */ja/* for the rest of your life". The emphasis Lisa places on the word "rest" not only communicates the expectation of procreation at some point in one's life, but stresses just how undesirable infertility is. That infertility would

mean never being able to have children once again shows up the privileging of biological parenthood.

As stated earlier, pronatalist discourses include the construction of parenthood as an inevitably wonderful or positive experience. While this may be done in ways which deny hardship during parenting, it may also be done in ways which acknowledge this difficulty but significantly downplay it (Morison, 2011). Next, I therefore turn to a glorification of parenthood discourse.

6.2. The glorification of parenthood

As Morison (2011) describes in her doctoral thesis on White Afrikaner womxn and mxn's narratives of parenthood decision-making, a significant corollary of pronatalist discourses is the glorification of parenthood. This is achieved by extolling the wonder, joy, and sometimes ease of parenthood. It is also achieved by either masking, altogether, negative parenting experiences such as distress, fatigue and unhappiness etc., or by downplaying the challenges of parenting as ultimately manageable. In this study, this discourse was only used by one participant, a health service provider. I have included it here, however, to demonstrate the various ways in which pronatalist discourses were used by participants.

> *Extract 35* [site 2] {healthcare provider} <E>
>
> **I:** okay (1) ok /mm/ u::m (2) just so just generally um what has been your experience with (.) providing counselling in the TOP (.) services?
>
> **Chanelle:** […] we believe that every one person (.) who changes their mind um basically has (.) a little human being whose life has been given a second chance /mm/ um and those babies come into the world (.) they're purposeful (.) /mm/ they live a life (.) and they give a lot of joy and purpose to those parents (.) who initially were considering abortion /mm/ (2)
>
> **Chanelle:** […] u::m not every woman will go for adoption (.) u::m a lot of the ladies decide to keep their babies /ok/ but then they may (.) need to be walked with and and u::m (.) counselled /*ja*=/ =in order to accept that new challenge for their lives (1)

In extract 35 above, I (the interviewer here) am speaking to Chanelle, a counsellor working at site 2, about her experience of providing pre-abortion counselling. In the first text of this extract, which is preceded by Chanelle's discussion of the educational purpose of the counselling, Chanelle describes children as intrinsically valuable in giving "a lot of joy and purpose" to their parents. By doing so, she similarly constructs parenthood as an inherently positive experience and one which is worthwhile because it gives one's life meaning.

As the second text in extract 35 shows, a glorification of reproduction is complemented by a downplaying of any difficulties and struggles that may come with parenthood. Explaining the need for counselling in situations where womxn decide to continue with the pregnancy and parent, Chanelle states: "but then they may (.) need to be walked with and and u::m (.) counselled in order to accept that new challenge for their lives". Interestingly, Chanelle's response can be read as an acknowledgment that parenthood may in fact not be desired by some womxn. However, childlessness as a genuine choice is undermined in the very language deployed. Thus parenthood, although challenging, emerges as comparable to and not more difficult or stressful to manage than any other challenge that one may encounter in life. Furthermore, implicit in this construction is that while the challenge may be difficult, it is an exciting one, which is captured by the 'newness' of the challenge.

In the next section, I discuss how participants constructed a discourse in which first-time motherhood was particularly imperative and a womxn's first pregnancy was constructed as a special, and momentous occasion which should be celebrated and cherished. These interrelated discourses relate and contribute to mothernormativity: the normative expectation that womxn will be mothers and the privileging of this role for womxn. I argue that the imperative of (first-time) motherhood and distinctiveness of first pregnancy had implications for womxn who were terminating a first pregnancy.

6.3. The imperative of (first-time) motherhood and distinctiveness of first pregnancy

Part of pronatalist discourses is the construction of motherhood as imperative: as a duty and expectation that is required. This is demonstrated in extract 36 below where Lisakhanya is relating her experience of a waiting room interaction with one other womxn who, incidentally, was at the womxn's clinic for reasons other than abortion.

> *Extract 36 [site 3]* {womxn} <E/X>
>
> **I:** ok (.) so now (.) can you say a bit more about this waiting room (.) this waiting room /like/ what was your experience?
>
> **Lisakhanya:** *yoh* a- it was [laughs] I did not experience nothing *neh* (.) but the problem is that (.) there was another older woman *neh* /mm/ *ja* that woman she told me that (.) how she gave birth to her own child (.) and what happened and so on (.) so she she was thinking that 'why man this thing [abortion] why don't you leave it' *neh* (.) because (.) 'I was able to carry my child for 9 months' *neh* (.) and it was not out of love because it was something she had not expected or was prepared for (.) it had been (.) just a rape *neh* /o::h/ then now (.) at least me *neh* (.) me I know (.) I mean me my child *neh* (.) it will be helped whereby its father will love it and stuff *nje* with love *neh* (.) so I cannot now complete [the pregnancy] (.) I cannot *shem* (.) because of the situation at home (.)

like (.) I also want to complete [the pregnancy] *neh* (.) but the situation at home does not say /mm/ *ja*

In the conversation that Lisakhanya recalls, the womxn attempts to dissuade Lisakhanya from having an abortion. Thus, Lisakhanya relates the interaction: "'why don't you leave it' *neh* (.) because (.) 'I was able to carry my child for 9 months' *neh* (.) and it was not out of love because it was something she had not expected or was prepared for (.) it had been (.) just a rape". Anti-abortion discourses sometimes make allowances for specific circumstances, such as rape, where not desiring the pregnancy or the resulting child are understood to be logically acceptable. Read against this, the womxn's comparison of her own circumstance of rape where she nevertheless continued the pregnancy and parented (it is assumed) to Lisakhanya's own circumstance where her child "will be helped whereby its father will love it and stuff" has the effect of constructing parenthood as an imperative that can never be reasonably and understandably avoided. Indeed, after conveying this interaction, Lisakhanya finds herself in a troubled position where she is called on to explain and defend her decision to terminate the pregnancy, as her child would be loved and have a father. The effect is that motherhood is constructed as the norm.

As suggested earlier, participants' talk sometimes constructed first-time parenthood as particularly obligatory. An example is provided below. In the extract, Thembakazi (extract 37) gives an idea of some of the conversations that took place between herself and other womxn waiting to be attended to at site 3.

Extract 37 [site 3] {womxn} <E/X>

CR: […] I would like to know of your experience of the the waiting room (.) and the interaction when you spoke (1) how was it?

Thembakazi: […] we ask each other that how many [months] are you how many [months] are you /ok/ what has made you start to come now /ok/ like we ask things like that /ok/ then if there are no children (.) <u>why</u> is it you are having your first child then you are thinking of aborting things like that /ok/ so a person gives their reason that <u>why</u>

In extract 37 above, Thembakzi states: "if there are no children (.) <u>why</u> is it you are having your first child then you are thinking of aborting things like that /ok/ so a person gives their reason that <u>why</u>". The use of a foetal personhood discourse in referring to the foetus as a "child" is significant in that through it, the womxn position each other as *already mothers*. It therefore lends some force in constructing first-time motherhood as particularly obligatory. The implication of this is that abortion becomes a relatively acceptable and reasonable course of

action for womxn who have already parented or are already parenting. Conversely, terminating a first-pregnancy is especially unacceptable if not abnormal.

With the imperative of first-time pregnancy comes the notion that first-time pregnancy is somehow distinctive in character from subsequent pregnancies. Some participants thus constructed the first pregnancy as inherently special. This was tied to these participants' experience of emotional difficulty. Extract 38 below speaks to this.

> *Extract 38* [site 2] {womxn} <E>
>
> **I:** that's ok u::m the question wa::s (.) um how did you feel about (.) um you said that she didn't judge you but she:: was trying to persuade you (.) I was asking you about that=
>
> **Mpho:** =*ja ja ja ja* […] like (.) I mean (1) I already feel horrible (.) like the fact that I'm coming here hey like (.) it's my first child and I don't I won't I wouldn't wanna do that but then (1) well (1) I am doing it (.) but then like it w- it wasn't what I wanted but (1) wanted for my first like (.) for my pregnancy and stuff like that /mm/ and (.) I know that it's gonna haunt me for the rest of my life (.) and (.) *ja* she just didn't (2) judge us

In extract 38 above, I remind Mpho that the question I asked her related to how she felt and what she thought about the abortion care provider's lack of judgment in her counselling which was, nevertheless, in Mpho's own words (not shown here) an attempt to persuade her against abortion. Appreciating the lack of judgment, Mpho goes on to say: " I already feel horrible (.) like the fact that I'm coming here hey like (.) it's my first child and I don't I won't I wouldn't wanna do that". As she explains, the emotional difficulty Mpho experiences is due to it being her first pregnancy, which is emphasised. As with Thembakazi above, foetal personhood is constructed here. This time, the effect is the construction of first-time pregnancy as inherently special and magical: an event to be celebrated and cherished. And Mpho implies that this is indeed how she feels about the pregnancy: "it wasn't what I wanted but (1) wanted for my first like (.) for my pregnancy and stuff like that". This expectation that first-time pregnancy should be cherished results in Mpho's knowledge that her decision to terminate the pregnancy, the "first child", will be haunting for her.

7. Conclusion

As discussed in this chapter, womxn spoke about how healthcare providers discussed the risks around abortion. I argued that this is part of an awfulisation of abortion discourse where abortion is constructed as disadvantageous to womxn and even harmful.

Moralising discourses around abortion constructed abortion in various ways as a wrongful act. Abortion thus emerged as an act for which one should be ashamed, with health service providers' talk demonstrating that the 'truth' of abortion as a source of shame is accompanied

by expectations of an embodiment of shame. Through a religious discourse, abortion was constructed as sinful, with nuances in constructions of the gravity of abortion as sinful. In this chapter I discussed how a significant effect of moralising discourses around abortion is that having one abortion is constructed as less problematic and more acceptable than having multiple abortions which becomes particularly stigmatised and unacceptable. In problematising multiple abortions, health service providers drew on a culture of abortion discourse.

In constructing pronatalist discourses, participants drew upon constructions of motherhood as an imperative. First-time motherhood was constructed as especially obligatory, owing to the construction of first-time pregnancy as distinctive in being magical: an event to be cherished and celebrated. Terminating a first pregnancy was thus conceptualised as a particularly deviant act, one which was distressing for some womxn.

Womxn and health service providers drew on (neo-)liberal discourses in various way. Firstly, womxn accessing abortion services were responsibilised, by themselves and health service providers, for their unintended pregnancy. Through responsibilisation discourses, womxn were also positioned as having to accept the possible consequences of abortion which were constructed in a language of 'risk'. Womxn also framed the decision to have an abortion as a responsible one. Liberal counselling practices were described with a focus on the womxn's choice. Lastly, womxn used a consumer-/client-oriented discourse in evaluating the service they received as 'good' or as a deviation from the kind of care they were not only expecting, but were owed. Constructions of 'good'/'bad' service were dichotomised into 'private'/'public' health care.

Through a psychotherapeutic discourse, womxn constructed a kind of counselling where healing relies on facilitating a genuine emotional connection to an event or experience. Within this discourse, experiencing emotional difficulty in relation to the information provided by the abortion care provider is normalised as a necessary effect of 'real talk'- honest, frank, truthful information which is provided empathically.

The first of three analytical chapters, this chapter functioned to provide a foundation for how womxn's narratives and healthcare providers' accounts of their PTOP healthcare encounter experiences, are to be understood. As such, I discussed various discourses drawn upon and constructed by participants when telling accounts of their experiences in an interview context. These discourses form the discursive context for the pre-abortion counselling encounter, at least as it takes place within three public health hospitals in the Eastern Cape.

Chapter 7: Womxn's micro-narratives of the PTOP healthcare encounter

1. Introduction

The first analytical task (of a three-pronged narrative-discursive approach, as outlined in chapter 5) in which the analyst goes back and forth across the data for the discursive resources used by participants in their interview talk formed the basis of the analytical work in the previous chapter. This chapter represents the second stage of analysis. In this chapter I analyse how discursive resources are used by womxn to construct micro-narratives- localised stories usually constructed in short bursts during question and answer interactions (O'Donovan, 2006)- of their experiences of the PTOP healthcare encounter. To identify the micro-narratives, I analysed participants' responses to the interview questions for a narrative construction of sequence ('and then') or consequence (causality). In an extension of Taylor and Littleton's (2006) approach, as part of this second task I draw on post-structural writers' work around power relations (gendered, as well as liberal, pastoral and sovereign/authoritarian) to analyse the data. Thus, this chapter includes a focus on the power relations referred to in the womxn's micro-narratives. In the next chapter, I apply this extended narrative-discursive approach to analyse the discursive resources (discourses and canonical narratives) drawn upon by the healthcare providers in accounting for pre-abortion counselling practices and the various forms of power which operate in these practices.

In the first part of this chapter, I speak to the following micro-narratives which were constructed around the pre-abortion counselling session itself: 'It was informative', 'I was guided', 'The counselling was healing/beneficial', 'I was ready to say oh I'm cancelling/I have doubts', 'Adoption is not an option', 'I didn't have a choice', 'I was so hurt', and 'I educated myself'. In the remainder of the chapter, I discuss the micro-narratives which were constructed around womxn's waiting room experiences. These are as follows: 'We were chatting/sharing stories', 'I was scared', 'They are not the kindest people/She was harsh', and 'It was as if we were being ignored'.

2. 'It was informative'

A micro-narrative of 'It was informative' was constructed by several participants when describing their experience of the counselling. Within this micro-narrative, participants gave accounts of how they experienced discussions around pregnancy options, i.e. terminating the

pregnancy, continuing the pregnancy and parenting, or continuing the pregnancy and placing the resultant child up for adoption, as helpful. As the diagram below (Figure 1) shows, this narrative featured as a kind of over-arching narrative. As such, participants would construct this micro-narrative in relation to the micro-narratives of 'I was guided', and 'I was ready to say oh I'm cancelling/ I have doubts' (depicted in the diagram below). Although each of these micro-narratives will be discussed separately, their interconnectedness should be kept in mind.

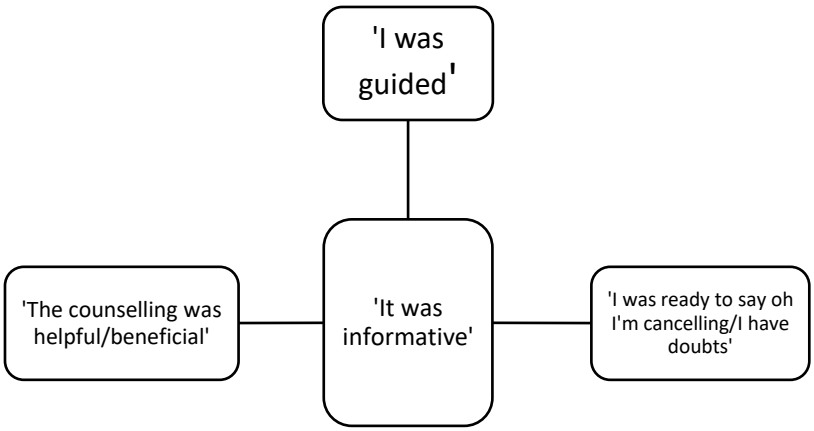

Figure 1: Micro-narratives cohering around 'It was informative'

Overall, most womxn interviewed for the present study said that they found the pre-abortion counselling to be informative, although in different ways as I suggest in the above discussion, or made comments about the counselling having gone well. For some womxn, learning about adoption was useful even though most did not feel themselves to be able to act on this information (I discuss this later in this chapter). For other womxn, receiving information about the abortion procedure was especially helpful.

Significantly, statements about how the counselling was informative and/or went well were made alongside expressions of shock and conflict at the information they received (to be discussed fully in a later discussion). Such responses might point to some womxn's need for information and the need for providing information in a nuanced and supportive way. These responses might also reflect the researcher-participant power relation where participants feel as is if they are expected to give a desirable answer (that is, desirable to the researcher) and feel unable to disagree or depart from this. Furthermore, that the interviews took place within the hospitals may have meant that womxn associated me with the healthcare staff and/or the hospital, despite explanations that we were students from Rhodes University. Power relations

between healthcare providers and clients/patients within clinical and hospital settings may also play a part as participants may not be/feel able to critique or problematise the content of the counselling, which a negative experience might be interpreted as, owing to the authority invested in the healthcare provider within such settings.

I now discuss the narrative 'It was informative/helpful'. As I will show, within this narrative, womxn spoke of the counselling as an educational or learning experience, with the abortion care provider being positioned as an educator providing useful information.

> *Extract 1* [site 2] <E>
>
> **Mpho:** what I think is that it was very informative because she:: she:: (.) well (.) the way she did it (.) she didn't judge us /ok/ and stuff (.) she was just basically informing us on like what was gonna happen /ok/ and like (.) the:: long-term effects not like the medical effects but like psychological effects /ok/ and u::m (.) well she did tell us about the long-term effects which was like (.) increase chances of breast cancer (.) and (.) other like psychological disorders after this and like um (.) reduce chances of having (1) having a child (.) (that ma::kes (.) you want to get pregnant) and she (.) told us about like other options besides abortion /mm-hm/ because she (.) um she said that there are other womxn out there who don't have children (.) um who can't have children /mm/ who would like to have children /mm/ and then like if you go through with the pregnancy and then (.) just give birth to that child and like you know (1) give that child a home /mm/ (do good and like what not) (.) (a child and support) (.) and then *ja*

As Mpho describes in extract 1 above, the information provided by the health service providers constructs abortion as a risk through liberal discourses. Thus, Mpho states: "the:: long-term effects not like the medical effects but like psychological effects /ok/ and u::m (.) well she did tell us about the long-term effects which was like (.) increase chances of breast cancer (.) and (.) other like psychological disorders after this and like um (.) reduce chances of having (1) having a child". As the extract shows, pronatalist discourses play an integral role in underpinning abortion as risk. Regarding infertility, for abortion to be negatively constructed as harmful, assumptions need to be made about procreation as both inevitable and as an imperative, and childlessness constructed as undesirable. Within this discursive context, the possibility of infertility[21] then emerges as valuable information that may make a difference when deciding what to do about abortion.

[21] Research indicates that abortion may result in infertility if an infection occurs, which is unlikely when performed in a healthcare environment but is likely when abortion is performed clandestinely by non-professionals and/or outside of an appropriate healthcare facility (Torres-Sanchez, Lopez-Carrillo, Espinoza & Langer, 2004). Indeed, Ipas' (2010) health provider resource and the Western Cape DoH's (2000) guidelines, policy and protocols document on TOP instruct health service workers to inform womxn about *rapid fertility return* post-abortion.

The force of pronatalist discourses is apparent when Mpho describes the abortion care providers' talk around pregnancy options: "she (.) told us about like other options besides abortion /mm-hm/ because she (.) um she said that there are other womxn out there who don't have children (.) um who can't have children". It is significant here that Mpho moves from womxn who *don't* have children to those who *can't* have children. The ambiguity of the former (the possibility of voluntary childlessness) of course opens up questions around the necessity of including information around adoption (those who choose childlessness would not adopt). It also, I argue, risks leaving room for the normalisation of childlessness by *choice*. Interestingly, adoption is constructed as a societal good: "just give birth to that child and like you know (1) give that child a home /mm/ (do good and like what not)". The implication of adoption as 'doing good' is that abortion is conversely constructed as immoral in depriving a child of a home.

Within this educational context then, which operates through power relations between educator and learner, the information given to the womxn is taken for granted as 'information': as fact and truth. Questioning the 'truth' of this information is difficult if not impossible given the womxn's subject positioning relative to the abortion providers': ignorant and expert respectively.

Sandisiwe's extract below (extract 2) also constructs the pre-abortion counselling as informative and therefore helpful, but does so in a different way. In the extract, she responds to a question about whether she and the abortion care provider spoke about her personal life and how she experienced this discussion.

> *Extract 2* [site 2] <X/E>
>
> **I:** about your situation /the situation/ ok (1) and u::h and how was (.) how was it (.) how did you feel about that part of the discussion when you were talking about now (.) if other people know?
>
> **Sandisiwe:** oh *ja* she did ask me why did I [inaudible] as well /*ja*/ mm
>
> **I:** ok and how did that feel (.) speaking about those things of your life?
>
> **Sandisiwe:** mm (3) [laughs] it was (.) ok because (.) you don't open about it every day /mm/ you don't say it every day /mm/ it (.) it's (1) it's actually (3) not relieving but (1) because the problem is still there /mm/ but you know (1) it just (.) shows you how much (.) of a problem that (.) or how much of a:: (3) how (.) in trouble I am (.) *ja* /o::h I see/ *ja*
>
> **I:** ok but (.) you say it was u::m (1) not relieving but (.) you know because we don't speak about (.) it's not something that we speak about all the time /mm/ so:: (.) the chance to speak about it?

> **Sandisiwe:** *ja /ja/* i::s (2) is kind of like showing me that ok /mm/ you a::re (.) in this thing (1) I think I've been (.) in denial for such a long time so now (.) when I talk about it I'm like ok you know /mm/ see that actually [inaudible]

Sandisiwe's extract above (extract 2) also constructs the pre-abortion counselling as informative and therefore helpful. Drawing on a psychotherapeutic counselling discourse, Sandisiwe constructs the counselling as informative in what it reveals about the self. Hence, she states: " it just (.) shows you how much (.) of a problem that (.) or how much of a:: (3) how (.) in trouble I am". Here, we see counselling as an extension or consolidation of confessionary practices where, as Foucault argues, the counsellor's expertise is necessary as it not only interprets the confession given by the speaker, but *constitutes* it. Thus, it is through the counselling that Sandisiwe is able to 'see' the truth of her situation: that she is "in this thing" and that she has "been in denial for such a long time" about the pregnancy and needing to resolve it. This eye-opening effect, however, at least within the specific context of pre-abortion counselling, has limitations as Sandisiwe shows. While it is an opportunity to speak about something that "you don't open about it every day", it is "not relieving…because the problem is still there". In Sandisiwe's case specifically, she was unsure whether she would be able to have an abortion as she was told during the counselling that, being in the second trimester, given the unavailability of hospital beds for a surgical procedure, and given a long waiting list, abortion might not be a possibility for her.

Although not a dominant feature across all womxn's narratives of' 'It was informative', 'real talk' operated alongside and was part of a psychotherapeutic discourse and was thus instrumental in the narratives in which it featured (at the second site where the counselling was outsourced on a voluntary basis to a pregnancy crisis NGO) in upholding the taken-for-grantedness of the 'information' given by abortion care providers during counselling. Not only did it protect the information as 'fact', but it also justified the counsellor's provision of this sometimes-upsetting information. As extract 2 above suggests, 'real talk' is part and parcel of psychotherapeutic counselling, and as such, it is *necessary* for healing. Within psychotherapeutic counselling, counsellors cannot therefore be blamed for the upset that results, even when the counsellor provides little to no relief. Thus, Sandisiwe draws on the understanding that counselling is *meant* to "show how in trouble" she is.

In the next section, I discuss the micro-narrative of 'I was guided' which speaks the pastoral care relations of power described by some of the womxn in this study.

3. 'I was guided'

Sometimes, womxn not only constructed the counselling as informative, as with the examples in the previous section, but also spoke about receiving guidance from the healthcare provider, in terms of what the womxn should or should not have done or what they should or should not do in future. In this section I speak to these particular micro-narratives wherein womxn referred to pastoral relations of power between themselves and their healthcare provider. Extract 3 below is one such example.

> *Extract 3* [site 2] <X/E>
>
> **CI:** mm (.) in your view how did you feel about the opportunity where the nurse gave you information during the counselling?
>
> **Nowu:** um I was actually very happy (1) I (.) I don't know I was very happy (1) cause I think (.) sometimes being advised (.) it's not about sulking/being angry or not sulking/being angry but (.) being happy that (.) you know that (.) this thing that you are being told you are learning (.) you learning from something *ja*

When asked how she felt about the information provision, Nowu states: "um I was actually very happy (1) I (.) I don't know I was very happy". Her use of the word "actually", the initial 1 second silence, and that she repeats the phrase, all indicate that, given the information she has received, happiness is an unexpected response. Although it must be noted that this could be a function of the perhaps problematic assumptions contained in the question itself, that such information would and even *should* be upsetting, Nowu accounts for her happiness thus: "sometimes being advised (.) it's not about sulking/being angry or not sulking/being angry but (.) being happy that (.) you know that (.) this thing that you are being told you are learning". In doing so, she constructs and draws attention to pastoral relations of power.

As Foucault discusses, pastoral care imitates the relation between the pastor and their flock where the pastoral role is one of providing moral guidance, such as giving advice for example. Macleod (2006) highlights the prescriptive nature of pastoral guidance in her research on contraceptive counselling, where pastoral care involves directing one's flock about what to do and what not to do. Nowu speaks to this feature of pastoral care within pre-abortion counselling and demonstrates the rules and expectations which govern those caught up in these power relations. Thus, "sulking/being angry" as a reaction to "being told", presumably about the error of one's ways, and "learning from something" emerges as an inappropriate, and perhaps even immature response. Conversely, her happiness is normalised as a legitimate emotional reaction to receiving guidance from the counsellor.

Extract 4 below is another example of an 'I was guided' micro-narrative. Like the previous extract, it demonstrates how pastoral power may operate within pre-abortion counselling sessions. Sbongiseni (extract 4) was the only participant who said she had decided against abortion because of the counselling.

> *Extract 4* [site 2] <E>
>
> **I:** […] what you what were you expecting (1) would happen when you came here (.) did you have any expectations?
>
> **Sbongiseni:** I thought I was going to be given a pill /mm/ and then I was going to swallow the pill (.) everything would be gone (.) then I saw pictures of how they do abortion abortion /mm/ then they explained how dangerous it could be (1) and I could get infected with so::me cancer (.) *ja* /mm/ *ja* (.) and then um maybe (.) it's my first and last child I will never have (.) another one /mm mm/ then (.) I (.) I was confused I felt like (1) I felt like I'm doing something wrong /*ja*/ *ja* (1) and (.) I don't really want to do it (.) but I I (.) before I knew that (.) before (.) I:: didn't know that ok I could keep the pregnancy (.) then (.) give away the baby then (.) come and take care of it again /mm/ so I was like I I'm (.) I'm not working /mm/ I'm studying and at home they're not going to like it (.) so I have to do it I really have to do it (.) so now (1) I think (1) I made a (.) right decision (1)

In extract 4 above, Sbongiseni describes the simple, easy process she had in mind: "I thought I was going to be given a pill /mm/ and then I was going to swallow the pill (.) everything would be gone". However, several aspects of her pre-abortion counselling encounter changed her mind. The first of these were "pictures of how they do abortion", which were put up in the waiting room. While some womxn may find the depictions useful in preparing themselves for what they are about to go through, Sbongiseni found this distressing. Also contributing to her distress was the information she received during the counselling which constructed abortion as risky and "dangerous". Thus, she describes: "they explained how dangerous it could be (1) and I could get infected with so::me cancer (.) *ja* /mm/ *ja* (.) and then um maybe (.) it's my first and last child I will never have (.) another one". One significant effect of constructing abortion through discourses of risk and responsibilisation, as well as through pronatalist discourses, is that abortion is not only undermined as a legitimate course of action, but may further emerge as a wrong thing to do, thereby inducing guilt. This effect is demonstrated by Sbongiseni when she states: "I was confused I felt like (1) I felt like I'm doing something wrong". Thus, once again, shaming is deployed as a technique of pastoral care the objective of which is guide the flock onto the correct path.

Although Sbongiseni found the information on adoption useful and subsequently changed her decision, her confusion and conflict stemmed from the ways in which abortion was spoken about by the counsellors. Given that most womxn who constructed this narrative were not in a

position to change their decision, the deployment of this language around abortion may be particularly hazardous considering that pre-abortion counselling may take place within and be governed by a) pastoral power relations where the counsellor is positioned as an expert voice on moral issues and b) relations of power that operate within clinical/hospital settings where the health care providers' words carry the force of scientific and medical facts (Foucault, 1976) to which womxn seeking abortion services may not have access.

As I mentioned earlier, most womxn in the study described the counselling they received as informative and useful in some way (contradictions notwithstanding). Similarly, womxn in a study conducted in Malaysia by Tong et al. (2012) described the pre- (and post-) abortion counselling that they received as informative. Some womxn did, however, express dissatisfaction at the insufficient level of procedural detail provided by the abortion care providers (Tong et al., 2012). Likewise, Birdsey et al. (2016), who conducted a study in the KwaZulu Natal province of South Africa, reported that while womxn who had already decided on abortion tended to be satisfied with the content of the counselling, some womxn (19 out of 60) found the counselling to be insufficient in detail. For others (33 womxn), the procedural information (the only information provided) was found to be irrelevant to the personal circumstances of their pregnancy and instead they wanted information that spoke to their realities.

In the following section, I discuss a micro-narrative where womxn described the counselling as healing and/or beneficial.

4. 'The counselling was healing/beneficial

As depicted in Figure 1 above, a micro-narrative of 'The counselling was healing/beneficial' tended to be linked to 'It was informative'. Several womxn constructed a narrative of 'The counselling was healing/beneficial' in response to the initial narrative eliciting question around their abortion experience. Interestingly, this micro-narrative was only constructed by participants who accessed abortion services at the second and third sites, where, at the second site qualified counsellors from a Christian NGO provided what they referred to as 'options counselling' and at the third site, despite not being a qualified counsellor the nurse providing the counselling was repeatedly praised for her counselling skills. Within this micro-narrative, participants often described non-directive, balanced, supportive and empathic counselling. Because of this care, womxn often described moving from negative emotions when they arrived at the facility, to positive emotions after having received the pre-abortion counselling, thereby describing, through a psychotherapeutic counselling discourse, a kind of healing

process that took place. In highlighting womxn's emotions, this micro-narrative speaks to womxn's embodied experiences.

Extract 5 below is the first example addressed in this micro-narrative where womxn spoke about what they understood and experienced as 'counselling'. In extract 5, Sbongiseni describes her emotional state before she arrived at the abortion facility and after receiving pre-abortion counselling.

> *Extract 5* [site 2] <E>
>
> **I:** […] how was the counselling what you::r experience of the counselling (.) you had there?
>
> **Sbongiseni:** (2) oka::y um (2) it was (3) very well (.) just (1) it (.) ok first before I got there neh (.) I felt like crying and running (1) I had (.) I was emotional I was crying /mm/ so (.) when I got there (.) we talked to that lady and (.) I just (.) felt calm /mm/ mm (.) and u::h (1) I had time to think about what I want to do /ja/ so:: I think (2) I think I made a wise decision /mm/ when I got there (1) and she explained a lot of stuff to me that I didn't understand (1) so it was (.) fine it was (.) (relevant) it was great

Describing how she felt when she had first arrived at the facility, Sbongiseni states: "ok first before I got there neh (.) I felt like crying and running (1) I had (.) I was emotional I was crying". Because of the counselling, and the genuine and meaningful reflection that is necessary for healing in a psychotherapeutic discourse, Sbongiseni becomes calm: "we talked to that lady and (.) I just (.) felt calm". Although I heard, through nurses and some womxn I had interviewed, about womxn who had decided to continue with the pregnancy, and although several womxn I had interviewed expressed *wanting* to change their mind, Sbongiseni was the only one out of the 30 interviewed who had decided against terminating the pregnancy. In her extract above, she refers to this as a "wise decision". While it is clear from her interview that the decision to have an abortion was made not having had access to information about the possibilities of adoption, it is significant that she here uses a responsibilisation discourse, which relies upon a construction of abortion as immoral, to frame her final decision. Such talk around making 'wise decisions' and 'wise choices' was used (as I will show in the next chapter) by the counsellors at the facility used by Sbongiseni. This talk implicitly constructed abortion as always 'unwise' and therefore 'irresponsible'. Thus, when deployed in pre-abortion counselling, responsibilisation discourses may have implications for womxn's decisions.

Like Sbongiseni, Thamie in extract 6 below also describes a change in emotions as a result of the counselling she received.

> *Extract 6* [site 3] <E>

I: […] if you can just tell me:: um (.) what you experienced in that consultation room how was that experience for you?

Thamie: (.) well [laughs] when I came here /mm-hm/ (1) uh how can I put it (.) I was very heavy (.) neh /mm-hm/ but after the:: (.) session /mm-hm/ in the consultation room I feel very light (.) I'm sure of what I want to do and (.) *ja* (.) that's how good it was /ok ok/ *ja*

Thamie: […] first of all yoh (.) she's good /mm/ cause I wasn't expecting that /mm/ she's a very nice person she's gentle /*ja*/ (.) polite /mm/ (2) *ja* (.) the the way she:: she talks and explains it just (1) someway somehow I can say she's a psychologist for God sake /ok (.) ok/ she (.) she just […]

Describing a different emotional transition, Thamie states the following: "I was very heavy (.) neh but after the:: (.) session in the consultation room I feel very light". For Thamie, an effect of the counselling she received is that the burden of doubt and emotional conflict she had been experiencing is relieved and replaced by certainty: "I'm sure of what I want to do". Unlike Sbongiseni, and like several other womxn in the study, the counselling had the effect of affirming her decision to terminate the pregnancy. Drawing on a psychotherapeutic discourse, Thamie lists certain qualities that, for her, are necessary for and constitute 'good counselling'. Thus, she states: "she's a very nice person she's gentle /*ja*/ (.) polite". In summary, Thamie exclaims: "she's a psychologist for God sake". As Parker (1998) explains, a personal experience with psychotherapeutic counselling is not needed to be able to recognise it as such, for a psychotherapeutic discourse is often deployed in various media, film, self-help books, and autobiographies for example. As a dominant discourse on the self and understanding the self, it is easily recognisable as Thamie demonstrates in this extract. Thus, although Thamie does not elaborate beyond "she's a psychologist", as the interviewer listening to her (and to a certain extent as readers reading this), it was clear what she was constructing: gentle but honest probing combined with 'real talk' which facilitates a meaningful connection to the experience or event.

'Good' counselling was also constructed by several participants as empathic and therefore supportive, as can be seen in extracts 7 and 8 below.

Extract 7 [site 3] <X/E>

I: it's recording (1) ok so (.) u::m can you tell me:: just in general (.) just *nje* /ok/ eh u::m how *i*-counselling (.) went?

Asiphe: *ja* the counselling it's (.) it went well and the nurse she counselled me well because (.) you know when you (.) come to do a (.) abortion (.) there are some people maybe (.) is gonna ask you many questions why do you this why /mm/ because why you had sex but now you want to do abortion so (.) those names that are rude (.) talk through rude names to you but that nurse (.) she did give me right information (.) and explain that what's gonna happen (.) what I'm doing and it's not blaming me about the decision

I made /mm/ they just support me and she asked me why I do this but I did tell this thing that (.) I feel that (.) this thing I can't

Extract 8 [site 3] <X/E>

CR: oka::y (.) ok thank you /[laughs]/ and the::n (.) what would you tell a friend eh if they come here to the womxn's clinic?

Thembakazi: *tjo* (.) though I'm not against abortion and though I'm not like (1) judging people /mm/ but (.) co- coming here is not (1) I don't feel it's like a (.) a good thing (.) but a person's situation it (.) takes them to a place they were not expecting /mm/ like me (.) I never thought I would end up here /mm/ so I would just (2) tell her (1) and (.) support her /mm/ that you can go:: then you will find support at least the sister is supportive /mm/ (1) she knows how to (1) feel make you feel (.) like you came here holding on and then she chats (.) /ok/ she remove this tension that you are going to do something (.) you see

In extract 7 Asiphe starts off her account of the counselling with a positive evaluation: "she counselled me well". What follows, however, is more than an exercise in evaluating the counselling as 'good'; Asiphe draws on and constructs 'good counselling' practices which revolve around non-judgment. As Asiphe explains, judgment is a likely possibility when it comes to abortion and it manifests itself in calls for womxn to justify their abortion: "you know when you (.) come to do a (.) abortion (.) there are some people maybe (.) is gonna ask you many questions why". Calls for justification rely on, and must be contextualised within, liberal discourses of responsibilisation. This is shown through Asiphe's enactment of a scenario in which a womxn is being questioned about her decision to have an abortion: "why you had sex but now you want to do abortion". For womxn being questioned in this way, the message being communicated is clear: responsible and rational womxn either use contraception or have sex to procreate and therefore plan their pregnancies accordingly. Those who fail to do so, must responsibly and rationally accept the consequences (risks) of their actions and *continue* with, not terminate, the pregnancy. A 'good' counsellor, however, such as the one counselling Asiphe, would not "blame" her for her decision but would instead provide support, which involves information provision that allows Asiphe to prepare herself for what she is going to experience. It is interesting, however, that Asiphe in fact goes on to describe being asked by the abortion care provider about her decision to terminate the pregnancy, but describes this as being done in a supportive manner, as an opportunity to be heard.

Thembakazi (in extract 8 above) demonstrates the force of moralising discourses around abortion such that abortion as an immoral act persists as a 'truth' despite non-judgment. In the extract, Thembakazi has been asked, hypothetically, how she would describe her experience of

the pre-abortion counselling encounter to a friend. Thembakazi begins: "though I'm not against abortion and though I'm not like (1) judging people /mm/ but (.) co- coming here is not (1) I don't feel it's like a (.) a good thing". The emphasis she places on the word "good" is important as it is from and through this that we are to understand that abortion is in fact 'bad'. And Thembakazi is able to construct abortion in this way precisely because of what she understands non-judgement to mean: the understanding that womxn are compelled, by and through their circumstances, towards abortion. Past research (Chiweshe, 2016; Mavuso, 2015) has shown that this does indeed reflect some womxn's experiences. However, constructing abortion as understandable and not worthy of judgement only when womxn state being compelled into having an abortion, enables the judgment of womxn for whom abortion is a choice *not* something that is compelled by their circumstances. Certainly, the understandability of abortion arising from compulsion, versus the incomprehensibility of abortion as desired or chosen, may reflect the dominance of the awfulisation of abortion in which abortion cannot be desired or fully chosen because it is necessarily an act of desperation. Furthermore, it belies a construction of abortion as already immoral.

Like Asiphe, therefore, it is within this context that supportive counselling must be understood. Thus, Thembakazi hypothetically tells her friend: "you can go:: then you will find support at least the sister is supportive". Explaining what she means by "support", Thembakazi adds: "she knows how to (1) feel make you feel (.) like you came here holding on and then she chats (.) /ok/ she remove this tension that you are going to do something". Once again, through a psychotherapeutic discourse, counselling emerges as a positive change in emotions, in Thembakazi's case a removal of tension. Crucially, this tension and sense of "holding on", is linked to the sense that abortion is a (morally) profound or significant "something". Significantly, in Thembakazi's description, the healthcare provider's counselling practices have the effect of (temporally) disrupting this notion.

In the next section, I discuss micro-narratives where womxn constructed the counselling as informative and as causing decision conflict or doubt.

5. 'I was ready to say oh I'm cancelling/I have doubts'

Another micro-narrative that was linked to 'It was informative' was a micro-narrative of 'I was ready to say Oh I'm cancelling/ I had doubts'. Within this micro-narrative, participants described how aspects of the counselling, such as pregnancy resolution 'options', information around the 'risks' of abortion, and/or details of the abortion procedure (usually medical abortion) resulted in conflict around their decision to terminate the pregnancy. For most of the

womxn who constructed this micro-narrative, the conflict was unresolvable as abortion was the only course of action for them.

In extract 9 below, Thombulelo describes the discussion around pregnancy options as directive and persuasive.

> *Extract 9* [site 1] <X/E>
>
> **I:** okay then just to speak about (.) the options (.) if there were options given to you (.) what was the:: how did you experience that (.) that part of the conversation (.) part of the counselling=
>
> **Thombulelo:** =that part of the options? /*ja*/ (.) it was u::m (4) it was like u::h (3) they don't wanna they don't want me to do the termination (1) /ok/ *ja* it was like she didn't want me to do it /mm/ and I have no reason for me to do it /mm/ a::nd I can just keep the baby /mm/ and give it out (.) give it up for adoption /ok/ (and u::h just like make it ok) /ok/ *ja* so the option was like (.) she was trying to do that
>
> **I:** ok (.) and h- how did you experience that what what how did you feel about that?
>
> **Thombulelo:** mm (2) I felt (.) I felt like changing my mind at first /mm/ because I it was like I (.) like I (1) some (.) it felt so::me like I so::me how can I put this by the way (2) like it made me want to be sad/feel sorrow/pity = /=mm-mm mm-mm/ do you understand /mm-mm=/ =as in like (.) to think about what I'm going to do and how wrong it is /o::hh/ *ja* /how wrong it is=/ (that's why *ja*)

Reflecting on her experience, Thombulelo states: "it was like u::h (3) they don't wanna they don't want me to do the termination (1) /ok/ *ja* it was like she didn't want me to do it /mm/ and I have no reason for me to do it". Two things are worth noting in Thombulelo's description. The first is the abortion care provider's seemingly implicit communication of *her* preference for one course of action over another. The second is the message the abortion care provider conveys, through liberal discourses, about the requirement for rational, and therefore acceptable reasons for abortion and her own role in judging the validity of womxn's reasons accordingly. Both, I argue, must be understood within a context of pastoral care/relations of power where the health care provider, as moral arbiter, prescribes what the right course of action is and guides those in her care away from immorality.

That, according to Thombulelo, abortion is being constructed by the health service provider as immoral, and therefore shameful, can be seen in the following statement: "like it made me want to be sad/feel sorrow/pity = /=mm-mm mm-mm/ do you understand /mm-mm=/ =as in like (.) to think about what I'm going to do and how wrong it is". Macleod (2006) discusses how shaming is one technique of pastoral power where inducing shame about wrong doing is used to guide the members of the flock onto the correct path. Indeed, in this case the effect of using this shaming tactic is that Thombulelo initially feels like changing her mind. For Thombulelo,

however, as was the case with other womxn who constructed this narrative, adoption is constructed as a non-option through foetal personhood and preclusion of adoption discourses. Thus, Thombulelo states: "a::nd I can <u>just</u> keep the baby /mm/ and give it out (.) give it up for adoption". Her use and emphasis of the word "just" highlights the *impossibility* of placing the child up for adoption. Through it, Thombulelo communicates not only the health care provider's presumption about the ease with which one could continue with the pregnancy only to place the child up for adoption, but her own disagreement with this.

For some womxn who constructed this narrative, a risk discourse around abortion was emotionally troubling. Extract 10 below is an example.

> *Extract 10* [site 1] <X/E>
>
> **Lisa:** another another thing she told me is that (.) that she explained to me (.) she gave me more information about there that is contained in that paper (.) she said other things (1) that are that are <u>physical</u> damages are that for the future (.) I may go without having children /mm/ other people they say (.) because they have seen the child (.) they cannot erase that image (.) the image does not go away and they end up having problems /mm/ in their mind /mm/ yes it is like that so (.) I found that information /ok/ that is what made me like I have doubts cause […]

Lisa, in extract 10 recalls the two (over-stated) risks that made her have serious doubts about terminating the pregnancy. The first relates to the risk of future infertility which draws on pronatalist discourses which construct parenthood as inevitable and childlessness as undesirable, for infertility to be recognised as a 'risk' when having an abortion. Thus, Lisa says: "are <u>physical</u> damages are that for the future (.) I may go without having children". What is also revealed here is how pronatalist discourses function to preclude adoption, not only when deciding whether to terminate a pregnancy, but also when one is considering becoming a parent. That womxn recognise infertility as a risk, that is, as something to be concerned about demonstrates the power of pronatalist discourses. Indeed, Tong et al.'s (2012) research conducted in Vietnam around womxn's experiences of abortion counselling echo these concerns around infertility.

The second relates to the possibility of distress following abortion which Lisa recalls in the following way: "other people they say (.) because they have seen the child (.) they cannot erase that image (.) the image does not go away and they end up having problems /mm/ in their mind". By "seen the child" Lisa is likely referring to the information some womxn in this study appear to have been given around the medical abortion procedure where they are expected to watch for the products of termination to be expelled and are told that they would likely, depending on their gestation, recognise the foetus as human.

While some womxn may indeed experience distress following abortion, this may relate to several 'factors' which have been discussed in research by Major et al. (2009) and Kimport et al. (2011) and include: previous mental distress; conceptualising the foetus as living, discourses which privilege the foetus over the womxn, discourses which construct abortion as immoral, and discourses which make pregnancy prevention and child-bearing womxn's responsibility, all of which may result in feelings of guilt; and whether womxn have a surgical or medical abortion which differ in the level of involvement required by womxn undergoing abortion. The deployment of PAS in an awfulisation of abortion discourse masks these factors, however, in suggesting that womxn will always suffer both emotionally and mentally because of abortion itself and that abortion is therefore harmful and wrong.

At site 1, healthcare providers instituted a mandatory waiting period to get womxn to change their minds. Zimkhitha (extract 11) speaks to this below.

> *Extract 11* [site 1] <E>
>
> **I:** […] u::m (.) so now (.) before coming here (.) what were your expectations?
>
> **Zimkhitha:** just to get it over and done with /mm/ in a quick way /mm/ because it's a problem (.) and now it's going to affect me (.) uh for the period that they've given me (.) I have to think (.) they've given me a period for me to think over (.) u::m because (.) I chose this deci- this option /ja/ because it is the best way (.) now they (.) they given me (1) a period for me to think it over /mm/ I know what's right /mm/ now they've given me a period of 'no man go back (.) and think this over' /mm/ mm so (.) I didn't want that (.) still gives me stress more stress /ja/ ja

In extract 11 above, Zimkhitha describes how the practice of instituting a waiting period at site 1 (where only 4 participants were interviewed) served to complicate the abortion process which, like other participants in the study, Zimkhitha expected would be quick and simple. Zimkhitha states: "now they've given me a period of 'no man go back (.) and think this over'". When abortion is constructed as risky, harmful, and life-changing, waiting periods may not only seem in womxn's best interests in encouraging reflection before the procedure, but may even be justified in this way. However, this rests on several problematic assumptions as Zimkhitha herself demonstrates in this extract. One is that when the decision to terminate a pregnancy is made outside of healthcare facilities and without the guidance of healthcare providers, it is constructed as 'hastily' made, and therefore ill thought-out and detrimental.

In contrast, research demonstrates that by the time most womxn arrive at an abortion facility, they have already reflected on the options available to them and, having intimate knowledge of their circumstances, arrived at the best decision (Brown, 2013; Moore et al., 2011). Zimkhitha thus states: "I chose this deci- this option /ja/ because it is the best way…I know

what's right". Another assumption is that forced waiting periods are always inherently beneficial to womxn. As Zimkhitha shows, however, for womxn who have made the best decision given their circumstances, but who may nevertheless experience emotional difficulty about terminating the pregnancy (owing to various constructions of abortion), a mandated waiting period may be *harmful*. Zimkhitha thus explains: "it's a problem (.) and now it's going to affect me (.) uh for the period that they've given me".

Dean (2002) argues that liberal and authoritarian forms of government need not be thought of as antithetical and indeed often sit comfortably next to each other. In other words, liberalism should not be associated with unrestricted freedom and authoritarianism the absence of freedom. Rather, liberalism can and does involve the restriction of individual freedoms and impositions upon individual liberty to govern individuals. It is within this light that we may make sense of the forced waiting period Zimkhitha speaks about in the above extract. Thus, what emerges is a tactic (described as such by a health care provider at site 1- to be discussed in the next analytical chapter) of authoritarian power where womxn who are deemed incapable of self-governing through freedom are forced to wait a certain amount of time between the counselling and the day of the abortion procedure.

What is interesting to note is that, apart from one participant, womxn who constructed a micro-narrative of 'I was ready to say oh I'm cancelling/I have doubts' seldom criticised abortion care providers for providing this information in the first place. This, I argue, must be interpreted in light of the inequitable power relations between abortion care provider and womxn who receive abortion counselling which mean that healthcare providers exercise authority and power in making decisions about what information to include. Within these power relations in which he client/patient's role is to defer to the expertise of the health service worker, womxn may assume that information is necessary simply because it has been provided by the healthcare provider.

Below I speak to a micro-narrative in which womxn construct adoption as an unviable alternative to TOP.

6. 'Adoption is not an option'

In womxn's responses to how they experienced the pregnancy resolution options part of the consultation, womxn constructed a micro-narrative in which placing their child up for adoption was a non-option for them. Consequentially, what emerged was a 'choice' between terminating the pregnancy and parenting. Interestingly, this understanding of the options available to womxn was not present at all in health service providers' talk. For health service providers,

adoption was understood as an option that is always available to womxn (discussed in chapter 7). Thus, several of the womxn who constructed this narrative expressed their disagreement with and sometimes anger (reflected in their tone and/or facial expression) towards the health care provider for suggesting that adoption *was* an option. This narrative can therefore be read (and I argue should be read) as womxn's resistance to the idea that womxn's pregnancy options can be determined 'objectively' and by someone other than the womxn herself.

Extracts 12 and 13 below serve as examples of a micro-narrative of 'Adoption is not an option'.

> *Extract 12* [site 2] <E>
>
> **I:** a::nd how did you feel about the:: the way she spoke about the options?
>
> **Sascarlimseko:** hheyi (1) I cannot just give birth and dump it here /ja/ I rather just remove it in early stages /ja/ neh /ja/ because it will haunt me (1) that (.) I left a baby in the hospital you know /ja/ mm (1) /ok/ so (.) it's still it's i::n early stages so /mm/ (1) although they also mention that there's life there /mm/ (.) but due to the situation /mm/ that I am in (.) I can't I really just can't
>
> *Extract 13* [site 3] <E>
>
> **CR:** do you remember the information that was provided there?
>
> **Nomonde:** yes I remember when she told me there's also an option of giving the child for adoption /ok/ of which I refused because (.) it will be difficult for me as well to carry a child for nine months (.) once I see the child you see so (.) that's when I said I can't do it at that stage so I'd rather do it now /ok/ you see
>
> **CR:** so how how did you receive that information like what was the experience=
>
> **Nomonde:** =it touched me a little bit /mm/ so I don't want to lie but (.) /mm/ I've got two children already I don't need a third one you see /mm/ that's the problem

In extracts 12 and 13 above, both Sascarlimseko and Nomonde are passionate in expressing how continuing the pregnancy and placing the resultant child up for adoption is incomprehensible and intolerable, and therefore an unviable option for them. Sascarlimseko conveys this by likening adoption to abandonment: "I cannot just give birth and dump it here". The use of the word "dump" is particularly emotive as it compares the child to 'trash': necessarily unwanted. As Sascarlimseko explains, the act of leaving "a baby in the hospital" will haunt her and is an 'option' that is far worse than termination of pregnancy, which, it is implied, is not itself ideal or desired but is instead preferable *by comparison*. Within this micro-narrative then, it is preferable to terminate the pregnancy, as Sascarlimseko (extract 12) states: "I rather just remove it in early stages… although they also mention that there's life there ". In this statement, we see that a dilemma arises in the possibility that the foetus, although in "the early stages", has life which would effectively raise abortion to the level of abandonment, if

not reconfiguring it as an act of killing. However, given her circumstances, termination of pregnancy emerges as the only option.

Nomonde explicitly draws on a familiar discourse of the maternal-foetal bond by stating: "I refused because (.) it will be difficult for me as well to carry a child for nine months (.) once I see the child you see so". Because of this bond, it is assumed that an attachment and emotional relationship will develop between mother and child, making separation impossible. Although implicit in Sascarlimseko's response (extract 12) also at work in her extract is a pronatalist discourse around the maternal-foetal/mother-child bond which would make abandoning the "baby" impossible. Thus, the strength of this bond is such that it precludes adoption from both womxn's decision-making. An alternative interpretation of Sascarlimseko's response is that child abandonment would be an immoral thing for a mother to do, thus, evoking motherhood discourses which construct a mother's role as one of protecting and caring for one's children. Furthermore, motherhood and pronatalist discourses problematise *not wanting* one's child, which is exemplified in Sascarlimseko's narrative as abandoning a baby. Significantly, then, both womxn manage to position themselves, through pronatalist and motherhood discourses, as 'good' mothers, despite having decided on TOP.

In extract 14 below, we also see that adoption is not recognised by Vanessa as an *option* available and open to *her*. In the extract she describes the interaction between herself and the counsellor.

> *Extract 14* [site 2] <E>
>
> **I:** mm (1) no I understand that (.) so was it the:: discussion (.) u::m around your options that was making you maybe want to change your mind (.) or was it them (1) which part of the counselling was it=
>
> **Vanessa:** = […]and then it was ok if you don't want the baby why don't you keep it and (.) give it up and that's not an option if I choose to I will keep the baby /mm/ but they were (.) just hearing about how other people abandon their babies and you know (.) that whole emotional thing (.) but still hearing that you do have options you don't have to do this /mm/ but if you do there are people who will want the baby or you know (1) so *ja* it was just (1) it was every- it was very informative (.) but (.) unfortunately […]

Describing the healthcare providers' discussion around adoption as a possibility, Vanessa states: "then it was ok if you don't want the baby why don't you keep it and (.) give it up ". The emphasis on "give" suggests how strongly Vanessa feels about the unviability of adoption. And this is explicitly communicated in her words that follow: "that's not an option if I choose to I will keep the baby".

Two things are particularly important about the above extracts. The first is how they demonstrate the subjectivity entailed in determining what one's or indeed someone else's options are. This is evidenced by the fact that, in each case, both the womxn and their healthcare providers arrived at different conclusions about what the womxn's options are: for the womxn, termination of the pregnancy is the only possible option whereas for the counsellor, adoption *is* an option, perhaps necessarily because abortion should not be. The second is that the extracts demonstrate how, when abortion is constructed and understood in particular ways by abortion care providers, the pre-abortion counselling session may play out as a pastoral struggle, between the womxn requesting an abortion and her abortion care provider, over whose voice and authority matters in not only appraising one's 'options' as options but in determining what is a moral or responsible decision. This is evident in extract x when Vanessa says: "but still hearing that you do have options you don't have to do this". Significantly, the health care provider's assertion of Vanessa's *options* and therefore choices (which serves to responsibilise Vanessa), despite Vanessa's own expressed feelings (to me and as her interview suggests to the counsellor as well) about and evaluation of her circumstances, is presented by Vanessa not as a refusal to listen to *her* voice but as "informative" and therefore part and parcel of the health care provider's role and indeed authority/expertise.

In the next section, I discuss a micro-narrative of 'I didn't have a choice' where womxn constructed abortion not only as the only option available to them, but as arising out of a sense of compulsion owing to their circumstances.

7. 'I didn't have a choice'

In constructing a micro-narrative of 'I didn't have a choice', womxn constructed the decision to have an abortion as arising out of a sense of compulsion, due to the circumstances surrounding the pregnancy. As with the womxn who constructed a micro-narrative of 'Adoption is not an option' (discussed in the previous section), womxn expressed their disagreement with and sometimes anger towards the health care provider for suggesting that adoption was an option. Unlike with the previous micro-narrative, however, in 'I didn't/don't have a choice' womxn did not just speak about the untenability of adoption but also spoke about abortion as the only option.

In extract 15 below, Likhona constructs a micro-narrative of 'I didn't/don't have a choice' in describing her experience of the information she received around the risks of abortion.

Extract 15 [site 2] <X>

CI: ok the thing that scared you is what was said that is you do it you do it at your own risk?

Likhona: yes because it was explained to me that (.) people who do this thing (.) they get cancer (1) /mm/ I did not know /mm/ that is what was scary /mm/ and I kept thinking I do not have a choice with this thing (.) I want to do it (2)

In extract 15 above, Likhona describes how information around the over-stated risks of abortion scared her. Thus, she states: "it was explained to me that (.) people who do this thing (.) they get cancer (1) /mm/ I did not know /mm/ that is what was scary". The one second pause is indicative of how scary the risk of cancer is for Likhona. And indeed, her phrasing (and possibly the counsellor's) constructs it not so much as a risk but as a certainty. When drawn upon in pre-abortion counselling, liberal discourses of risk and responsibilisation and an awfulisation of abortion discourse have the effect, if not the overt/covert aim, of making a decision to continue with the pregnancy the only rational and responsible thing to do. However, for Likhona, abortion is the only option. She therefore states: "I kept thinking I do not have a choice with this thing".

In the extract below, Vanessa also constructs a micro-narrative of 'I didn't/don't have a choice' but does so in relation to a conversation, during the counselling, about her reasons for having an abortion and the alternative options available to her.

Extract 16 [site 2] <E>

Vanessa: *ja* they were asking me why I chose to do it (.) and it was purely because of financial reasons actually /mm/ I mean I already have three kids and this was totally unplanned (.) and u::m (.) *ja* you know like (.) how do you feel about it do you really wanna do this and (.) they actually make you question whether you wanna do it /mm/ and I think if I had (.) u::m had really a choice I:: because of (.) how they spoke to me /yes/ I would not have done it /ok/ but because I don't have a choice (.) u::m you know I'm going through with it (.) but they actually (.) they like ask you:: how you feel about it (1) u::m (.) make sure that you're making the right decision if it's the right decision […]

In constructing the micro-narrative 'I didn't/don't have a choice', Vanessa explains how the counsellor asked her to account for why she chose to have an abortion. In response to this question, Vanessa states that abortion is the only option for her: "I think if I had (.) u::m had really a choice I:: because of (.) how they spoke to me /yes/ I would not have done it /ok/ but because I don't have a choice (.) u::m you know I'm going through with it". Within this micro-narrative then, we see once again that the evaluation of what one's 'options' are is always not only subjective but is conditioned by one's circumstances, something which is masked by liberal discourses which entail assumptions that womxn have equally viable options from which a choice can be made. For Vanessa, abortion is the only option due to economic

resources which are already strained by needing to parent three children. Furthermore, while liberal discourses may emphasis individual choice and freedom, a sense of what is the most rational, responsible and therefore "the right decision" is nonetheless conveyed.

In the following section, I look at how womxn constructed a micro-narrative of 'I was so hurt'.

8. 'I was so hurt'

In this micro-narrative, some of the womxn at site 2 spoke about the hurt they felt during the counselling because of the (over-stated) risks of abortion or being encouraged to opt for adoption. Tied to these feelings of hurt or sadness was the sense that abortion could not be avoided. Extract 17 and 18 are examples of this micro-narrative.

> *Extract 17* [site 2] <X>
>
> **Nandipha:** I did go into the counselling (.) they spoke with me [interference] in the counselling /yes/ here (.) but (.) something that bothered me or hurt my feelings a bit (.) it didn't hurt me as such because it was the truth (.) that this is my first time falling pregnant /mm/ and now I'm having an abortion /mm/ that (.) what if this was my last egg /mm/

In extract 17 above, Nandipha has been asked about her experience of the counselling. As Nandipha states: "they spoke with me [interference] in the counselling /yes/ here (.) but (.) something…bothered me or hurt my feelings a bit". What bothered Nandipha was the information she was told that the egg that was fertilised could be her last one and, given that it is her "first time falling pregnant", the consequence of terminating the pregnancy could mean that she will never have a child. As discussed in the previous chapter, the awfulisation of abortion constructs abortion as risky and damaging or otherwise as having negative consequences. However, as is shown in this extract, it relies on other discourses for its power. Thus, through gendered and pronatalist discourses, infertility is made sense of as risk, that is, childlessness is understood as undesirable and biological parenthood is reinforced as the only legitimate way to have children. Furthermore, first-time pregnancy is constructed as an occasion which should be celebrated and continued until birth. Significantly, extract 17 makes visible the power relations between healthcare provider and client/patient within the clinic where, as Foucault (1976) argues, the doctors' words have the authority and power of scientific truth which clients/patients may find difficult to challenge or question. Thus, Nandipha says: "it didn't hurt me as such because it was the truth".

In extract 18 below, Nziweni is narrating her experience of the pregnancy 'options' part of her consultation with a counsellor at site 2.

Extract 18 [site 2] <X>

Nziweni: […] I was so hurt I don't want to lie /mm/ but I had already taken a decision /mm/ that I want to do this /mm/ you see (1) and I have to /mm/ because of the situation (.) you see (1) /mm mm/ *ja*:: so /*ja*/ getting hurt there (.) I was hurt /mm/ and then I feel bad about (.) what I'm going to do (.) because I never do this before it's my first time to do it /*ja*::/ *ja*:: then (1) *ja* I was so hurt man /*ja*/ cause I even cried and /mm/ u::h (1) can it be that I save this child or /mm/ what do I do /mm/ I didn't have a choice /*ja*/ I can't carry the baby for nine months and give (.) give uh (.) give her or him away (.) no (1)

Although Nziweni at first (not shown in this extract) describes her experience of the discussion as "being advised on the right things", she then goes on describe the hurt she felt because of it. Thus, she states: "I was so hurt I don't want to lie /mm/ but I had already taken a decision /mm/ that I want to do this /mm/ you see (1) and I have to /mm/ because of the situation". For Nziweni, her hurt arises from having no other recourse but to continue with the termination of pregnancy due to her circumstances which demand abortion of her. As she goes on, however, her hurt also arguably comes from having been effectively responsibilised and shamed through what is possibly be the counsellor's deployment of several discourses which Nziweni herself evokes. This can be seen from the following statements: getting hurt there (.) I was hurt /mm/ and then I feel bad about (.) what I'm going to do". Feeling "bad" or guilty about her decision is an expected embodiment of shame (discussed in the previous chapter) for womxn about to experience an abortion and links to moralising discourses which construct abortion as wrongful and thus shameful. It is also an effect of foetal personhood discourses which, in constructing the foetus as a child or baby, necessarily position womxn as mothers and therefore nurturers and protectors of their children.

The power of foetal personhood and motherhood discourses is evident in Nziweni's next words: "I was so hurt man /*ja*/ cause I even cried and /mm/ u::h (1) can it be that I save this child or /mm/ what do I do". Her use of the word "save" is particularly notable in its likening of abortion to an act of death and the subject positions it makes available to her: she can either rescue the child and be a 'good mother', or participate in its death and be a 'bad' one.

In the following section, I speak to a micro-narrative, which was only constructed by two womxn, in which the womxn described accessing the internet to prepare themselves for what they would experience.

9. 'I educated myself'

Some womxn in the study took advantage of waiting room conversations and/or the presence of other womxn in the waiting room to gather information about what they could expect from the whole process (discussed in the following section entitled 'We were chatting/sharing

stories'). In contrast, two womxn mentioned having searched the internet for procedural and experiential information around abortion. I discuss this in a micro-narrative entitled 'I educated myself', although a minor micro-narrative, has important effects and accomplishes important effects which I discuss below. The following extract serves as an example.

> *Extract 19* [site 2] <E>
>
> **Mpho:** she showed us like a photo of like an aborted baby but then *ja* (1) but then I guess that is what we have to like see and stuff /ok/ or I think
>
> **I:** so how did you feel about the:: photo?
>
> **Mpho:** well I'd already [laughing] seen pictures before /yes you researched [laughing]/ but then u::m (.) like another lady (1) u::m like in the room she was like (.) it kinda traumatised her because u::m (1) I like I think she didn't like (.) do like any research or anything like that

In extract 19 above, Mpho tells me about a photo that the counsellor at site 2 had showed to the group she was counselling: "she showed us like a photo of like an aborted baby". Mpho, not entirely sure of whether to evaluate this practice as necessary or not, and therefore as appropriate or inappropriate, goes on to say: "but then I guess that is what we have to like see and stuff /ok/ or I think". Here, Mpho draws on a discourse of risk and responsibilisation which, I argue, obliges womxn accessing abortion to receive potentially disturbing information that is constructed as necessary for womxn to make a fully informed decision. Mpho draws on this discourse further when, in response to my asking about how she felt about seeing or being shown the photo, she implies that she herself was unaffected by it but that another womxn had been traumatised. To explain the difference between her experience and that of the other womxn, she states: "it kinda traumatised her because u::m (1) I like I think she didn't like (.) do like any research or anything like that".

Mpho's response can be seen as an attempt to mitigate the troubled subject position of being unaffected by an aborted 'baby', which is arguably the purpose of including such material in abortion counselling (that is, to position clients as womxn, emotional and sentimental beings, and as mothers). How she achieves this is significant. On the one hand, Mpho positions herself as the ideal responsible liberal subject who, through taking the initiative to educate herself, manages the risk of traumatisation. In contrast, the other womxn is positioned as irresponsible and is therefore accountable for her own trauma for failing to educate herself in the same way. In this sense, in the age of the internet (which to a certain extent brings health-related information closer to people by extending it beyond the traditional physical borders and authority of medical institutions), discourses of risk and responsibilisation may be mobilised

and may operate in ways which shield counsellors from being accountable for that trauma and instead put the onus on womxn to prevent trauma by exposing themselves to potentially harmful information prior to the counselling.

On the other hand, however, it is perhaps Mpho's self-preparation which allows her to subvert discourses of risk and responsibilisation, and to counter discourses of foetal personhood and the awfulisation of abortion when drawn upon by healthcare providers within pre-abortion counselling. By exposing herself to the potentially harmful information *beforehand*, she can avoid the intended effect of the photo, which is to get her to recognise the personhood of the foetus, witness the awfulisation of abortion, and therefore responsibly decide *against* abortion, having been duly informed (and traumatised).

The following micro-narrative begins a series of micro-narratives which were co-constructed around experiences of waiting room interactions. I start with womxn's responses about the comfort they received in sharing, with other womxn in the waiting room, their stories about abortion.

10. 'We were chatting/sharing stories'

As explained in the methodology chapter, included in the interview schedule was a question around womxn's experiences of the waiting room as a space for interaction between womxn and health care providers, and among the womxn themselves. Within a micro-narrative of 'We were chatting/sharing stories', womxn describe waiting room conversations they had with each other while waiting to be counselled and/or waiting for the TOP procedure (at sites 2 and 3 where this was conducted on the same day). Within this micro-narrative, two patterns emerged. In the first, womxn spoke about their embodied experiences of talking with others, about abortion, which for some led to a normalisation of abortion where abortion was no longer conceived as an *abnormal* or unusual thing to do. In the second pattern, womxn spoke about how the conversations were useful for gathering information about what was to come.

The extract below is an example of how some womxn spoke about the comfort and solace they received from speaking about abortion with other womxn, and how they realised, through these conversations, that abortion is not an unusual thing to do.

> *Extract 20* [site 1] <E>
>
> **Zintle:** (1) u::m (1) my experience being the::re it was like oh okay (.) u::h I I felt at ease mm /mm/ because we were chatting sharing ou::r our experiences and /mm/ you see (.) then I was at ease because I knew that (.) I'm I'm not doing it (1) because I'm not forced (.) to do it /mm/ I'm doing it for (.) the reasons or maybe I (.) I do have a motive

behind /mm/ you see (.) and so (.) when we were sharing and talking about (.) the experiences and (.) everything else that we chatting about (.) I:: I felt strong because I had questions /mm/ within me and I was feeling like (1) uh sometimes (.) I want to:: pull out /mm/ u::h or I just (.) should stop /mm/ but then (.) ja (1) the chat and the being with the other womxn made me understand and realise /mm/ (.) that I (.) ja /ja/ it's not really the (2) worst thing in life to do

Zintle in extract 20 above describes how the "chat" with the other womxn in the waiting room removed her discomfort and instead made her feel "at ease". From her discussion with the other womxn, Zintle comes to the realisation that her decision to terminate her pregnancy is motivated by specific reasons, presumably just like the other womxn waiting alongside her, and is therefore necessitated. Hence, she states: "then I was at ease because I knew that (.) I'm I'm not doing it (1) because I'm not forced (.) to do it /mm/ I'm doing it for (.) the reasons or maybe I (.) I do have a motive behind /mm/ you see". Through liberal and moralising discourses around abortion, Zintle constructs her abortion as rational, reasonable and therefore somewhat acceptable. In doing so, however, Zintle evokes distinctions between womxn who are not compelled towards abortion or for whom abortion is 'unnecessary' and a choice on the one hand, and womxn who are forced to have an abortion. The former is implied to be irrational, and less acceptable, and the latter rational and more acceptable.

Zintle goes on to describe that sharing her own experience and hearing the experiences of others makes her feel not only at ease but "strong" enough to continue with the termination of pregnancy. Importantly, speaking with others about abortion and their reasons for abortion, and more than that, being with womxn who had also decided to have an abortion, resulted in the knowledge that abortion may in fact not be as wrongful as she had thought. Thus, she states: "the chat and the being with the other womxn made me understand and realise /mm/ (.) that I (.) ja /ja/ it's not really the (2) worst thing in life to do". Thus, the waiting room spaces allowed for a challenging of the awfulisation of abortion discourse that was sometimes used by the healthcare providers

Like Zintle (extract 20) Thombulelo in extract 21 below describes finding comfort and solace in the conversations that took place, both outside the facility and inside the waiting room, between her and the other womxn.

Extract 21 [site 1] <E/X>

I: ok (.) what was your experience (.) /[laughs]=/ =being in that waiting area?

Thombulelo: […] so when I came here it was all the girls /mm/ we we::re outside for u::h it wasn't opened here /ok/ so we were sitting outside and they were all going on (.) about this termination thing so I felt kinda <u>free</u> /*ja*/ for me also to talk about it /ok/ so I:: I noticed that u::h (2) they they (.) we <u>all</u> here for the same thing /mm/ and u::h we <u>all</u>

> here to do:: this termination /mm/ and having our own uh different reasons /mm/ so (.) by by me sitting there and knowing what others are here for /mm/ and why /mm/ it made me like (.) to feel comfortable /mm/ and not u::h being scared like I was when I was coming here alone cause I was (.) I was I was very scared coming here because I wa- didn't even know what was going to be said or (1) maybe (2) like u::m (1) I was scared because I wasn't I I:: (.) I didn't know what to expect /mm/ actually /oka::y/ when I was here with them I just felt free and I:: I just thought there's nothing to it /mm/ *ja*

For Thombulelo in above extract (extract 21), the social act of speaking about abortion, which despite being widely practiced is heavily stigmatised, leads to her feeling free to also speak about and share her own experience. Hence, she states: "so we were sitting outside and they were all going on (.) about this termination thing so I felt kinda free /*ja*/ for me also to talk about it". Moralising discourses which construct the 'truth' around abortion as something to be ashamed and therefore silent about, is thus contradicted by her embodied experience of feeling comfortable and free.

Through this sharing of experiences, abortion is normalised in two ways. Firstly, the waiting room presents an opportunity for womxn to see *other womxn* accessing abortion services, thus contradicting the construction of abortion as abnormal and practiced by an 'immoral' few. Thombulelo thus states. "so I:: I noticed that u::h (2) they they (.) we all here for the same thing /mm/ and u::h we all here to do:: this termination". The emphasis she places on "this" is worth noting here as it suggests how stigmatised abortion is. Indeed, a few womxn in the study expressed pleasant surprise and joy at the realisation that there were others in their situation as they had been expecting to arrive at the facility and be the only one there. Secondly, abortion is normalised through the swapping of stories about their *myriad* reasons for deciding to have an abortion.

Through the normalisation of abortion then, the 'truth' that abortion is generally unacceptable, with a few narrow exceptions, is contradicted. Abortion therefore becomes a rational course of action across a variety of circumstances. This is evidenced when Thombulelo says the following: "and having our own uh different reasons /mm/ so (.) by by me sitting there and knowing what others are here for /mm/ and why /mm/ it made me like (.) to feel comfortable /mm/ and not u::h being scared". What results is the realisation that abortion is not an inherently profound, or indeed significant act which therefore warrants silence and fear. Consequently, abortion is lowered to the level of the everyday, as Thombulelo herself implies: "when I was here with them I just felt free and I:: I just thought there's nothing to it".

For a few womxn who constructed a narrative of 'We were just chatting/sharing stories', waiting room conversations were primarily a means to gather information, acquired first-hand from

womxn who had gone through it before, about the embodied experience of abortion. Extract 22 below is one example.

> *Extract 22* [site 3] <E>
>
> **CR:** ok (.) do you mind then telling me of these cause um sure cause here I see womxn amongst you know there's this area and then that side (.) so can you just tell me your experience of waiting with the womxn and like (.) the interaction?
>
> **Nomonde:** well (.) it wasn't easy because for me it's the first time to be here /mm/ so I don't know what's going on /mm/ so I was asking questions as well /oh ok/ how does it feel /mm/ and all of that stuff they told us that they get tablets (.) they put under their tongue now they gonna go for cleaning and all that stuff /mm/ but when when I go inside the room (.) I found out that there are two or three different ways to do it because (.) I I'm not gonna go through their process /mm/ I'm not gonna go for surgery or cause I'm still (.) lower than them /mm/ it's just gonna drink tablets and it's gonna be normal menstruation

As Nomonde in extract 22 above explains, waiting room conversation was a way for womxn who had no previous experience of abortion to adequately prepare themselves for what would happen, both procedurally and in an embodied sense. Nomonde, therefore, states as follows: "it wasn't easy because for me it's the first time to be here /mm/ so I don't know what's going on /mm/ so I was asking questions as well /oh ok/ how does it feel /mm/ and all of that stuff". From the nurse who counsels her, however, Nomonde finds out that there are different procedures and that her experience might be different from that of the womxn sharing theirs. Thus, she states: "when I go inside the room (.) I found out that there are two or three different ways to do it because (.) I I'm not gonna go through their process /mm/ I'm not gonna go for surgery or cause I'm still (.) lower than them /mm/ it's just gonna drink tablets and it's gonna be normal menstruation".

Interestingly, one health care provider had described the waiting room conversations that take place between the womxn as a source of frustration as, for her, these conversations provided inaccurate information which she would later have to correct, suggesting an undermining of the role and authority played by health care providers as carriers of factual information. By turning to people other than healthcare providers for information, Nomonde and Mpho may indeed be read as disrupting the kinds of power relations that play out in clinical/hospital settings. Narratives such as Nomonde's may also, however, as is suggested by Andersson et al. (2014), point to how womxn might require different kinds of information, and perhaps from different sources, in preparing themselves for their abortion experience. In Andersson et al.'s (2014) study conducted in Sweden, womxn sought experiential information from others who had gone through abortion to prepare themselves. Regarding the present study, it could be that

some womxn accessing abortion services have expectations about the kinds of information they are likely and unlikely to receive from health care providers.

Below, I discuss a micro-narrative which revolved around the womxn's experiences of fear while sitting in the waiting room.

11. 'I was scared'

Not all womxn who spoke about waiting room interactions between themselves and other womxn described a supportive waiting room experience. Thus, for some womxn, waiting room conversations were described as "scary stories" in which womxn who had previous experience with abortion shared their experiences of pain and discomfort. For other participants, the fear they experienced was not due to waiting room conversations but due to not knowing what to expect from the whole process. I discuss both patterns, in turn, as part of a micro-narrative entitled 'I was scared'.

In the extract below, Promise Rose is describing her experience of the waiting room conversations that took place during her time at the abortion facility.

> *Extract 23* [site 3] <E>
>
> **I:** ok and then (.) just going to speak now about /mm/ the waiting room here /yes/ this waiting area /mm/ ok so how was the:: /=experience/ =experience *ja*
>
> **Promise Rose:** the experience is I don't know [laughs] /[laughs]/ it's (.) I don't know it's u::m (.) I won't say it's comforting /mm/ because I think everyone that comes here is already (.) went through the experience /mm/ o::r (1) is going (.) um through the experience /mm/ or they're going (.) um to start the experience now /mm/ so (.) we were sh- we just sharing experiences (.) and then we just scaring each other like people telling stories (.) *ja* so it's not (1) I won't say it's comforting I don't have the word for it /ok/ it's just a normal conversation you have with people /ok/ mm (1) but it's not comforting (.) cause I think the other woman that was here /mm/ she left us (.) a- after they gave us the Act (.) *ja* so she left (.) said she's not going to do it anymore she changed her mind /o::hkay/ *ja* (.) so people cause I think (.) uh the (.) the more we discuss (.) the more (.) we think (.) you see /about/ mm (.) so (.) the more we discuss the more we exchange information the more it (.) hits home /mm/ you really doing this /ok ok/ *ja*

Struggling with how exactly to describe her experience, Promise Rose initially states: "the experience is I don't know [laughs] /[laughs]/ it's (.) I don't know it's u::m". She then goes on to describe what it is not: "I won't say it's comforting", which she repeats later. After providing some context about the different levels of abortion experience that can be encountered in the waiting room, Promise Rose settles on a description of her own experience and the experience of others: "we were sh- we just sharing experiences (.) and then we just scaring each other like people telling stories".

Just as the point of a ghost story is to produce fear in the audience, the scary stories Promise Rose refers to were not meant to comfort and console but to frighten. However, while ghost stories need to have an element of believability, this needs to be balanced with an element of the improbable, allowing the audience to dismiss it as a 'scary story'. In contrast, Promise Rose demonstrates that her discomfort lay in the eye-opening effect of the 'scary stories'. In other words, for Promise Rose, the stories shared demonstrated the 'truth' of one's situation. Promise Rose therefore states: "so people cause I think (.) uh the (.) the more we discuss (.) the more (.) we think (.) you see /about/ mm (.) so (.) the more we discuss the more we exchange information the more it (.) hits home /mm/ you really doing this". Unlike the extracts discussed in 'We were chatting/sharing stories', implied here is a sense of the profundity and significance of abortion. Thus, Promise Rose describes how for one womxn, the 'stark reality' portrayed through the other womxn's scary stories made the womxn change her mind about going through with the abortion.

As stated earlier, during their interviews a few womxn described the waiting room as a particularly anxious space and period for them, owing to reasons other than the sharing of 'scary stories' in the waiting room. In extracts 24 and 25 below, Nikibha and Likhona, respectively, describe having been fearful while waiting to receive counselling. This fear stemmed from not knowing what to expect.

> *Extract 24* [site 2] <X>
>
> **CI:** […] I ask you to tell me how you felt during that time you were waiting to speak with the nurse in the waiting room (1) you can start wherever
>
> **Nikibha:** *yhu* I was scared *wethu* /ok/ I did not know how long I would be waiting [interruption from nurse]
>
> *Extract 25* [site 2] <X>
>
> **CI:** […] I ask you to tell me how you felt during that time you were waiting to speak to the nurse in the waiting room (.) you can start wherever (.) during that time you were sitting there (.) you you were waiting to be called how did you feel (.) is it not so you said at first (.) at first you were scared?
>
> **Likhona:** *ja* (.) I was scared but I did not know what would be said (.) I did not know that there were things like counselling /mm/ I did not know

For Nikibha, her fearfulness arises from not knowing whether she would wait for a long time before being seen to. For Likhona, anxiety also centred around not being able to predict what would be said to her. Thus, she states: "I was scared but I did not know what would be said". While it is not clear here, not knowing "what would be said" could stem from how she might be treated by the health care staff, which has been repeatedly reported in South African

healthcare research as rude if not abusive treatment (Prickles, 2013). It was also discussed by a minority of participants in the present study in the narrative entitled 'They are not the kindest people/She was harsh' (to be discussed in the next section below). Likhona also adds that not having known about the counselling, and then being presumably informed of the counselling once she arrived at the facility, also contributed to her anxiety.

For other womxn, like Lindokuhle in the extract below (extract 26), anxiety stemmed from a discomfort around doing abortion which perhaps signals a taking up of moralising discourses around abortion.

> *Extract 26* [site 2] <X>
>
> **CI:** […] in that time you were interacting with other (.) other womxn did you (.) how did you feel?
>
> **Lindokuhle:** (1) *yo::h* (1) it is scary [inaudible] /hm/ *ja* (.) it is scary /mm/ because you are going to do this so (1) you are not comfortable (1) you are nervous
>
> **CI:** but perhaps the (.) the feeling that (.) *hhayi* I am not by myself you see others are waiting here (.) perhaps it (lessens) things that are fearful (.) fear
>
> **Lindokuhle:** *hhayi* I did not feel it
>
> **CI:** you did not (.) perhaps when you left home *hheyi* (.) 'it is as if it is me only' but when you arrived here (.) you saw that huh-uh (.) 'I am not alone you see there are lots of people in my situation'?
>
> **Lindokuhle:** *ja* but u::h (.) the feeling you have is yours alone

Lindokuhle states in extract 26 above: "it is scary [inaudible] /hm/ *ja* (.) it is scary /mm/ because you are going to do this so (1) you are not comfortable (1) you are nervous". The interviewer, in response, prompts Lindokuhle as to whether being with other womxn who are also accessing abortion services mediates or even assuages this fear, as was reported by some of the womxn who constructed a 'We were just chatting/sharing stories' micro-narrative. Thus, the interviewer asks: "but perhaps the (.) the feeling that (.) *hhayi* I am not by myself you see others are waiting here (.) perhaps it (lessens) things that are fearful". As Lindokuhle explains, however, her own experience was different: "I did not feel it". At the interviewer's second prompting about whether fear and anxiety stem from feeling that one is about do something that is simply not done (both prescriptively and *de facto*) and whether seeing other womxn accessing TOP would normalise abortion, Lindokuhle again asserts her own experience which has been (inadvertently) abnormalized by the interviewer. Lindokuhle's response highlights that for some womxn abortion is also experienced at an *intra*personal level.

In the next two sections, I speak to micro-narratives wherein womxn spoke about waiting room interactions between themselves and healthcare providers. The first is entitled 'They are not the kindest people' and the second is 'It was as if we were being ignored'. Both contrast with experiences of non-judgmental and empathic interactions discussed at the beginning of this chapter in the micro-narratives of 'It was informative' and 'The counselling was healing beneficial'.

12. 'They are not the kindest people'

When asked about their experiences of waiting room interactions with health care providers, a majority of womxn who were interviewed spoke about the empathic care they received, not only during the counselling, but outside of the counselling as well. These experiences thus usually formed part of 'The counselling was healing/beneficial' and/or 'It was informative'.

For a few womxn, however, interactions between themselves and abortion care providers were in some ways typical of the interactions reported elsewhere in South African research around reproductive healthcare. While some womxn's experiences centred around neglect (as I will discuss a little later), a minority (notably at site 1) experienced treatment that should, I argue, be read within authoritative power relations that often occur alongside pastoral and liberal care (Dean, 2002; Foucault, 1978, 2003, 2008) discussed earlier in this chapter.

> *Extract 27* [site 1] <E/X>
>
> **I:** […] what were your interactions with the other nurses (.) so you've spoken about with the womxn (.) did you have interactions with the did you::
>
> **Thombulelo:** actually the nu::rses are not the kindest people /mm/ and the nurses (.) they they are always on a:: on a shouting attitude /mm/ do you understand /mm mm/ ja /mm/ [laughing] they are always on a shouting attitude they can even shout you (.) for like (.) for you to stand and go take your folder you can be shouted for that /ja/ you can be shouted for (.) why did you wait for like u::h this long for you to come /mm/ you can be shouted and stuff so (.) me and the nurses (.) we were not cool because (.) I was in fear /ja/ of every time they call my name (.) I have that fear of 'oh God what are they going to say now' /mm/ understand /ja/ so:: the nurses [laughs] aren't so aren't so kind at all (1)

In extract 27, Thombulelo describes her interactions with the healthcare service providers at site 1. Thombulelo states: "the nurses (.) they they are always on a:: on a shouting attitude /mm/ do you understand". Thombulelo here describes a show of authority and power, on the part of the nurses, which should usually be reserved for administering rebuke and chastisement in the event of wrong-doing. As Macleod (2006) argues, chastisement and rebuke are strategies used by pastoral agents to guide the flock and govern their behaviour towards that which will ensure their salvation. However, in this case, Thombulelo describes an authority or power which is

excessive and tyrannical, bearing resemblances to the sovereign power of the King Foucault speaks about in *Discipline and Punishment* (1975/1990).

That this show of authority is a constant feature of interactions (Thombulelo compares it to an attitude or general disposition) implies that it is unnecessary and irrational beyond the *display* of authority for its own sake. This is further communicated by Thombulelo's next words where, through the instances she provides as examples, we are to understand that the nurses' "shouting attitude" is even and *unjustly* applied to trivial matters which do not require rebuke, that is, instances where the womxn have not done anything wrong. Thus, she states: "they can even shout you (.) for like (.) for you to stand and go take your folder you can be shouted for that". Implied here is that a simple request or instruction would not only be sufficient but also *appropriate* given the absence of wrong-doing, a conclusion that Thombulelo's narrative implies would be reached by any reasonable person. The next example she provides suggests that sometimes, the nurses' shouting is intended to get the womxn to behave in ways which are suitable to the nurses but without prior communication or seemingly without reason. Thus, she states: "you can be shouted for (.) why did you wait for like u::h this long for you to come /mm/ you can be shouted and stuff so". The effect of this display, as Thombulelo explains, is the instilling of fear of the nurses' power which appears absolute: "I was in fear /ja/ of every time they call my name (.) I have that fear of 'oh God what are they going to say now'".

Other womxn's narratives of their interactions with the healthcare providers referred to pastoral power relations between the nurses and womxn accessing abortion services.

> *Extract 28* [site 2] <E>
>
> **I:** she was really informative already */ja/* ok (.) um and then just u::m just to shift to:: the waiting room (.) when you were waiting here how was that experience?
>
> **Mpho:** it wasn't nice /mm/ *ja* it wasn't nice because (.) I don't think (.) the nurses enjoy what they do (.) and then obviously it's going to be horrible and like the attitude is going to be like different (.) for example like if I were to come here again and you were to come here again (.) she'd be like a lot more nicer to you than me because like (.) she doesn't like what I'm doing /mm/ and she doesn't believe in (.) what I'm doing it's like not somebody who's there to be like (.) 'ok I understand our situation' it's like (.) 'ok let's get this over and done with' /mm/ 'like (.) you should have done this you should have done this'

In extract 28 above, Mpho speaks about her experience of interacting with the nurses in the waiting room. She begins: "it wasn't nice /mm/ *ja* it wasn't nice because (.) I don't think (.) the nurses enjoy what they do". In making sense of her "horrible" interactions with the nurses, Mpho draws from career narratives which tie workplace performance, for example, caring and friendly interactions with customers/clients, to employee enjoyment of and passion for their

work. As such, Mpho explains that the reason for her ill-treatment is the nurse's anti-abortion position which prevents her from enjoying her work: "she doesn't like what I'm doing /mm/ and she doesn't believe in (.) what I'm doing". Owing to her anti-abortion position, the nurse would treat Mpho and me (the interviewer in the extract) differently if both of us were to return: as someone merely *interviewing* womxn about their abortion counselling experience I would be dissociated from the womxn and therefore exempt from their judgment and ill-treatment. Mpho, on the other hand, would not. As Mpho explains, the nurse's anti-abortion position plays out in her brusque, "'ok let's get this over and done with'" approach which is overlaid with implicit reprimands: "'like (.) you <u>should</u> have done this you <u>should</u> have done this'". Thus, the nurse is positioned as a pastoral agent who, through reprimands/a reprimanding demeanour, communicates to a member of the flock, Mpho, the error of their ways and prescriptively advises on responsible and moral behaviour for the future.

In the following section, I discuss a micro-narrative where the womxn described feeling neglected by the healthcare providers.

13. 'It was as if we were being ignored'

Waiting room interactions between healthcare providers and womxn were characterised in a variety of ways by the womxn. For some womxn, the engagement between themselves and the abortion care providers in the waiting room was minimal and limited to the nurse or counsellor calling for the next client so they could be attended to. For three participants who were interviewed at site 3 where there was only one abortion care provider (a nurse), their experiences of the waiting room interactions were characterised by insufficient contact and communication with the abortion care providers. These experiences were narrated using a narrative of 'It was as if we were being ignored/neglected'.

Extract 29 [site 3] <E/X>

CR: ok (.) the time then she made you feel neglected (.) compared to the time now when she's apologising /*ja*:: I was like=/ =how was it=

Thembakazi:= really pissed off /o::h/ to tell you the truth I was like <u>annoyed</u> /mm/ I even told those guys this is not (.) this is not on she's supposed to give us information and then she must explain (.) we know what's written here we can read it /mm-mm/ we can read it in Xhosa we can read in English but she <u>can</u> at least say (.) ok guys I'm giving you this information this information is about this and this and this /mm/ not just ask you (.) Xhosa or English then give you the paper and say <u>read</u> /*ja*::/ that's not on /and then=/ =you can't even do that to (neglect us) /mm/ you must <u>explain</u> /ok/ […]

In the above extract, Thembakazi is reflecting, at the interviewer's prompting, on how she felt when she and the other womxn were being neglected. Thus, she explains: "really pissed off /o::h/ to tell you the truth I was like annoyed". As Thembakazi goes on to explain, her annoyance and irritation stem from expectations around the level of care and service she is owed, which revolves around sufficient communication. Thus, Thembakazi says: "I even told those guys this is not (.) this is not on she's supposed to give us information and then she must explain". The use of the words "supposed to" and "must" is significant here as they suggest that Thembakazi is constructing an ideal level of service as *normative*. We are to understand then that the service she *actually* receives transgresses socially accepted standards. She goes on to describe the nurse's behaviour, which qualifies as unacceptable service: "not just ask you (.) Xhosa or English then give you the paper and say read /*ja*::/ that's not on… you can't even do that to (neglect us) ".

Thembakazi (extract 29) does not have to have prior experience with abortion care to know what level/kind of service is normatively expected and desirable. These normative expectations are constructed within consumer-/client-oriented discourse which Skålén et al. (2006) argue can be read as a form of liberal governmentality, a means through which organisations and institutions can be governed, can govern their employees and through which employees are expected to self-govern towards behaviour that is geared towards customer/client satisfaction. Drawing on this discourse, Thembakazi compares the service she received to the kind of conduct that is required of employees, one of which Skålén et al. (2006) identify as responsiveness. Interestingly, as is mentioned by the interviewer in the extract, the nurse Thembakazi speaks about apologises to her for her conduct. In doing so, the nurse not only confirms that certain behaviours are normatively required of her, but also recognises her transgression and, in addressing it, takes up the position of what Skålén et al. (2006) describe as a customer-determined subject who, having internalised the conduct required of them, actively governs themselves in this way.

What was particularly striking to me about responses like Thembakazi's above and some of the other womxn who problematised the waiting room interactions between themselves and abortion care providers, which were relatively rare, was their strong and passionate critique of the healthcare providers' conduct. During the interviews I conducted, I increasingly felt that some womxn were either holding back on their critique or disagreements with the service they received, or were going out of their way to produce a balanced or even empathic account. Although as researchers and interviewers we must be careful not to look out for a particular

response and thus 'read' into responses that deviate from that, I wondered if participants were telling me what they believed I wanted to hear, stories of 'good service provision', and thus felt constrained by the researcher-participant relation of power which would make disagreeing with me difficult and undesirable. I wondered too if the power relations between the womxn and the health care providers (who may also be elders for some of the younger womxn), manifesting in a politics of respectability, were precluding narratives of critique. The fact that the interviews took place at the abortion facilities, and that to the womxn I obviously enjoyed an amicable relationship with the abortion care providers (as Mpho pointed out earlier) certainly might have contributed to the (im)possibility of critique. In this light, responses such as the above were welcomed.

14. Conclusion

Womxn constructed several micro-narratives, some of them interconnected, around their experiences of the waiting room/area interactions among themselves and between themselves and abortion care providers, and around their experiences of the pre-abortion counselling itself. Taken together, they construct a picture of womxn's embodied experiences of the PTOP healthcare encounter. These micro-narratives also illuminate how waiting room interactions had implications for how the counselling was experienced by some womxn.

As I suggested, there was no single overarching narrative which encompassed womxn's experiences of the PTOP healthcare encounter, possibly because the interview questions pivoted around two main focal points. Regarding womxn's experiences of the abortion counselling itself, I argued that a narrative of 'It was informative' was not only a common micro-narrative but linked 'The counselling was healing/beneficial', and 'I was ready to say oh I'm cancelling/ I had doubts' together. In simultaneously constructing these contradictory micro-narratives, wherein counselling was both educational and shocking or distressing, womxn often positioned abortion care providers as educators who were simply imparting neutral truths that the womxn needed to know, thus positioning themselves as transitioning from a subject position of ignorance to one of having been duly informed. Power relations inherent in confessionary practices and within clinical/hospital settings between womxn/clients and healthcare providers were implicated in and shaped these accounts and experiences.

Through a micro-narrative of "Adoption is not an option' and 'I didn't have a choice', womxn expressed frustration and sometimes even anger at the nurse/counsellor's suggestion that continuing the pregnancy and placing the child up for adoption was an option. Within these micro-narratives, womxn drew on pronatalist and moralising discourses to construct abortion

as the 'lesser of two evils', which was also constructed as a decision that was necessitated and dictated by womxn's varying circumstances. Womxn here positioned themselves not only as 'good mothers', but also as an authority on what options are available to them.

Narratives of waiting room interactions among the womxn constructed the waiting room as a space in which womxn's embodied experiences of talking about abortion created possibilities for how abortion may be normalised and re-imagined outside of the realm of immorality. For some womxn, however, these interactions were not a source of support and instead added to their concerns and fears around their experience of the counselling and the procedure itself. While for some womxn abortion care providers were empathic pastoral agents who were providing guidance, others' waiting room experiences were shaped by an authoritative sovereign power. Through a consumer-/client-oriented discourse, womxn described their interactions with abortion care providers as 'good' or 'bad' service, and therefore as adhering to or deviating from the level of care they were owed.

In the following chapter, I discuss healthcare workers' interview responses as justificatory accounts of the counselling service they provide.

Chapter 8: Justifying PTOP healthcare practices: Healthcare providers' accounts

1. Introduction

Abortion care providers' responses were constructed as accounts which served to both present the counselling practices they engage in and to justify those practices. Although the questions posed to the womxn and healthcare providers were similar in that both sets of participants were asked about their experiences of the pre-abortion counselling encounter, abortion care providers' renditions of their experiences entailed giving a defensive account of their practices, perhaps by providing (and therefore being responsible for) the counselling (and thus by virtue of the questions posed to them). As noted previously in the methodology chapter (chapter 4), there were insufficient numbers of health service providers to analyse their accounts in terms of similarities and differences in micro-narrative construction. I have, nonetheless conducted a narrative-discursive analysis of the healthcare providers' interview data in terms of the discursive resources used to present and justify certain counselling practices and the various forms of power that operate through these practices.

Healthcare providers drew on the hero, career, conversion and personal testimony canonical narratives in their interview talk and used these as resources not only to justify certain practices but also to positively position themselves in various ways (such as caring and selfless, and a credible and qualified expert). In addition, moralisation discourses, a responsibilisation discourse, the awfulisation of abortion discourse as well as a psychotherapeutic discourse were also resourced by the healthcare providers in this study. These discursive resources were drawn upon to justify liberal, pastoral and authoritarian counselling practices, as well as healthcare providers' injunction for womxn/clients to take up governmental self-formation practices (knowing, mastering and caring for the self).

In the first part of this chapter, I discuss the canonical narratives and discourses drawn upon exclusively or predominantly by the healthcare providers (the discourses drawn upon by both womxn and healthcare providers having already been outlined in the first analysis chapter, chapter 5). Then, in the second part, I address how these were used to justify the various counselling practices, as well as the various forms of power that I argue operate in and through these practices as they were described.

2. Discursive Resources

Various discursive resources were used by health service providers in this study. In this section I discuss these discursive resources. To avoid repetition, the discursive resources discussed here are only those which were used exclusively by healthcare providers and were thus not included in chapter 5. However, as I will show in the section on counselling practices, moralisation discourses, a discourse of responsibilisation, a foetal personhood discourse, and an awfulisation of abortion discourse were also drawn upon by the health service provider participants. In this section, I discuss the hero, career, and personal testimony canonical narratives which were used as discursive resources. While I have predominantly chosen extracts which speak to healthcare providers' motivations for becoming involved in abortion work, this is to illustrate how these canonical narratives were used and to show how healthcare providers' narrated motivations dovetail with the counselling practices they describe. In this section I also note the absence of a rights discourse in accounting for abortion service provision. Lastly, I look at gendered discourses which were drawn upon by participants in accounting for particular practices.

2.1. The hero

As a canonical narrative or trope, the hero narrative has several features (as described by Autio, Heiskanen & Heinonen, 2009; Gillbert, Ussher & Perz, 2014): personal sacrifice for the greater good; challenges and obstacles which need to be faced and overcome and, although a daunting and demanding task, are in fact overcome; special skills, qualities or a unique suitability to overcome these challenges; and strength and agency on the part of the hero figure.

In extract 1 and 2 below, Thembi and Sam, who are both nurses working in different hospitals and are responsible for carrying out abortion procedures and conducting the pre-abortion counselling, draw on the hero narrative or heroic tale as a discursive resource in giving an account of what it is that motivated them to become involved in abortion care.

Extract 1 [site 1]

Thembi: oka::y /ja/ (1) oka::y like eh:: (2) when I came here before I came here I was asked neh /mm/ if I was eh:: willing to come and work here before I was here I worked in three wards /ok/ this is the third ward one /ja/ so while I was in those wards the matron asked me if I can come and work here /mm/ then I:: accepted (.) the offer /mm/ becau::se I:: asked myself mm because I know so many people are anti are against the abortion /mm mm/ but then when I heard they do it I asked myself so if I don't help them /ja/ who will /ja::/ that is why I came here because you these people they do thisss backstreet abortion and they end up getting eh eh killed and all that so:: I just told myself I::'m I'm just here because i- if we if I don't help who will? /mm/ ja

Extract 2 [site 3]

Sam: well I was (.) always wondering why people want to do TOPs neh /mm/ and then I- (.) then someone said to me now there's this course that is coming up soon /ok/ neh (.) so:: I said to myself ok (.) it's just because of curiosity anyway I was never interested in you know for religious reasons /ok/ neh (.) I said I would never ever (.) but when (.) I went to this course (.) there was this stats this statistics which said that abortions /mm/ over the years have been 74 000 /ja/ people dying of illegal abortion /ja/ then (.) I thought wow (1) you know all these HIV stats and all the TB stats /mm/ you know the accident stats (.) but we didn't know people are dying of illegal abortions outside I think that is what said to me uh-uh /mm/ someone has to be interested /mm/ I am here I might as well just do it /mm/ so I went for the cour::se I did everything and then (1) started working /ok/ (1)

For both womxn, the decision to become an abortion provider is narrated as being necessitated by the numbers of womxn who die from accessing illegal 'backstreet' abortions (in a context where abortion is legal). The countless deaths are thus constructed as unnecessary and needless. Thembi states thus: "that is why I came here because you these people they do thisss backstreet abortion and they end up getting eh eh killed". Thembi invokes a risk and responsibilisation discourse here where the womxn are positioned as irresponsible in needlessly risking their lives. Thembi, in turn, positions herself as responsible, and heroic, in saving them from this ultimate risk. Similarly, Sam also positions herself as heroic in saving womxn from death by illegal abortion: "I went to this course (.) there was this stats this statistics which said that abortions /mm/ over the years have been 74 000 /ja/ people dying of illegal abortion". Both she and Thembi place emphasis on the words "dying" and "killed" respectively, which contributes to the sense that their heroism is compelled by morality and the greater good: the need and duty to save lives, literally. As such, they draw on a public health discourse which, significantly, was drawn upon (in addition to a human rights framework) in a similar way for abortion legislative reform to occur in South Africa (Klugman & Varkey, 2001; Mhlanga, 2003). This discourse constructs phenomena as problems due to the disastrous effects they have on the health and well-being of the population, and the large-scale costs to the public health system which becomes over-burdened in attending reactively to these health problems. The hero narrative is thus buttressed through this discourse. In this instance, a public health discourse positions womxn who access backstreet abortion as in need of saving. It also, however, potentially positions them as problematic in the costs they impose on the public health system. This kind of positioning resonates with positioning womxn as irresponsible, as Thembi seems to do above, through the othering implied in "these people".

Adding to this duty and compulsion to serve is the absence of other candidates who would otherwise obviate the need for Thembi and Sam's own involvement. For Thembi, conscientious

objection, or a refusal on the part of healthcare providers to be involved in abortion services owing to adopting an "anti-abortion" position, means that she *must* provide abortions. She has no choice not to. Thus, she states: "because I know so many people are anti are against the abortion /mm mm/ but then when I heard they do it I asked myself so if I don't help them /ja/ who will". Although Sam does not state this explicitly, it is implied in her phrasing: "but we didn't know people are dying of illegal abortions outside I think that is what said to me that is what said to me uh-uh /mm/ someone has to be interested /mm/ I am here I might as well just do it". What emerges then, is the sense that both Thembi and Sam, but more so Thembi, are uniquely positioned, because of the dearth of willing providers, to save womxn's lives by providing legal abortion services.

Simultaneously, both Thembi and Sam initially suggest that their involvement was voluntary. Thembi does so by saying that when she was approached by management, she accepted the offer: "before I was here I worked in three wards /ok/ this is the third ward one /ja/ so while I was in those wards the matron asked me if I can come and work here /mm/ then I:: accepted (.) the offer". In doing so, Thembi can position herself as caring for womxn. For Sam, her initial involvement in the training was out of curiosity: "well I was (.) always wondering why people want to do TOPs neh /mm/ and then I- (.) then someone said to me now there's this course that is coming up soon /ok/ neh (.) so:: I said to myself ok (.) it's just because of curiosity". This voluntary involvement is, however, later countered by a narrative of moral compulsion discussed above, which may serve to mitigate any stigma and judgment that may come from *choosing* to provide abortions. Read in this light, both Thembi's and Sam's accounts involve justificatory labour for why, in a discursive climate that constructs abortions negatively, they are involved in the work of providing abortions. The hero narrative can then be read as providing a counter-narrative to a narrative in which *not* providing abortions is normative because of the stigma attached to abortion. Within a discursive climate of abortion stigma, it is significant, then, that neither Sam nor Thembi position themselves as 'pro-choice' or 'pro-abortion' in giving an account of their involvement in abortion work. Thembi positions other healthcare workers as anti-abortion but is silent on her own positioning which might trouble positive reflexive positioning, given that my own position (as the interviewer) on abortion had not been stated up front.

Sam and Thembi's reliance on a hero narrative and a public health discourse also, however, presents potential trouble in leaving them open to the question of why they had previously not been involved in providing abortions, given the large-scale deaths that both describe in their

accounts. Significantly, Sam's religious positioning, which draws on moralising discourses which frame abortion as immoral and sinful, is used to reasonably justify her previous lack of interest in providing abortions. Thus, she states: "I was never interested in you know for religious reasons /ok/ neh (.) I said I would never ever". Sam also justifies her lack of involvement in legal abortion services by stating that "we didn't know people are dying of illegal abortions", thereby possibly mitigating her own complicity in contributing to a context where womxn abort outside of legal facilities. Interestingly, with the word "we", Sam further mitigates her own individual responsibility. Given both Sam and Thembi's explicit and implicit positionings around abortion, providing abortions is thus implicitly framed as a personal sacrifice.

2.2. Career narrative

LaPointe (2010) discusses career narratives as master narratives (or canonical narratives) which impart assumptions around what careers are and assumptions about individual identity in relation to a career. Career narratives also contain expectations around normative trajectories for establishing a career: choosing a career, training for that career, securing the first job; progressing in that career through developing experience and expertise. Both Heather and Chanelle in extracts 2 and 3 below drew on career narratives in accounting for providing abortion counselling.

Extract 3 [site 2]

Heather: I've always had a love for people because obviously being a pastor's kid /mm/ my dad was the most amazing pastor (.) all my school reports from I grew up grade 7 unusual gift with people lo::ve people (.) they're my passion in that field yes /(ok)/ because I know I felt it was a life big devastating experience I only told my folks when I was eight months pregnant /mm/ I didn't wanna get married it was all I'll never forget that pain (1) and eh I studie::d Christian counselling it's a diploma:: I've added to it along the way with little things (.) I I [inaudible] trainer as well (.) I've added to my CV a little bit but um (.) yes I just heard about this and immediately /mm/ the passion and my vision aligned with theirs and um *ja* the approach

In extract 3 above, Heather constructs and draws upon the career development narrative in giving an account of how she became involved in providing abortion counselling at site 2. In doing so, she constructs her values and personal characteristics as a focal point or core of her career development, thus presenting a coherent and stable identity and career trajectory. In describing her values and personal characteristics, Heather states: "I've always had a love for people because obviously being a pastor's kid… all my school reports from I grew up grade 7 unusual gift with people lo::ve people (.) they're my passion". Through this, Heather situates her pastoral counselling practices (to be discussed below), which she later goes on to describe,

as a manifestation of her passion for, and gift with, people. Within this career development narrative, Heather's decision to study Christian Counselling, become involved in the pregnancy crisis centre for which she volunteers, and subsequently provide abortion counselling, are all constructed as coherent, emanating as they do from her love for people. Thus, Heather not only positions herself as an expert and as suitable to provide pre-abortion counselling, but she also positions herself as someone who cares about the well-being of others, and particularly as someone who cares about the well-being of the womxn she counsels.

Similarly, Chanelle (extract 4 below) constructs a career development narrative.

> *Extract 4* [site 2]
>
> **I:** and what motivated you to do (1) this kind of work?
>
> **Chanelle:** I've always been very interested in:: u::m (.) in assisting people and I've really enjoyed being able to work with people one on one /mm/ and (.) I studied psychology /m 'kay/ u::m I have an honours degree in psychology so for me it was really (.) um what would I do with that degree that would really be able to complement /mm/ my love for people and also the (.) the background of psychology that I'd studied so (.) u::m I became involved with [name of pregnancy crisis NGO] first as a uu::m as a safety mom I'd t- go and (.) volunteer initially (.) look after babies in the place of safety /mm-hm/ u::m and then take babies out on the weekends and (.) my love for the organisation grew and um and u::m my knowledge of (.) of what I was (.) was really good hat /mm/ good at really shone through and thus I got involved with the counselling side of it

Chanelle, above, constructs continuity and coherence in her career development by highlighting her personal interests and characteristics and the role they played in her career choices. Thus, Chanelle states: "I studied psychology /m 'kay/ u::m I have an honours degree in psychology so for me it was really (.) um what would I do with that degree that would really be able to complement /mm/ my love for people and the (.) the background of psychology that I'd studied". The result was that she became involved with the NGO, volunteering for tasks that were, however, unrelated to abortion counselling. Unlike Heather, Chanelle describes her career development as being shaped by her "love for the organisation". Thus, her movement within the organisation eventually leads to her becoming "involved with the counselling side of it". Significantly, Chanelle also positions herself as qualified to provide abortion counselling and as concerned with helping people. This, particularly the latter, provides important context for how she later justifies the counselling practices she describes.

2.3.The personal testimony

I draw my understanding of the personal testimony as an autobiographical narrative from Park-Fuller (2000) who describes it as a narrative where speakers "bear witness" to the struggles they have been through and surpassed. Personal testimonies, as Park-Fuller (2000) argues, have, among others, two salient features. The first is shared with legal and religious testimonies in that personal testimonies implicitly "take sides"; they involve or are based around contestation. Thus, in legal contexts testimonies are provided for or against an accusation while religious testimonies are often personal tales about the victory of 'good' over 'evil'. The second feature is that personal testimonies are distinct from confessionary practices as analysed by Foucault; where confessionary practices involve and indeed rely on the confession of a transgression of societal norms (for example, womxn being asked to confess, during pre-abortion counselling, how they failed to prevent the pregnancy they wish to terminate), personal testimonies are constructed in such a way that the speaker is understood to be unrepentantly telling a courageous truth.

Extract 5 below is the end part of a longer response given by Heather around her work experience and her motivation to become involved in TOP counselling. In the extract, Heather constructs and draws on the personal testimony in providing some context for her involvement in abortion counselling.

Extract 5 [site 2]

Heather: […] so you know my (.) there's a little bit more life experience (.) I am divorced I had a teenage pregnancy at seventeen (.) and I'm a pastor's kid so:: I know there's a lot of empathy you know (.) I also was booked for a termination /mm/ and changed my mind (.) so my story is I've walked this /ok/ so I think the empathy comes through and the non-judgment because it is my story /ok/ [name of daughter] is thirty-seven now she got three children and ja (.) my marriage failed but I got four amazing children (.) and so my story is one of own mistakes and one of victories /mm/ and I think once the girls get that (.) they see that you're not perfect and (.) you're already creating a bit of a bond /mm/ and you ha- win the right to speak to (in their eyes) /mm/ I see you have to (.) morning [greeting someone] you have to (.) win trust */ja/* and you've got to:: (.) have permission (.) to step into their world and because I've been there (.) actually it is a huge tool /ok/ moving forward *ja* (.) so (.) to answer your question (.) bit about myself I've been in the wards four years

In drawing on a personal testimony canonical narrative, Heather establishes her credibility and expertise in counselling womxn on what to do about a pregnancy, and positions herself as being uniquely able to understand what womxn requesting an abortion are going through, and what is best for them.

In constructing her personal testimony, Heather begins by stating that she has relevant and *relatable* life experience which enables her to counsel womxn in a way that is empathic and non-judgmental. Thus, she states: "I am divorced I had a teenage pregnancy at seventeen (.) and I'm a pastor's kid so:: I know there's a lot of empathy you know (.) I also was booked for a termination /mm/ and changed my mind (.) so my story is I've walked this". The relevance of her experience lies in that she too had a "teenage pregnancy", which here is implicitly problematised in a way that is taken-for-granted and thus requires no explanation from Heather. More importantly, however, Heather constructs her expertise and credibility as stemming from having requested a termination, like the womxn to whom she provides counselling, but having decided *against* it. Two implications arise from this. The first is that only someone with this *particular* life experience is suited to providing abortion counselling. The second implication is a particular understanding in which guiding womxn against having an abortion is and should be the purpose of pre-abortion counselling. In this sense, Heather's personal testimony "takes sides" in arguing against abortion.

An important feature of personal testimonies is that they discuss personal struggles and victory over those struggles. Heather does so by stating the following: "[name of daughter] is thirty-seven now she got three children and ja (.) my marriage failed but I got four amazing children (.) and so my story is one of own mistakes and one of victories". Within her narrative then, having an 'unintended' pregnancy is framed as a challenge which she successfully meets by deciding against abortion, culminating in "four amazing children". Heather's story, then, becomes a success story.

Importantly, Heather reveals that this success story, necessarily framed as the telling of a courageous truth taking place as it does within a discursive context of the problematisation of 'unintended' pregnancy and a construction of abortion as immoral, forms part of her counselling practices. As she herself describes, her personal testimony is specifically used to relate to the womxn she counsels: "I think once the girls get that (.) they see that you're not perfect and (.) you're already creating a bit of a bond /mm/ and you ha- win the right to speak to (in their eyes)". This "bond" or relationship is premised on Heather positioning herself within the counselling as humanly flawed and therefore as a relatable guide, a pastoral agent who has personal experience in matters on which she is giving advice and who is acting for womxn's best interests.

By framing her decision against having an abortion as a success story which she can use to relate to her clients and guide them to follow in her footsteps, Heather simultaneously deploys a hero narrative. Thus, using her personal testimony, Heather hopes to save womxn from making a mistake that she managed to avoid, thus positioning herself as a hero and positioning the womxn as in distress and in need of saving. Significantly, in extract 5 above Heather implicitly positions the foetus as in need of saving. She does so by framing her children as successes and as a positive outcome of her unintended pregnancy. Through this, it is implied that abortion has two costs associated with it; the womxn who is compromised by going down the incorrect path, and the potential life of the foetus.

In the next section, I turn to the gendered discourses that were constructed and drawn upon by healthcare providers in describing and accounting for their counselling practices.

2.4. Gendered discourse

Occasionally, healthcare providers would draw on a gendered discourse to justify certain practices. Within a gendered discourse, differences between womxn and mxn are essentialised, with both being constructed as homogenous groups. Traditional/dominant notions of womxnhood and mxnhood are draw upon to construct womxn as emotional and mxn as rational/practical. In addition, inequitable gendered power relations are invoked.

In extract 6 and 7 below, Heather and Chanelle use a gendered discourse to justify the inclusion of a client's male partner on the grounds that it is beneficial.

Extract 6 [site 2]

Heather: =I encourage that /ok/ I actually do um (.) I think it's amazing when the man comes with (.) and to me those have been (.) if you can call them that (.) some of my success stories /ok/ where the man owns it (.) cause I've got a problem with the mxn /ok/ I'm in a ward here and you see so little of the mxn */ja/* (.) I think it's amazing when the man comes with (.) I encourage a friend because it is a network (.) it's a spor- it's a support structure […] I think it flows easier I think decisions are made quicker /mm/ and I find my follow-up better if there's accountability (.) you know if it's one person you can get lost in the system (.) if your friend say 'no you've got an appointment next week' /mm/ 'hey she told you to do this or that come on' I just find the accountability better

Extract 7 [site 2]

Chanelle: […] we do:: have the boyfriends in occasionally /ok/ (.) and I find that very helpful /ok/ u::m because (.) we can hear the boyfriend's side of the story as well */ja ja/* if he's here it means him and the girl usually have a good relationship /I see/ because they're g- a young girl has allowed the information that she's pregnant */ja/* to be passed onto the partner […] and then it sparks a (.) a dual medium a a a (.) dual (.) u::m level of u::m (1) of counselling /mm/ of openness (.) which is fantastic because we like to see that the womxn have got the support /yes/ from their partners

Heather (extract 6 above) states the following: "I encourage that /ok/ I actually do um (.) I think it's amazing when the man comes with (.) and to me those have been (.) if you can call them that (.) some of my success stories /ok/ where the man owns it". Thus, the benefit of involving a client's partner lies in the fact that it enables Heather to successfully guide womxn's decision-making during the counselling. Heather's religious reflexive positioning and her use of moralising discourses, a discourse of responsibilisation and an awfulisation of abortion discourse (which construct abortion as immoral and a threat to both foetus and pregnant womxn) converge to imply that her understanding of a "success story" is restricted to situations where womxn have decided against abortion because of the counselling.

Significantly, Heather recognises the gendered power relations that result in womxn being burdened with the responsibility for child-rearing and making reproductive decisions. These gendered power relations are underscored by mxn's absence in womxn's reproductive healthcare services: "cause I've got a problem with the mxn /ok/ I'm in a ward here and you see so little of the mxn". Notably, however, Heather also simultaneously uses a discourse of responsibilisation to frame continuing with the pregnancy as the only responsible and commendable course of action. By implication, womxn who terminate their pregnancies are also positioned as irresponsible, but are able to mitigate this irresponsibility by being counselled.

Relatedly, Heather argues that third-party involvement in the counselling is beneficial because it makes possible and improves the accountability of the clients she sees. Thus, Heather states: "you know if it's one person you can get lost in the system (.) if your friend says 'no you've got an appointment next week' /mm/ 'hey she told you to do this or that come on' I just find the accountability better". Implied here is that accountability takes place within a context of having decided to continue with the pregnancy. Interpreting this within Foucault's (1978, 1995) work on surveillance, third-parties become useful strategies in ensuring that womxn who have decided to continue with the pregnancy remain visible within and by the healthcare system which can then monitor and oversee their compliance with the injunction to be responsible citizens and womxn. Significantly, Heather frames this surveillance as beneficial for her clients, thus positioning herself as caring for and about the womxn to whom she provides pre-abortion counselling.

In extract 7 Chanelle similarly constructs third-party involvement in the counselling as beneficial to womxn undergoing pre-abortion counselling, albeit justifying it in different ways.

Chanelle states: "I find that very helpful /ok/ u::m because (.) we can hear the boyfriend's side of the story as well". By phrasing it in this way, Chanelle positions herself as a kind of arbiter having to reach a verdict or pronounce guilt. Presumably, by "the boyfriend's side of the story", Chanelle is referring to his desires or wishes about what to do about the pregnancy, which cannot be accessed in his absence. Given that womxn undergoing pre-abortion counselling are requesting an abortion, it is significant that Chanelle does not explain why hearing a client's partner's side would be beneficial to the counselling process, something which I as the interviewer failed to question her about. From Chanelle's following lines, I argue, it is possible to assume that the value in hearing the womxn's partner's story lies in the likelihood of the womxn deciding to continue with the pregnancy. Chanelle therefore says: "if he's here it means him and the girl usually have a good relationship /I see/ because they're g- a young girl has allowed the information that she's pregnant /ja/ to be passed onto the partner". As Chanelle suggests by invoking a psychotherapeutic discourse, the implications of third-party involvement, in the case of a womxn's partner, is that psychotherapeutic intervention is enabled through heightened access to the client, upon which confessionary practices are reliant (Foucault, 1978). Thus, Chanelle states:" it sparks a (.) a dual medium a a a (.) dual (.) u::m level of u::m (1) of counselling /mm/ of openness". Significantly, Chanelle's understanding of the benefits of male-partner involvement in pre-abortion counselling seem to be founded on the assumption that mxn who are partners to womxn requesting an abortion are essentially against abortion. This relates to dominant constructions of manhood which place a value on male virility and procreation in the interests of furthering the male line. In turn, good relationships are necessarily those which enable womxn to continue with her pregnancy.

In research conducted by Beja and Leal (2010) among abortion providers in Portugal, third-party involvement was discussed by the participants. In that study, as in the present study, third-parties were generally allowed by some providers while others allowed third-party involvement only in certain circumstances. Further differences in the way abortion care providers managed third-party involvement were that some counselled third-parties separately, others brought them in after counselling the womxn alone, and others involved third-parties for the whole counselling session. Unlike in the present study, the management of third-party involvement seemed to be both guided by the womxn seeking abortion. Thus, participants who allowed third-party involvement described first discerning from the womxn whether she wanted a third-party present (Beja & Leal, 2010). Healthcare providers also stated that where third-parties were involved, healthcare providers would attempt to discern whether there was any pressure

from the third-party for a specific pregnancy outcome, although how this was managed is unclear. Comparing the talk of participants in the present study and in the study by Beja and Leal (2010), third-party involvement in the counselling may not only be framed in different ways, but may also be used for different ends which has implications for how womxn's reproductive autonomy may be enabled or undermined.

In the next section, I discuss how various forms of power operated in the counselling practices described by healthcare providers. I also analyse how various discourses (moralisation discourses, an awfulisation of abortion discourse, and a responsibilisation discourse) are used as discursive resources to justify particular counselling practices.

3. Counselling practices

In this section of the chapter, I discuss the liberal, pastoral and sovereign forms of power referred to by healthcare workers in their accounts of their counselling practices. I also discuss how, during their interviews, healthcare providers called upon womxn accessing abortion services to relate to themselves in particular ways. As I will show, particular understandings of unintended pregnancy, abortion and pre-abortion counselling are implicated in healthcare providers' accounts of their pre-abortion counselling practices. Through this discussion then, I mean to demonstrate how liberal, pastoral and sovereign forms of power may operate within the PTOP healthcare encounter, to produce healthcare providers and womxn as particular subjects, and in ways which have the effect of producing directive pre-abortion counselling.

3.1. Liberal practices

In her paper on healthcare providers' management of risk in providing contraceptive counselling, Macleod (2006) discusses liberalism as a form of government which acts not through direct coercion but instead acts indirectly upon individuals by shaping and thus acting on their behaviour, wishes, choices and desires whilst deferring to individuals' rights, desires, wishes, choices and needs. Liberal counselling practices can therefore be understood as counselling which deploys these tactics of government. Thus, within liberal counselling practices, the healthcare provider is produced as an educator who facilitates womxn's agentic decision-making and choice. In the context of the clinic where the healthcare provider is a guardian of womxn's well-being, the healthcare provider creates the conditions necessary for responsible decision-making, but does so without direct intervention.

In extract 8 below, Thembi describes her role as a healthcare provider in pre-abortion counselling.

Extract 8 [site 1]

I: so:: you::r what is your e::m your role in the counselling? /my role in the counselling/ =ja /ok=/ for you as a:: as a as a (2)

Thembi: I:: I am here to:: to support /ja/ to:: educate /mm/ ja I'm here to support the clients they come here they need support /mm/ some of them they are here (.) the::y not decided (.) so you see you give support (.) as much as you:: you give information (.) about what they are coming here to do /mm/ you help them make the decision /mm/ you give them as much information as you can /mm/ ja that is what we are here for /ja/ we are not here to (.) decide for them no you you:: you can't do this /ja=/ =no we help them towards (.) making the decision /mm/ ja:: (.) that is why we are here (.) /ok so you support/ mm we are here to provide to support and eh provide the:: correct (.) service /mm/ to them mm=

Thembi, in extract 8 above, makes sense of her role, and the limits to her role, within a discourse of liberalism. Thus, Thembi states: "I am here to:: to support /ja/ to:: educate /mm/ ja I'm here to support the clients they come here they need support /mm/ some of them they are here (.) the::y not decided (.) so you see you give support". As Thembi goes on to say, the support she is required to give is informational: "you give information (.) about what they are coming here to do /mm/ you help them make the decision /mm/ you give them as much information as you can". Describing her role as one of providing informational support to the womxn to whom she provides abortion services, Thembi draws on a liberal discourse to circumscribe the boundaries of what she can and what she cannot do. Thus, in deferring to the womxn's own desires and wishes, Thembi cannot "decide for" the womxn who are undecided but can only "help them towards making the decision" by providing them with all the information they need to make *their* decision. By deferring to her client's right to make their own decision, Thembi positions herself as caring for her clients and as respecting their rights, autonomy and desires. What is masked here, however, is the ways in which information provision, as a form of liberal government, may be used to shape and act on the womxn's choices and behaviour so that certain choices and behaviour seem rational, responsible and thus the only option.

In the extract below (extract 9) I have asked Chanelle to describe when and how information provision may vary.

Extract 9 [site 2]

Chanelle: (1) u::m it all depends o::n the actual (.) situation at hand /mm/ u::m you know (.) far be it that we ar::e in any position to make a decision */ja/* <u>for</u> these ladies they've got to make a decision for themselves */ja/* u::m but obviously a <u>rape</u> victim (.) your counselling is slightly different to:: a woman who i::s (.) 42 who has <u>thought</u> that she has been on contraception for 10 years (.) who finds herself pregnant (.) */ja/* u::m you know the the the <u>whole</u> situation is <u>so</u> completely different (.) so we've got to take <u>each</u> and every situation um (.) individually /mm/ and u::m <u>how</u> we counsel obviously

> (.) depends on on the client /mm/ and the counselee (.) and what she <u>needs</u> right then /mm mm/ u::m what <u>empathy</u> she actually needs /mm/ (2)

Chanelle, like Thembi above (extract 8), describes the counselling as enabling womxn to reach a decision and restricts the intervention of the counsellor to exclude coercing womxn into a decision. Thus, she states: "u::m it all depends o::n the actual (.) situation at hand /mm/ u::m you know (.) far be it that we ar::e in any position to make a decision /*ja*/ <u>for</u> these ladies they've got to make a decision for themselves". Here, Chanelle uses a liberal discourse to imply that she and her colleagues do not and cannot directly intervene because the womxn they counsel need to be held accountable and be responsible for the decisions they make. Tailoring the information she provides to the womxn she counsels is part and parcel of liberal counselling as it recognises the different informational and support needs womxn may have. As such, it individualises womxn. Chanelle, therefore, says: "we've got to take <u>each</u> and every situation um (.) individually /mm/ and u::m <u>how</u> we counsel obviously (.) depends on on the client /mm/ and the counselee (.) and what she <u>needs</u> right then /mm mm/ u::m what <u>empathy</u> she actually needs". Notably, Chanelle suggests as to the possible differences between clients, and the possible differences in their needs, by stating the following: "obviously a <u>rape</u> victim (.) your counselling is slightly different to:: a woman who i::s (.) 42 who has <u>thought</u> that she has been on contraception for 10 years (.) who finds herself pregnant".

Chanelle's use of examples has important implications. Firstly, what is implied here is that while the 42-year-old womxn may be given information that is geared towards responsibly continuing with the pregnancy, the rape victim may understandably be exempt from that, given that her "situation is so completely different" and requires a different kind of empathy. Secondly, what is implied here is that the womxn differ in their accountability and responsibility for the pregnancy and that this is the basis for distinguishing between their informational needs, thus creating a hierarchy of the acceptability of abortion. Interestingly, Beynon-Jones' (2013) study among Scottish healthcare professionals involved in abortion care also found that healthcare professionals stratified reasons for abortion, based on how the womxn requesting an abortion was socially located, on a scale of rational, normal and acceptable, to irrational, abnormal and unacceptable. Thus, the requests of teenaged womxn, womxn without the socio-economic means to raise the child, and womxn who already had children, were all seen as acceptable and even necessary (Beynon-Jones, 2013). In the present study, however, constructing abortion as immoral and sinful may act to restrict the acceptability of abortion to situations that reflect womxn's unaccountability for the pregnancy.

Excluding third-parties from pre-abortion counselling was also described as a part of liberal counselling practices in facilitating womxn's decision-making, without undue influence. The extract below is an example.

> *Extract 10* [site 3]
>
> **Sam** it i::s not easy for me to counsel with a (.) mother or a friend or a boyfriend /ok/ (1) becau::se um (.) they are the ones tending to influence /mm/ the counselling session (.) that is supposed to be one on one /*ja*/ the only time when I do have (.) allow (.) family if there's a language barrier /oka::y/ the that is the only time for me I don't want to influence anyone (1) because this is confidential (.) if she says yes it's fine (.) we can do that uh she'll prefer that or you prefer that (2) then (1) I also don't want that (.) /ok/ because you are the one that wants (1) you are the one that says you want to do this /mm/ so I'm talking to you /mm/ I'm not talking to anyone else /mm/ you are the one I need to give this service to (1) it's for you (.) to tell that one /*ja*/ (1) neh /*ja*/ (1) and for the pure reason that (.) we don't actually allow people (.) to wait because it's confidential people come here and say oh:: that one was at the clinic the other day neh doing that neh /*ja:*/ and then they people think that it's us that gives the information /mm/ yet it's the it's the people that were escorting

In her initial justification, Sam constructs the involvement of third-parties as undue, negative influence on the counselling: "it i::s not easy for me to counsel with a (.) mother or a friend or a boyfriend /ok/ (1) becau::se um (.) they are the ones tending to influence /mm/ the counselling session (.) that is supposed to be one on one". In doing so, Sam constructs pre-abortion counselling as necessarily occurring between the client and healthcare provider, a practice which is only disrupted "if there is a language barrier" so as to ensure effective communication. The reason for usually prohibiting third-party involvement is the need to ensure the client's autonomy in reaching a decision about her pregnancy, but also to ensure that her right to confidentiality and privacy are respected. Thus, Sam states: "I don't want to influence anyone (1) because this is confidential". In doing so, Sam draws on a liberal discourse to position herself favourably as deferring to the rights of her clients. This positioning is reinforced when Sam says that she allows third-party involvement if it is desired or requested by the client herself: "if she says yes it's fine (.) we can do that uh she'll prefer that".

However, Sam also suggests that preventing third-parties from being included in the counselling is her *own* preference: "I also don't want that (.) /ok/ because you are the one that wants (1) you are the one that says you want to do this /mm/ so I'm talking to you /mm/ I'm not talking to anyone else /mm/ you are the one I need to give this service to (1) it's for you". As such, Sam seems to invoke a liberal discourse of responsibilisation to position the client as needing to take responsibility for her desire and subsequent decision to have an abortion by attending the counselling *without* accompaniment. Sam also appears to draw on this discourse

in upholding and protecting her clients' autonomy, thus positioning her clients as under threat of undue influence and positioning herself as an advocate of their right to autonomous decision-making.

Sam further accounts for her position, which possibly contradicts her earlier deference to her clients' wishes by allowing third-parties if it is desired by the *client*, by stating the following: "we don't actually allow people (.) to wait because it's confidential people come here and say oh:: that one was at the clinic the other day neh doing that neh". Here, Sam points to abortion stigma where abortion is constructed as shameful and womxn accessing abortion services are positioned as abnormal and noteworthy for their transgression of dominant ideals around womxnhood. Thus, she argues that counselling should be one-on-one so that privacy and confidentiality are maintained to shield womxn from the effects of abortion stigma. Significantly, Sam also argues that maintaining the privacy and confidentiality of the pre-abortion counselling session is necessary to enable healthcare providers to protect themselves from being unjustly held accountable, by clients and management presumably, for people finding out about their abortion: "then they people think that it's us that gives the information /mm/ yet it's the it's the people that were escorting". Sam is thus able to mitigate her troubled position of going against womxn's wishes to disallow third-party involvement by positioning herself as heroically acting on *behalf* of the best interests of her clients. Sam also seems to position herself as a victim of false accusation, and in doing refers to hierarchical relations of power which might mean that she would face consequences for being accused of breaching clients' confidentiality.

Sometimes, health service providers described liberal counselling practices but acknowledged the limits of this kind of counselling in a resource-challenged environment. The extract below is an example. In it, Thembi accounts for why a discussion on pregnancy options is not a routine practice in the pre-abortion counselling that she and her colleagues provide at site 1.

> *Extract 11* [site 1]
>
> **Thembi:** actually we we focus on the (.) termination /ja/ but we do have the:: (.) social workers who deal (.) who deal with adoption (.) /ok/ but (.) we just mention /just ok/ we don't dwell on that one /ja/ because it's not (1) but we do mention so that when the person go to (.) w- eh dis- (.) make a decision (.) they are normally around but these days eh they say they are stopping the services (.) until further notice /oh/ mm those people (.) I don't know what is going on /ja/ so:: we don't dwell much on the (.) uh because now we will be confusing them /ja::/ you see /ja/ but if they are here those people are here we do send them to them so that they talk their side /ok/ mm because we're no::t it's not part of (.) of /yes your/ mm mm

In extract 11 above, Thembi states: "actually we we focus on the (.) termination /ja/ but we do have the:: (.) social workers who deal (.) who deal with adoption". As Thembi explains, at site 1 abortion services are fragmented so that social workers are primarily responsible for providing information around adoption. Working within this fragmentation, Thembi circumscribes their own role as focusing on providing information on abortion while mentioning adoption "so that when the person go to … make a decision (.) they are normally around" and can be approached for detailed information, if womxn are considering adoption. In this way, womxn normally have all the information available to them, should they need it, and can reach their own decision. However, as Thembi goes on to say (at the time of the interviews) the social workers were no longer at the hospital: "they are normally around but these days eh they say they are stopping the services (.) until further notice". As a result, the liberal counselling practices are compromised by limited human resources at the facility.

Interestingly, the lack of information around adoption presents some trouble for Thembi. In attempting to mitigate this trouble, Thembi justifies the practice of not including adoption in the abortion counselling by implying that doing so is necessarily not their responsibility due to the fragmentation of the services: "we just mention /just ok/ we don't dwell on that one /ja/ because it's not (1)". Notably, Thembi implies but stops short of saying that providing information on adoption is not within the realm of her responsibilities. This is repeated later: "because we're no::t it's not part of (.) of /yes your/ mm mm". Arguably, this indicates the potential trouble that lies in making such a statement. Indeed, in my own interjection, I as the interviewer also did not *say* the words. Our collective silence then works to cast the exclusion of adoption from the counselling as taboo; as a *refusal* (despite the fragmentation of services) to provide the full extent of the service owed to womxn. That excluding information on adoption would be problematic is premised on the notion that pregnancy options *should* form part of pre-abortion counselling. As further defence, Thembi suggests that it is in fact in womxn's best interest to not to be given information on adoption. Thus, she states: "we don't dwell much on the (.) uh because now we will be confusing them". Thembi therefore positions womxn who are requesting an abortion and therefore have already decided as impressionable and needing to be shielded from information that may confuse them, influence their decision or create internal conflict. Significantly, as discussed in chapter 6, womxn's talk seemed to suggest that for those who did not want to have an abortion but felt compelled to because of their circumstances, information around adoption, at least when it *cannot* be acted upon, is not only *unhelpful*, but may indeed be harmful in creating a conflict that cannot be resolved.

In the following section, I discuss how pastoral power is implicated in the counselling practices described by the healthcare providers in this study.

3.2. Pastoral practices

In pastoral relations of power, the healthcare provider who secures the well-being of those in their care by directing them in matters of right and wrong is produced. Pastoral counselling practices were described by some healthcare providers as an approach to counselling where the objective was to guide womxn to continue with their pregnancy. As I will show, pastoral counselling practices were defended through discursive resources which enabled the healthcare providers to position themselves as concerned with their clients' well-being, thereby justifying their practices.

In extract 12 below, Chanelle uses a conversion narrative as a discursive resource to describe pastoral counselling practices in which she and her colleagues engaged. Griffin (1990) discusses the conversion narrative as revolving around a moment of epiphany or enlightenment where the narrator speaks about a significant change in their life and in doing so constructs a problematic past that contrasts against a reformed/improved present.

Extract 12 [site 2]

Chanelle: […] although we are options-based counselling and we:: give them the options (.) um as a Christian organisation ourselves /ja/ we're very sad to see so many young girls making very bad options (.) very bad choices rather for their lives /ja/ um because they leave very traumatised (.) /ok/ and they you know having a termination is not a quick fix to the problem /mm/ and many of these girls just want that /mm/ and they think about the consequences after the deed has already been done /mm/ so we feel that our role of counselling before that (.) is hopefully just going to:: educate them (.) open their eyes (.) um it's going to open their hearts to a second possibility (.) another option /ok/ u::m and we do get it right (.) not all the time /ja/ u::m but we do get it right uh that's what keeps us here in the hospital because we believe that every one person (.) who changes their mind um basically has (.) a little human being whose life has been given a second chance /mm/ um and those babies come into the world (.) they're purposeful (.) /mm/ they live a life (.) and they give a lot of joy and purpose to those parents (.) who initially were considering abortion /mm/ (2)

Chanelle's account of her experience of providing pre-abortion counselling begins by pre-empting possible criticisms of the pastoral counselling practice she goes on to describe. Thus, she states: "although we are options-based counselling and we:: give them the options (.) um as a Christian organisation ourselves /ja/ we're very sad to see so many young girls making very bad options (.) very bad choices rather for their lives /ja/ um because they leave very traumatised". Through a discourse of responsibilisation, and a discourse of the awfulisation of abortion, having an abortion is constructed as risky and harmful and therefore irresponsible. It is also constructed as immoral and sinful, given Chanelle's religious framing of the

organisation. Implied here, then, is that a) continuing the pregnancy is the responsible choice/decision, and b) pastoral counselling necessarily involves counselling womxn against abortion, which is not explicitly stated as it would leave room for the criticism that the counselling being practised is not options-based counselling but is in fact directive counselling.

Through these discourses, Chanelle thus positions herself as paternalistically acting in womxn's best interests by saving them from the harm that abortion poses, as is required in pastoral counselling practices. Thus, she also takes on the hero subject position provided for within a hero narrative. Significantly, the use, once again, of "young girls" to signify womxn accessing abortion services not only positions them as especially vulnerable, but reinforces the awfulisation of abortion. Consequentially, counselling that is morally prescriptive on the decision that womxn should take concerning their pregnancy is therefore justified through the deployment of discourses of responsibilisation and the awfulisation of abortion, which enable Chanelle to position herself as caring for womxn.

As Chanelle describes, the purpose of counselling is to guide womxn against deciding on terminating their pregnancy. She relies on a conversion narrative to describe this counselling practice. Thus, she states: "so we feel that our role of counselling before that (.) is hopefully just going to:: educate them (.) open their eyes (.) um it's going to open their hearts to a second possibility (.) another option". Through the counselling, then, the hope is that womxn who are contemplating terminating their pregnancy will experience a moment of enlightenment and epiphany and in doing so realise that an option or possibility to which they had previously been closed off to is better and subsequently decide to continue with the pregnancy, which is framed as being in their best interests. This conversion narrative is again resourced when Chanelle states the following: "we believe that every one person (.) who changes their mind um basically has (.) a little human being whose life has been given a second chance /mm/ um and those babies come into the world (.) they're purposeful (.) /mm/ they live a life (.) and they give a lot of joy and purpose to those parents (.) who initially were considering abortion". Here, Chanelle describes a profound epiphanic change that some womxn go through, which, significantly is described as miraculous and seemingly without *direct* intervention from her or her colleagues; it is a change that Chanelle enables but is not accountable for, for it is the womxn who change their own mind. Thus, liberalism and pastoral care are once again entwined.

Buttressing this conversion narrative where a decision to terminate the pregnancy is framed as belonging to an immoral past and continuing with the pregnancy is framed positively, are foetal

personhood and pronatalist discourses which glorify procreation and construct children as intrinsically valuable. Thus, Chanelle states: "those babies come into the world (.) they're purposeful (.) /mm/ they live a life (.) and they give a lot of joy and purpose to those parents (.) who initially were considering abortion". In this narrative, Chanelle not only positions herself as a guide/facilitator but also as heroic in saving not only womxn who had previously considered abortion but in saving their children as well. Through these discourses, pastoral counselling practices that prescribe continuation of the pregnancy are justified by an overwhelmingly positive representation of parenthood.

Significantly, Chanelle further justifies the practice of pastoral counselling by framing abortion as a temporary and even inappropriate solution to the much bigger problem of 'unintended' pregnancy. She thus states: "and they you know having a termination is not a quick fix to the problem /mm/ and many of these girls just want that /mm/ and they think about the consequences after the deed has already been done". By problematising both unintended pregnancy and abortion, Chanelle positions womxn as irresponsible and immature in not thinking ahead, as misusing TOP services, and as needing to be educated on these matters.

In extract 13 below, Heather constructs the purpose of counselling, and her role within it, as centring on information provision, thus, positioning the "girls" she counsels as ignorant, in need of information and reliant upon her for that information.

> *Extract 13* [site 2]
>
> **I:** ok (.) um what would you say is the purpose (.) from your experience of the counselling that you provide?
>
> **Heather:** to make a difference /mm/ (.) to offer hope and to get girls to maybe make wiser decisions (.) sometimes they just don't know their options /mm/ so it's out of ignorance (.) and if they can get to heaven one day and say I have (.) someone told me there's no excuse /mm/ and if I can say I told them but they still chose TOP (.) that's their choice but I did my job /mm/ because I've also specialised in post-abortion I've done a course /ok/ and I've yet to see a girl come out unscathed /ok/ from a TOP (.) yet to (.) the emotional damage is deep (1) the depression (.) suicide attempts (.) u::m eating disorders (.) nightmares (.) anniversary often anniversary when the baby would've been born /*ja*/ trigger trigger trigger and they'll hit a (.) low (.) /mm/ u::m (1) *ja* if they might see a baby it's a trigger

As Heather explains, however, her information giving practices are geared towards a very particular outcome: to make sure that the 'girls' make responsible decisions regarding their pregnancy. Hence, she says of her role: "to make a difference /mm/ (.) to offer hope and to get girls to maybe make wiser decisions (.) sometimes they just don't know their options /mm/ so it's out of ignorance". Heather goes on to imply that making a 'wise decision' regarding one's

pregnancy necessarily means deciding to continue with the pregnancy, and conversely, that terminating a pregnancy can never be a responsible choice or decision. Heather therefore states: "and if they can get to heaven one day and say I have (.) someone told me there's no excuse /mm/ and if I can say I told them but they still chose TOP (.) that's their choice but I did my job". Thus, what is at work here is pastoral care which, as Macleod (2006) suggests, is directive in prescribing a moral course of action. And this pastoral power is exercised through the technique of warning. Thus, Heather describes her role as not only informing but also warning womxn about the irresponsibility and negative consequences of having an abortion. Heather, in this extract, therefore positions herself as giving womxn moral and spiritual guidance, not just for their salvation in this world, but in the next as well. In the process, through religious and moralising discourses, terminating a pregnancy is further constructed as sinful and immoral.

Significantly, through an awfulisation discourse, Heather goes on to explain why abortion is a wrong and unwise course of action: "I've also specialised in post-abortion I've done a course /ok/ and I've yet to see a girl come out unscathed /ok/ from a TOP (.) yet to". Through this discourse then, abortion is constructed as risky and damaging and as inevitably leading to negative mental health/psychological outcomes. Importantly, Heather positions herself as an expert of PAS, thus giving her statement the authority of 'truth'. Through this discourse, and through the use of the word "girls" which positions (young) womxn as especially vulnerable and ignorant, pastoral counselling practices wherein womxn are guided against terminating their pregnancies, are justified.

In extract 14 below, Heather describes the information she and her colleagues usually provide during the counselling.

Extract 14 [site 2]

Heather: we try to be very unemotive /*ja*/ and very factual (.) we don't want to work on emotions (.) that is manipulation /mm/ I will tell it exactly like I (.) like I'm telling you /mm/ maybe keep it in a monotone /mm/ so none of my own story would even come through (.) I never bring that in anyway (.) just here are the options /mm/ you're in a crisis this wasn't planned (.) I try keep it not critical not judgmental /*ja*/ it's (parenting) (.) and then how we assist /ok/ how we can assist practically /ok/ cause we have a shop in [name of area] /ok/ so we give vouchers and we try and help (.) with clothing /mm/ we have this formula where we can /mm/ but I stress we're an NGO (.) we've had girls come back and say 'you told us' /mm/ 'not to terminate where's the nappies where's the formula' (.) oh it's happened often (.) 'my child's ready for pre-school and you said' (.) /*ja*/ uh so it's got to be worded so carefully (.) we're an NGO (.) if we're blessed we will bless but I can't raise your child I mean the shop (.) can be have no stock in a month and then I::ve offered this (.) carrot /mm/ so I tell it very factually

Heather, above, states: "we try to be very unemotive /*ja*/ and very factual (.) we don't want to work on emotions (.) that is manipulation /mm/ I will tell it exactly like I (.) like I'm telling you /mm/ maybe keep it in a monotone". In stating the information they provide during counselling, Heather works to obviate the potential trouble posed by possible criticisms of manipulation Thus, she states that the information they provide is factual and is presented in an "unemotive" and monotonous way. In doing so, Heather positions herself as ethical and of good character. Heather also invokes dominant understandings of non-directive counselling which, shaped by positivism, assume that factual information is in and of itself neutral and value-free, and therefore poses no harm to clients and is unproblematic (Woodcock, 2011). Within such discourses, the ethical obligation to ensure informed consent is met simply by providing 'factual' information in an unemotive way. However, this discourse fails to acknowledge, or recuses the counsellors' accountability for, the intentions in providing information and the effects on the patient/client as a result of receiving this information (Woodcock, 2011). It is within this context that Heather can construct her own practices as non-manipulative, while simultaneously acknowledging the possibility of this.

Significantly, the information giving practices that Heather does go on to describe could be argued to be manipulative and directive in guiding womxn towards continuing their pregnancy, using incentives. Thus, Heather explains: "so none of my own story would even come through (.) I never bring that in anyway (.) just here are the options /mm/ you're in a crisis this wasn't planned". Arguably, using a discourse which necessarily constructs an unintended pregnancy as a "crisis" event and abortion counselling as crisis *management* is highly emotive in positioning the pregnant person as fragile and therefore in need of serious intervention, and additionally as a problem to be solved. It also enables a pastoral power relation in which the pregnant person's autonomy in decision-making may be justifiably undermined in deference to the expertise and authority of the counsellor who may then prescribe what is best.

In discussing the consequences that have resulted from providing womxn with information around how they may be practically assisted, Heather negotiates around the criticism, suggested through the womxn's voices presented in her account, that providing such information is manipulative. Thus, she explains: "I stress we're an NGO (.) we've had girls come back and say 'you told us' /mm/ 'not to terminate where's the nappies where's the formula' (.) oh it's happened often (.) 'my child's ready for pre-school and you said'". Significantly, through the womxn's voices, pastoral care is referred to here as the counsellors are described as telling womxn not to terminate their pregnancies.

By merely providing information about economic assistance to womxn who are terminating a pregnancy because the pregnancy, as well as subsequent child-bearing, is economically unsupportable may be manipulative, particularly in a context where this assistance cannot be consistently relied upon, as is the case with an NGO. Notably, Heather defends against this criticism by positioning the womxn as irresponsible parents who seek to transfer their parenting responsibilities onto someone else. In doing so, she fails to acknowledge the structural and economic realities of the womxn's lives which do not support parenting. Also, noteworthy, however, is Heather's use of metaphor which implicitly acknowledges that her counselling practices are arguably directive in trying to persuade womxn, by offering "this carrot" of practical assistance, incentive, to continue with their pregnancies. Thus, through this extract, the limits to pastoral counselling are shown up, as merely advising womxn not to have an abortion may not be enough; practical assistance may be required which, as Heather describes, is also limited.

In the following extracts (extract 15 and 16), the limitations of pastoral counselling practices, and the trouble that pastoral counselling potentially presents for healthcare providers, is again demonstrated. In the extracts, Heather describes tactics that are necessary, and justified, when womxn refuse to follow the guidance that pastoral counselling provides.

> *Extract 15* [site 2]
>
> **Heather:** […] then I say and if you do choose termination do you mind if I explain cause of the three different procedures (.) so I go through those options first /ok/ but very unemotive and then I say ok if this is what you do choose (.) up to nine weeks afte::r demand 12 after 12 (.) and then the dangers the staff like me to push /mm/ because I don't think people are aware it is life threatening as I say there is a lady lying in ICU as we speak but she was backstreet /mm/ fighting for her life *ja* (.) and then if they still (.) adamant we also the third thing is to push the dangers of the backstreet /ok/ *ja* we did lose four last year between [name of facility] and here /*ja*/

> *Extract 16* [site 2]
>
> **Heather:** […] but they do like me to they like me to be graphic /ok/ cause after 12 weeks (1) it is quite a dangerous procedure hey /*ja*/ you can give birth to life I have the twenty week baby here we use models quite a bit /mm/ it's not seen as manipulation they're life size from America /mm/ they prove very helpful this is twenty weeks (.) so this the limit in South Africa up to here hey /ok/ (1) so you can see it's gonna be already /mm/ a birth cut the cord then you come and get an e-vac (.) then you sleep over it is dangerous (.) and often you see it /oh/ cause you gonna push this out so you (.) you might see it but eh you can imagine how damaging that is /mm/ and of course it's medical waste there's no funeral /mm/ (.) ok that's why post-abortion is so much more difficult between 12 and 20

In extracts 15 and 16 above, Heather describes how providing information on the dangers and risks of both legal and illegal/backstreet abortion are sometimes necessary to persuade clients

who are particularly stubborn. In doing so, the two are conflated to construct termination of pregnancy, a medical/healthcare practice, as harmful and incredibly risky to womxn's health and life. Thus, in extract 15 Heather states: "the dangers the staff like me to push /mm/ because I don't think people are aware it is life threatening as I say there is a lady lying in ICU as we speak but she was backstreet /mm/ fighting for her life". Here, Heather admits that she is in fact referring to *backstreet* abortion, and not legal termination of pregnancy. The implication of this admission is that this is an inappropriate and inaccurate example to use. However, Heather goes on to explain how this information is used to direct womxn, positioned as stubborn and irrational in refusing to listen to reason, onto the correct path, that is, against abortion. Thus, she says: "then if they still (.) adamant we also the third thing is to push the dangers of the backstreet /ok/ *ja* we did lose four last year between [name of facility] and here".

Notably, Heather both implicitly acknowledges the possible critique of providing this kind of information and mitigates her own accountability for it. She does so by pointing out that "the staff like" her "to push" the risks of abortion, thereby deflecting responsibility and possibly signalling hierarchical power relations between the volunteer counsellors and the nurses. In doing so, Heather also masks her own position in providing this information. Importantly, Heather's use of an awfulisation of abortion discourse to construct abortion as inherently harmful enables her to position herself as caring for her clients. What is also enabled is a justification of this kind of information provision, on the grounds that it is in the best interests of womxn and is therefore her duty to do so.

In extract 16, Heather explains how explicit and graphic details of the medical abortion procedure are necessary to protect womxn from the harm caused by PAS. In doing so, Heather both implicitly acknowledges the potential for harm caused by the information in and of itself, and justifies this harm through an awfulisation of abortion discourse which constructs abortion as dangerous. Thus, Heather states the following: "they do like me to they like me to be graphic /ok/ cause after 12 weeks (1) it is quite a dangerous procedure hey". Significantly, the construction of (medical) abortion as harmful to womxn depends for its force on a foetal personhood discourse which constructs the medical abortion process as resembling child-birth. This is captured in the following statement: "you can give birth to life I have the twenty-week baby here we use models quite a bit…so this the limit in South Africa up to here hey /ok/ (1) so you can see it's gonna be already /mm/ a birth". The emphasis placed on the word "birth" implies just how traumatic the experience would be for womxn, an implication that Heather goes on to make explicit: "and often you see it /oh/ cause you gonna push this out so you (.)

you might see it but eh you can imagine how damaging that is". Notably, within pastoral counselling, the presentation of foetal models is "not seen as manipulation" and is justified in two ways. The first relates to the stated accuracy of the models (i.e., Heather states that they are "life-size"). The second relates to the assumption that, when presented with a graphic and concrete illustration of foetal personhood, womxn would be easily persuaded to abandon the idea of terminating their pregnancy.

It is significant that the conclusion Heather reaches, that "post-abortion is so much more difficult between 12 and 20" weeks, is not contextualised within a context of foetal personhood, the gestation of the pregnancy being terminated, the procedure of medical abortion, or the various other factors that have been found to significantly contribute to or mitigate against emotional distress in womxn post-abortion. Indeed, research on womxn's experiences of termination of pregnancy has shown that womxn's experiences of medical abortion vary. Some womxn who had a medical abortion located their distressing experience in having been actively and directly involved in the process (compared to surgical abortion) while for others experiencing medical abortion as a birth-like process was distressing, but particularly for those who had not given birth previously (Halldén et al., 2009). Contrastingly, some womxn terminating pregnancies in the first trimester and who did not experience the procedure as distressful likened medical abortion to a normal menstrual period, thus normalising it differently (Tong et al., 2012; Zamberlin et al, 2015). Instead, Heather's conclusion is used to prove that abortion is "an innately traumatic event that may cause psychological damage" (Hoggart, 2015, p.369), which forms part of the awfulisation of abortion. Therefore, in positioning womxn requesting an abortion "as inherently vulnerable and susceptible to duress" (Hoggart, 2015, p.369), it reinforces the justification, that womxn need to be rescued from this harm, and for including "graphic" procedural details around medical abortion.

Interestingly, regarding providers' accounts of normative information provision practices during pre-abortion counselling, the present study echoes some of the findings discussed by Beja and Leal (2010) whose study was conducted in Portugal, and Nguyen et al.'s (2010) study conducted in Vietnam. In both studies, and notably like the extracts discussed above in the present study, providers reported that providing information around contraception, with the aim of preventing future unintended pregnancies and encouraging long-term contraceptive uptake was a constant feature of information provision. Like Thembi's understanding of the purpose of pre-abortion counselling, all the providers interviewed in Nguyen et al.'s (2010) study believed that abortion counselling was about preventing future unintended pregnancies

and subsequent abortions. In Beja and Leal's (2010) study, some abortion providers included risks of abortion as part of the clinical information they provided to clients and some also reported that requests for womxn's reasons for abortion formed part of the counselling and were a regular feature framed as part of "understanding the circumstances of the pregnancy" (p.329).

Pastoral counselling practices were described as practices which, with womxn's best interests in mind and therefore *legitimately* and *unproblematically*, tried to persuade womxn to continue with the current pregnancy. However, the implications of such counselling practices are that pre-abortion counselling effectively amounts to directive counselling, which Lousie-Duant (2015) describes as counselling that seeks to persuade womxn, usually against terminating their pregnancies. Such persuasion strategies may be varied and can include but are not limited to: requiring womxn to view ultrasound images of their pregnancies, as well as certain types of information provision, such as foetal development and information around the risks of having an abortion.

3.3. Sovereign/authoritarian practices

Sovereign/authoritarian counselling practices entailed or deployed the use of force or coercion to govern womxn's conduct in particular ways. Gate-keeping tactics also formed part of authoritarian counselling practices as through these tactics, access could be allowed or disallowed, much like the juridico-legal power of the sovereign. The healthcare provider subject that is produced within this form of power is one who must act on behalf of others, without their consent or against their wishes, to secure their well-being.

The hero narrative was sometimes used to justify and defend certain authoritarian counselling practices, such as coercion around the uptake of LARCs around which there has been some debate in public health and healthcare service literature and professions as well as in feminist work on contraception (Gomez et al., 2014). Extract 17 below is one example.

Extract 17

I: (2) and e::m (1) eh the purpose what do you what what's (.) what is the purpose of the counselling here in in:: for wena=

Thembi: = ok our focus neh= /=ja/ when we do the counselling neh /mm/ as much as we:: those who qualify as much we give them the service /mm/ w- but we we we put our focus on the family planning /mm/ o- ok fine(.) you come here we are going to- ooh sorry [dropped pen] we're going to give you the service /it's ok [referring to the pen dropping]/ but at the same time (.) we promote the family planning /mm/ ja that is where the problem is /mm/ and we:: try now and eh push this e::h long-term family planning becau::se of these challenges (.) they're having neh /mm/ because that one the implant if you put it once (.) so you don't have to be going to tho::se clinics= /=mm::/ those nurses /mm/ that is what we do /ok/ we do the:: service for them then we put them on

> what we call the long-term (.) family planning /mm/ so that now they don't default (.) /mm/ ja we are trying to minimise (.) the defaulting and end up here /ok/ ja and it's working /ok that's ja ok/ ja it's working

In the extract, I have asked Thembi about what she felt is the purpose of pre-abortion counselling. In her response, Thembi begins by stating the following: "as much as we:: those who qualify as much we give them the service /mm/ w- but we we we put our focus on the family planning". In doing so, Thembi states that the focus is on providing womxn with contraceptives, in addition to establishing whether womxn qualify for abortion, thus positioning her and her colleagues as gate-keepers. While determining whether womxn meet the criteria is to be expected for second trimester pregnancies, the CTOP Act legalises abortion on demand for first trimester pregnancies, thus making this aspect of the counselling curious.

Significantly, Thembi's phrasing (above) indicates that she is pre-empting a possible critique that the focus of pre-abortion counselling is misaligned towards ensuring the uptake of family planning methods, which she later specifies as Long-Acting Reversible Contraceptives (LARCs). Healthcare providers' reliance and insistence on LARCs has increasingly come under feminist criticism due to the implication that womxn are in fact coerced or given little to no choice about whether to adopt LARCs and/or which method to use. Indeed, research by Orner et al. (2011) conducted in Cape Town on HIV-positive womxn's decision-making reports how some participants described being administered a hormonal injection immediately following the abortion procedure without their consent. When administered coercively, feminists have argued that LARCs become a method of population control that undermines womxn's reproductive autonomy (Gomez, et al., 2014). In South Africa, population control through family planning programmes is historically located in the Apartheid era where the government sought to reduce the Black population (Brown, 1987). Orner et al.'s (2011) study shows how the fertility of particular groups of womxn continues to be problematised.

Thembi's attempt to justify a focus on family planning suggests that such coercion takes place. Her justification also frames this coercive practice within the context of saving womxn from having to rely on clinics where the nurses are abusive. According to Thembi, clinics which aren't user-friendly or do not promote family planning negatively impact on contraceptive uptake which is normatively understood to be how reproductive citizens are supposed to conduct themselves. Thus, Thembi states: "we:: try now and eh push this e::h long-term family planning becau::se of these challenges (.) they're having neh /mm/ because that one the implant if you put it once (.) so you don't have to be going to tho::se clinics= /=mm::/ those nurses". By drawing on the hero narrative, Thembi frames the imposition of LARCs as underpinned by

moral principles: knowing the family planning challenges and obstacles faced by womxn and having a duty to rescue them from these difficulties, which include ill-treatment. Thembi thus positions herself as heroic and as caring for womxn's well-being.

Coercing womxn to take up LARCs is part of the authoritative/sovereign power that we see being exercised by some of the healthcare providers in this study (chapter 6 discussion on waiting room narratives, for example), and this sovereign relation of power between the healthcare provider and the clients is underscored in the following line: "we do the:: service for them then we put them on what we call the long-term (.) family planning". Within this relation of power, womxn are not given a choice but are instead dictated to in order for them to take up LARCs and be responsible reproductive citizens.

Thembi's final lines in extract 17 above provide further justification for coercing womxn to take up LARCs. She states: "so that now they don't default (.) /mm/ ja we are trying to minimise (.) the defaulting and end up here /ok/ ja and it's working /ok that's ja ok/ ja it's working". Here, Thembi discusses another, if not the primary, purpose of the counselling: to ensure womxn do not come back for another abortion. In doing so, Thembi draws on a health promotion discourse where individuals are responsibilised to 'care for the self' by *engaging* in practices and behaviour intended to maintain their own health and the health of others and *avoiding* those which would jeopardise this (Petersen, 1996; Larsen & Manderson, 2009). Thembi's talk here is reminiscent of the discourse around HIV and Anti-Retroviral (non)compliance where people living with HIV are responsibilised to be healthy by adhering to their ARV medication (Mykhalovskiy, McCoy & Bresalier, 2004). Here, however, Thembi acts on behalf of womxn by *pushing* LARCs to ensure that they responsibly reproduce.

Within Thembi's extract, then, unintended pregnancies are constructed as inherently problematic and requests for abortion become a means by which this problem is made visible, so it can be addressed. Interestingly, research conducted by Beynon-Jones (2013) among Scottish health professionals involved in abortion care yielded similar findings. In her study, the participants understood abortion as evidence of a bigger problem which could be addressed within the abortion counselling through contraceptive consultations. Beynon-Jones (2013) analyses such constructions as naturalising the need for womxn to be in control of their fertility and positioning womxn who do not as irresponsible.

Sovereign/authoritarian practices were also justified through the use of a health promotion discourse in which *holistic* health service provision or comprehensive care entails a focus on

all the health needs faced by clients (Larsen & Manderson, 2009). The extract below is an example.

> *Extract 18* [site 1]
>
> **I:** =mm ok/ ja / ok /mm/ um:: (1) and c- I do- can you say more about the:: the how you support? (.) Is it um::
>
> **Thembi:** the support we give? /ja ja / you know like some of them they come here the::y they have many problems /mm/ ja sick HIV:: and all tho- we cover all those things /ok/ because you see me what eh me the (.) with me you see since I'm from the clinic neh /mm mm/ you see that eh this person is eh:: pregnant /mm/ she's coming to do abortion /mm/ it doesn't end there /mm/ obviously for the fact that the person is pregnant /mm/ that means the person is not practising safe sex (.) then I must put the issue of uh:: HIV /mm::/ we test them /mm/ they know their status […] so we it uh (1) it's a lot of work /mm/ it's not about you come here you want to do abortion (.) we have to look on (.) are you fit /ja/ to do the procedure /ok/ because we don't want any death /ja/ as long as I've been here I've not had any deaths (.) so we want to keep it that way /mm/ so:: we we we have to give them (.) eh:: support which ever problem we experience

In extract 18, Thembi draws on a health promotion discourse in describing the support provided to womxn: "the support we give? /ja ja / you know like some of them they come here the::y they have many problems /mm/ ja sick HIV:: and all tho- we cover all those things". Thembi then goes on to specify some of the many problems faced by womxn: "since I'm from the clinic *neh* /mm mm/ you see that eh this person is eh:: pregnant /mm/ she's coming to do abortion /mm/ it doesn't end there /mm/ obviously for the fact that the person is pregnant /mm/ that means the person is not practising safe sex (.) then I must put the issue of uh:: HIV". As such, unintended pregnancy is understood as a failure to use contraception and is thereby decontextualized from the structural and economic conditions of some womxn's lives, as well as the power relations which make the taking up of contraceptives difficult. Furthermore, the juxtaposition of unintended pregnancy and serious health conditions such as HIV frames both as health problems which necessitate attention.

Importantly, Thembi describes this holistic service provision as a practice she carried over from her clinical work and experience. As Thembi's use of the word "fit" is ambiguous, it is possible that she may be using "fit" strictly based on her clinical experience in which certain health conditions may make abortion, child-birth or any other medical procedure, 'high-risk'. However, Thembi's description of holistic service provision can also be interpreted as a way to legitimise a gate-keeping practice and establish her own credibility and authority in applying that clinical experience to pre-abortion counselling service provision. Thus, one interpretation is that this practice is one way in which Thembi exercises authoritative power as what possibly emerges is a *primary* focus on womxn's overriding health concerns and the relegation of

abortion to a secondary order concern in order to categorise womxn into categories of medically 'fit' and 'unfit'. Thembi, thus states: "it's not about you come here you want to do abortion (.) we have to look on (.) are you fit /ja/ to do the procedure". Thus, holistic service provision is deployed as a means by which Thembi may prescribe whether a termination of pregnancy is the right course of action for her clients in terms of their health and medical fitness, thereby acting as a gate-keeper to the service. This gate-keeping tactic is thus enabled through the techniques of observation and measurement which, enabling a categorisation of womxn into 'fit' and 'unfit', are here being deployed through the clinical gaze. This gate-keeping is then justified by an interest and moral principle in preventing deaths that arise from health conditions which complicate recovery after abortion. Thembi therefore states: "because we don't want any death /ja/ as long as I've been here I've not had any deaths (.) so we want to keep it that way". By saying this, Thembi positions herself as having womxn's best interest in mind. Significantly, her positive reflexive positioning is further achieved by positioning herself as heroic in saving womxn from the fatal consequences of not screening for abortion 'fitness'.

3.4.Governmental self-formation

Through governmental self-formation, individuals' conduct is governed through the injunction to relate to the self, and thus self-govern, in particular ways, that is technologies of the self (Macleod, 2006). Through these technologies, individuals are called upon to know themselves, master themselves and care for themselves (Rose, 1996). In this section, I discuss how healthcare providers' justifications for certain practices revolved around governing womxn's conduct through the incitement for womxn to relate to themselves in specific ways.

In extract 19 below, Thembi explains that asking for womxn's reason(s) for requesting the abortion is an important starting point and feature of information-giving.

> *Extract 19* [site 1]
>
> **Thembi:** the counselling /mm/ (1) we:: first of all neh (.) we find out the reason why /ja/ neh? /ja/ they must understa::nd why they're here /mm/ then we:: focus /mm/ as I say I will go back to the family planning because that is why we are here /yes/ then we:: give them a lot of because some of them they don't know about these long-term things /mm/ so we have to give them information in fact because a lot of them they don't know /mm/ about the Implanon (.) and eh (.) even those th- that knows (.) they don't have the correct information= /=okay/ so you must try and correct /mm/ those misinformation /mm/ mm (.) what else what else information (.) we give (2) ja th- that is our main focus /ok/ ja

Thembi states: "the counselling /mm/ (1) we:: first of all neh (.) we find out the reason why /ja/ neh? /ja/ they must understa::nd why they're here". Thus, for Thembi, asking womxn to explain

their reasons for needing an abortion is not problematic in setting up a confessionary space where womxn are confessing a transgression and subsequently justifying or proving the need for an abortion. Instead, requiring womxn to provide their reason(s) is justified as being in womxn's best interests and therefore *necessary*. It is implied that in order for womxn to prevent future unintended pregnancies, which is desirable, they should understand what, in their own conduct, has led them to request an abortion. In other words, by asking womxn to provide reasons for their abortion request, womxn are incited to know themselves: to know what has led them to this point so that they can act differently and thus prevent unintended pregnancies in future. By knowing themselves in this way, womxn can become responsible sexual/reproductive subjects. Through the confession then, the healthcare provider plays the vital role of helping womxn to make sense of and interpret their problematic behaviour and to see their own accountability and irresponsibility.

Implied in extract 19 is that requiring womxn to explain why they are requesting an abortion is part and parcel of focusing on family planning and LARC up-take to prevent future unintended pregnancies. Thus, Thembi describes how providing information on LARCs follows naturally on from requesting reasons for abortion: "then we:: focus /mm/ as I say I will go back to the family planning because that is why we are here". Indeed, providing information on long-acting family planning methods so that any future need for abortion is obviated is described as the primary role of the healthcare providers. Within this context, the justification for providing this information, seemingly without asking womxn whether they want to receive that information or not, centres around Thembi positioning womxn as ignorant and therefore in need of such information. Hence, Thembi states: /yes/ then we:: give them a lot of because some of them they don't know about these long-term things". And because womxn need this information, providing this information becomes obligatory, as she goes on to explain: "so we have to give them information in fact because a lot of them they don't know /mm/ about the Implanon". Interestingly, further justification for providing this information centres around the duty to correct the inaccurate information held by those that know about contraception but nevertheless "don't have the correct information".

In extract 20 below, Sam also describes requests for information as a necessary part of providing information during the counselling.

> *Extract 20* [site 3]
>
> **Sam:** so you must really just (.) /put them at ease=/ =relieve the anxiety <u>first</u> before they can be open to anything that you say (.) /ok/ so it's (.) information giving is

very important /ok/ (1) then you can ask why /mm/ isn't there another option /mm/ uh:: (.) are you sure you want to do this /mm/ will you be able to cope with it /mm/ if you don't do you have a support system (.) people don't want to tell people /*ja*/ obviously (.) so asking for a support system is actually ridiculous /mm/ but you will have to ask (.) because if you don't want to go to your family or whoever you trust (.) rather go to a psychologist but people are not going to do that either they will rather go come for the next one /mm::/ neh /mm/ (1) the fear of people =/=[inaudible]/ knowing is greater than them coming here /mm/ do you understand

In extract 20 above, Sam states: "information giving is very important /ok/ (1) then you can ask why /mm/ isn't there another option /mm/ uh:: (.) are you sure you want to do this /mm/ will you be able to cope with it". Once again, womxn are incited to know themselves: to know why they are requesting an abortion and to know their desires and thereby assess whether abortion is a responsible option. With this self-knowledge then, womxn may presumably decide against abortion. Requesting that womxn provide their reason for abortion emerges, then, as means a through which womxn may be persuaded to consider continuing the pregnancy to term. Thus, this request is followed by asking womxn whether there is "another option" available to them, and whether they will be able "to cope with" abortion. Sam possibly invokes PAS here to suggest that abortion is necessarily and inherently an emotionally and psychologically difficult life event, the difficulty of which is only mitigated by womxn's coping abilities and strategies. As a result, these requests for information are implicitly justified as arising out of a concern for the womxn's well-being. Conversely, Sam's question around support is an attempt to mitigate emotional difficulty in response to abortion as research by Kimport et al. (2011) shows that emotional difficulty following abortion may be occasioned by a lack of social support.

In the extract below, excluding third-party involvement in pre-abortion counselling is described as a routine practice. In the extract, Thembi discusses how, in the case of minors, an exception to the rule is made so that minors may be incited to take up contraception and in so doing, despotically relate to the self by preventing unintended pregnancies.

Extract 21 [site 1]

Thembi: =no (.) no no no what we do is neh /mm/ you find that the parent can accompany /mm/ but we're going to deal with the:: person (.) even if it's 15 year old /mm/ the counselling se- session we deal with the 15 year old /mm/ but now there are parts where we have to call the mother /oka::y/ like in the case of eh:: family planning (.) we have to call the mother (.) and ask the mother (.) wh- who is the child staying with /oka::y/ how did the child get pregnant and all that (.) /ok/ you know then when we discuss the choice (.) the parent must be there (.) so that she knows what you're going to do to the child /mm/ and she also agree /ok/ because some of them you we do (it) the child and then the parent will come and say (.) why did you do this to my child /o::h=/ =so we must all agree (.) /okay/ [chuckles]

Thembi, in extract 21 above, states the following: "no no no what we do is neh /mm/ you find that the parent can accompany /mm/ but we're going to deal with the:: person (.) even if it's 15 year old /mm/ the counselling se- session we deal with the 15 year old". Significantly, Thembi's response *doesn't* account for excluding third-parties from the counselling and instead focusing on the client herself. Rather, her response reinforces that one-on-one counselling is maintained, even in situations that might be deemed inappropriate; for example, where the client is 15 years old and is therefore considered a minor. Within legal frameworks informed by development discourses within the discipline of Psychology, adolescence is constructed as deficit; a period of immaturity which is associated with an inability to comprehend the long-term consequences of one's actions and decisions. Contrastingly, the CTOP Act recognises the rights of minors to make their own decisions about their reproductive lives, including accessing abortion services, without the consent of a guardian. *Not* accounting for the exclusion from pre-abortion counselling of parental third-parties is therefore important: it suggests a taken-for-granted assumption, on Thembi's part, of how the world is and should be (Radley & Billig, 1996), in this case, how counselling does and *should* take place, a view which is in line with the CTOP Act.

What Thembi does attempt to provide justification for, however, is the practice of involving parents specifically when discussions around contraception are taking place. As Thembi describes, these "parts where we have to call the mother", revolve around responsibilising the mother: "we have to call the mother (.) and ask the mother (.) wh- who is the child staying with /oka::y/ how did the child get pregnant and all that". Thus, the mother is called upon, as a pastoral agent in charge of re-producing a normative (hetero)sexuality. Further justification for including the mother in discussions around contraceptive uptake is the need to avoid being held to account by the parent. Thembi explains thus: "the parent must be there (.) so that she knows what you're going to do to the child /mm/ and she also agree /ok/ because some of them you we do (it) the child and then the parent will come and say (.) why did you do this to my child". Thus, by including the mother, Thembi co-opts her into inciting the minor to take up a long-acting contraceptive and prevent unintended pregnancy, thereby having mastery over the self. Significantly, it is implied that the contraceptives are administered coercively, that is, without the consent of the parent (or child) and that this is justified as contraceptive discussions fall under the healthcare providers' ambit of care. Notably, this contradicts provisions in the law which allow minors to access contraceptives and contraceptive advice without parental consent (Strode, 2010).

During interviews with healthcare providers, adolescent womxn were also incited to relate to the self through care. I asked Chanelle to elaborate on a statement she had made much earlier in the interview about the bad choices young womxn make which lead to a decision to have an abortion. The extract below is part of her response to this.

Extract 22 [site 2]

Chanelle: […] possibly we need to have more (.) more open (.) um debate /mm/ uh universities (.) should have open debates where womxn get together and discuss (.) the various issues related to:: proper contraception /mm that doesn't happen/ doesn't happen /mm/ (2) you know u::m womxn must know how to take care of themselves /mm/ u::m and womxn should be able to say no /mm/ (2) a lot of womxn don't believe that they can say no /mm mm/ (.) and u::m (1) that is a sad place to be in (2) /it is/ (.) you know because (.) they are (1) making decisions on their life (.) that are going to affect them forever (2) and u::m (.) womxn also don't realise that the::y have sex because of an emotional need (.) /mm/ the man is having sex because of a physical need /mm/ (1) so at the end of the day the woman is developing (.) all these insecurities (.) that are affecting her emotionally (1) u::m and the man moves on (.) to the next person (3)

In extract 22 above, Chanelle describes possible solutions to the problem of unintended pregnancy: "possibly we need to have more (.) more open (.) um debate /mm/ uh universities (.) should have open debates where womxn get together and discuss (.) the various issues related to:: proper contraception". To be responsible sexual subjects therefore, womxn need access not only to contraceptives, but to information on how to use them responsibly. However, as Chanelle explains, even with access to information around contraception, womxn may not be able to make responsible sexual decisions, due to inequitable gendered relations which form part of the context in which unintended pregnancies occur. Within these gendered relations, womxn don't feel able to negotiate sex with their partners. Thus, she states: "womxn should be able to say no /mm/ (2) a lot of womxn don't believe that they can say no".

When womxn cannot say no, the consequences are borne out by womxn alone: "that is a sad place to be in (2) /it is/ (.) you know because (.) they are (1) making decisions on their life (.) that are going to affect them forever". Significantly, in describing these long-term consequences, Chanelle draws on gendered discourses which construct womxn as emotional in general and as emotionally-driven when it comes to sex. Mxn, by comparison, are constructed as driven by physiology. Because of these differences, womxn, who are positioned as inherently vulnerable, suffer from psychological consequences while mxn do not: "so at the end of the day the woman is developing (.) all these insecurities (.) that are affecting her emotionally (1) u::m and the man moves on (.) to the next person". Thus, we see how the solution moves from having access to and applying information around contraception, to only having sex with one partner at a time, if at all. In this sense, Chanelle draws on a gendered

discourse which upholds a sexual double standard wherein womxn are expected to be sexually chaste while mxn are not. In order to avoid negative and long-term psychological consequences, and unintended pregnancy and therefore become psychologically well-adjusted responsible sexual subjects, womxn are therefore incited to care for the self: "womxn must know how to take care of themselves".

4. Conclusion

This chapter was divided into two main parts. In the first part, I focused on the discursive resources that were exclusively drawn upon by healthcare providers. Thus, I spoke to the hero, career and personal testimony canonical narratives, as well as a gendered discourse. I also noted a silence around a reproductive rights' discourse. I demonstrated how these discursive resources were used to construct particular accounts, for example around healthcare providers' motivations to become involved in abortion work.

In the second part, I discussed how healthcare providers described various pre-abortion counselling practices that they engaged or did not engage in and how they justified their (non-)engagement in the activities they described. I argued that these practices amounted to directive counselling. Drawing on Foucauldian scholarship around discourse and power, I discussed how liberal, pastoral and sovereign power operated in practices around information provision (including whether information provision varies in different situations, and requests for womxn's reasons for abortion), discussions around pregnancy options, and third-party involvement in pre-abortion counselling. In justifying these practices, healthcare providers drew on the following discourses: moralising discourses; a liberal discourse of responsibilisation; an awfulisation of abortion discourse which drew on PAS; a health promotion and public health discourse; pronatalist discourses; and a psychotherapeutic discourse. I also discussed how in health service providers' talk and attempts to justify their counselling practices, womxn were called upon to take up particular subjects by relating to the self through self-knowledge, self-mastery and self-care.

In the next and final chapter of this thesis, I pull the various findings of the three analysis chapters together in order to discuss their implications for abortion service provision. I also identify the limitations of this study and make recommendations for future research.

Chapter 9: Concluding discussion

1. Introduction

In this last chapter, I reflect on the findings of the preceding analysis chapters in order to discuss what the implications of these findings may be for the provision of pre-abortion counselling services in the Eastern Cape Province of South Africa and possibly elsewhere. I also reflexively look at the limitations of the study and make suggestions for future research that can address the shortcomings I have identified in the present study. Before that, it is important to situate this reflection by looking at the research questions which guided the study, as well as the theoretical frameworks which underpinned the research.

Through this study, I sought to explore and compare womxn's and health service providers' talk about their experiences of the PTOP healthcare encounter (waiting room interactions and pre-termination of pregnancy counselling) as practised in the Eastern Cape public sector. To do so, the following research questions were developed: 1) How do health service providers describe/speak about their experiences of providing pre-abortion counselling and interacting with womxn in the waiting room? What discursive resources are drawn on and what practices are described? 2) How do womxn describe/speak about their experiences of receiving pre-abortion counselling and interacting with health service providers in the waiting room? What discursive resources are drawn upon in their micro-narratives and what practices are described? 3) How do womxn and health service providers position themselves and the other party in talking about PTOP counselling and waiting room interactions? 4) How do health service providers' and womxn's accounts of the PTOP counselling diverge or converge (to be addressed in this chapter)? And how might these have implications for PTOP counselling service provision? 5) What power relations are referred to or evident in health service providers' and womxn's talk? And what are the implications of these for PTOP counselling service provision?

Little research has been conducted on pre-abortion counselling experiences, with studies mostly being conducted in the US and the UK and some studies being conducted in European countries. That most of this research is conducted in these contexts may be because of the mandatory counselling regulations imposed in some of these contexts, such as some states in the US and parts of Europe (the UK does not have mandatory counselling laws), where mandatory abortion counselling is taken to be directive and indeed pushed by an anti-abortion

agenda (Joffe, 2013). In South Africa, where the CTOP Act stipulates that abortion counselling (both pre- and post-abortion) should be non-mandatory but must be made available, very little knowledge has been produced on experiences of pre-abortion counselling. Birdsey et al.'s (2016) study conducted in KwaZulu Natal province is one exception. This gap in South African knowledge production is particularly troubling as others have noted with concern the likelihood that pre-abortion counselling is directive, despite the stipulations of the CTOP Act (Vincent, 2012). Globally, when research has been conducted on experiences of abortion counselling, womxn's and healthcare providers' experiences have been explored in separate studies. As a result, the divergences and convergences in the experiences of womxn and healthcare providers, interacting in the same abortion facility, constitute a gap in research on abortion experiences more generally, and abortion counselling experiences specifically. Lastly, while globally, research on abortion has yielded some information on how womxn generally speak about and experience interactions outside of the counselling session with healthcare providers, to my knowledge this has not formed part of the main problematics of research studies. Furthermore, where it is included in research, it has been limited to womxn-healthcare provider interactions. Thus, little is known about whether and how waiting room interactions between womxn and the healthcare providers and among womxn themselves shape how womxn and healthcare providers go on to experience the counselling interaction. These absences and the need (and desire) to fill them formed the rationale of the study.

An African feminist post-structural approach was used to theoretically frame the study. Post-structural work on power and discourse were then infused into a narrative-discursive approach to analyse womxn's and healthcare providers' interview data which were collected from three public hospitals in the Eastern Cape.

To answer the research questions of the study, the analytical work was divided into three chapters. In the first chapter (chapter 6), I analysed the discourses which were used as resources by participants in this study. To avoid repetition of the health service provider data (which was limited by comparison), I predominantly drew on womxn's interview data to illustrate the discourses used by participants. In chapter 7, I analysed how womxn used these discourses to construct micro-narratives of their experiences of pre-abortion counselling and waiting room interactions, highlighting the various forms of power referred to in the womxn's micro-narratives. In the previous chapter (chapter 8), I looked at the canonical narratives and discourses resourced by healthcare providers and then analysed how these were used to

construct accounts which described and justified certain counselling practices, highlighting how power operated in and through the practices thus described.

2. Convergences and divergences in womxn's micro-narratives and healthcare providers' accounts of PTOP healthcare experiences

For the most part, womxn and healthcare providers drew on the same discourses in their interview talk. Thus, moralisation discourses, a discourse of foetal personhood, an awfulisation of abortion discourse, a discourse of responsibilisation and pronatalist discourses were used to construct abortion in particular ways. Notably, womxn often attributed this kind of talk to healthcare providers in describing the information provided during the counselling and their experience of this information. However, womxn also sometimes took up these discourses themselves.

Through moralisation discourses, abortion was predominantly constructed as immoral, with some participants drawing on a religious discourse to construct it as sinful as well. Womxn were thus positioned as deviant and as committing a wrongful act while healthcare providers positioned themselves as saving womxn from abortion. Although both womxn and healthcare providers constructed abortion as shameful, there were notable differences in how this was done. For healthcare providers, the immorality of abortion was tied to some healthcare providers' expectations of the embodiment of shame where womxn were expected to be visibly ashamed of what they were about to do. When womxn did not act in this way, this was problematised in the healthcare providers' talk. Thus, womxn who were seen to be happy, calm, and free, and womxn who chatted with other womxn in the waiting room were positioned as especially abnormal, deviant and as exploiters of TOP services compared to womxn who did embody shame.

Demonstrating the force of abortion stigma, some womxn spoke about a shaming gaze wherein they felt that others were shaming them for having an abortion. The construction of abortion as shameful was also tied to the notion of an 'abortion culture' wherein having more than one abortion is evidence of a (problematic) permissibility around abortion. This was drawn upon by the healthcare providers while it was only invoked by womxn when speaking about their waiting room conversations. A foetal personhood discourse constructed the foetus as independent from the pregnant womxn and as a citizen endowed with rights which need to be both respected and foregrounded. In turn, womxn were positioned as mothers who need to nurture and protect the foetus. This discourse was often used in tandem with moralisation

discourses and/or religious discourses to construct abortion as the taking of a life and thus additionally position womxn as criminals.

Using an awfulisation of abortion discourse, abortion was constructed as risky, dangerous and harmful to both womxn and foetus. This positioned both womxn and the foetus as vulnerable and under threat and as needing to be saved from this threat. Notably, however, the construction of abortion as threatening to the foetus carried the implication of positioning womxn as a threat. The risks of abortion included a risk of contracting cancer, risk of infertility, as well as the certainty of mental or psychological ill-health. Womxn attributed this discourse to healthcare providers' information provision but also took up this discourse themselves. Notably, this discourse was used by the two qualified counsellors who volunteered at site 2, and was used particularly with reference to PAS.

Through a responsibilisation discourse, womxn were positioned, by healthcare providers and themselves, as needing to be held accountable and needing to accept responsibility for the decisions they make. As such, womxn were held accountable by themselves and healthcare providers for having an unintended pregnancy in the first place, but also for needing to protect the well-being of the foetus. Through liberal counselling practices, the decision to have an abortion was also framed by healthcare providers as a decision that womxn needed to make by themselves, that is, without undue influence from the healthcare provider or third-parties.

Pronatalist discourses that were drawn upon by the participants constructed parenthood as inevitable. One of the counsellors used pronatalist discourses to construct the glorification of parenthood where the challenges of parenthood were downplayed, and parenthood emerged as an overwhelmingly positive and exciting experience. Tied to this, children were constructed as intrinsically valuable and as providing meaning and purpose to their parents' lives. Interestingly, womxn did not deploy a glorification of parenthood discourse. Rather, womxn constructed parenthood as an imperative, with first-time pregnancy being simultaneously constructed as particularly obligatory and a special milestone to be cherished. Womxn's and healthcare providers' use of pronatalist discourses also belied the prioritisation of biological parenthood. Thus, for example, at site 3 womxn reported being asked how they would feel if they found out at a later point in their lives that they could not become pregnant due to the abortion they had previously. Indeed, the provision of information about the risk of infertility, and even interview questions around womxn's experience of receiving this kind of information,

belies this construction of parenthood as desirable and inevitable and belies the privileging of biological parenthood.

By drawing on a psychotherapeutic discourse, womxn conveyed certain expectations about what counselling is and what it is not, what the role of the counsellor is and what the purpose of the counselling should be. Thus, womxn described counselling as facilitating healing which required honesty and frankness on the part of the healthcare provider doing the counselling. This honesty and frankness was expected both in terms of providing factual information, such as the risks of abortion, which may be difficult to hear, as well as asking hard hitting questions which would encourage clients to connect genuinely and meaningfully with their emotions around the abortion decision. Thus, through this discourse, any distress, related to the information provided or the discussions had (as expressed by the womxn during interviews) was normalised as part and parcel of counselling and even necessary. Thus, the power relations operating in and through confessionary practices was demonstrated wherein healthcare providers could not be held accountable for any harm caused, being as it is part of the process and part of the role of the counsellor.

Healthcare providers also drew on the hero, career, and personal testimony canonical narratives as resources in their talk, mostly in accounting for being involved in abortion (counselling) service provision but also at other times as well. Through the hero narrative, which drew on a public health discourse, the two nurses constructed their involvement in abortion service provision as necessitated by the need to save womxn from the consequences of illegal abortion. Both highlighted how the dearth of others willing to provide this service meant that they were uniquely positioned to provide the service and that they had no choice but to provide the service, despite their own position on abortion which was either not addressed (in the case of Thembi who spoke of others' anti-abortion stance but was silent on her own stance) or took a religious framing where abortion was constructed as sinful (in the case of Sam). The two counsellors drew on a career narrative to frame the decision to provide abortion counselling as being in line with personal qualities (such as a love for working with and helping people) and/or a love for the NGO through which they volunteered. A personal testimony narrative was resourced by one counsellor whose own personal experience with an unintended pregnancy, where she had considered abortion but had decided to parent, was used to position her as qualified, relatable and empathic in her approach to counselling. It is important to note the different levels of involvement in abortion services among the participants. While the nurses conducted the abortion counselling and performed abortion procedures, the counsellors were

only involved in providing abortion counselling. This may explain the differences in their narratives around their motivation for being involved in TOP work.

Two of the healthcare providers also drew on a gendered discourse wherein differences between mxn and womxn were essentialised such that mxn are practical and logical in their abortion decision-making and womxn are emotional. This construction of femininity as grounded in emotionality was also extended to young womxn's sexual decisions being driven by emotions, in comparison to mxn who are driven by physiological needs, making womxn vulnerable to psychological insecurities and poor psychological development.

In terms of the narratives and accounts that womxn and healthcare providers constructed, there was general overlap in that both womxn and healthcare providers spoke about how the counselling was experienced as non-directive. For womxn, this was expressed in the micro-narratives of 'It was informative', 'I was guided', and 'The counselling was healing/beneficial'. However, these were often constructed alongside or intertwined with the micro-narratives of 'I was ready to say oh I'm cancelling/I have doubts', 'Adoption is not an option', 'I didn't have a choice' and 'I was so hurt'. Thus, the view that the counselling was satisfactory and non-directive was maintained even though womxn sometimes spoke about how the information they received around the risks of abortion, or the graphic detail used to describe the medical abortion process created conflict ('I was ready to say oh I'm cancelling/I have doubts') that could not be resolved because adoption was not an option that was available to them ('Adoption is not an option') and/or abortion was necessitated by their circumstances ('I didn't/don't have a choice'). This construction of the pre-abortion counselling as being non-directive also held even while womxn described the hurt they felt because of receiving information about foetal development which was provided alongside a foetal personhood discourse, and/or the hurt they felt around discussions of adoption as always already an option ('I was so hurt').

Notably, participants' accounts diverged in two important aspects. In the first, while womxn constructed adoption as a non-option by drawing on a maternal-foetal bond discourse in which continuing the pregnancy and placing the resultant child up for adoption was impossible to do, healthcare providers tended to construct adoption as an option that is always already there. I argued that this reveals assumptions that have been made in abortion counselling literature that pregnancy options may be objectively determined by the counsellor instead of viewing abortion decision-making as situated within the discursive, social and structural (economic and power relations) conditions of womxn's lives which then enable or constrain 'choices' and either open

up or foreclose 'options'. The second related to how some womxn constructed their abortion decision as arising out of a sense of compulsion in comparison to healthcare providers' understanding of abortion as one (albeit it irresponsible) choice out of three equally viable options.

As noted above, both healthcare providers and womxn constructed abortion counselling as non-directive. Thus, through liberal discourses, liberal counselling practices were described where healthcare providers emphasised (as reported by womxn and by healthcare providers during one-on-one interviews) womxn's choice and the need to facilitate and uphold that choice through information provision. Indeed, healthcare providers' accounts described how their role during the counselling was limited, within liberal counselling practices, to information provision only. In line with liberal counselling practices, counselling was seen as non-directive insofar as the information provided was factual and was delivered in a neutral, unemotive way. Thus, positivist notions of language as a reflection of an external reality and therefore knowledge as value-free were drawn upon, particularly by one healthcare provider. Importantly, however, the information that was provided during the counselling included the risks of abortion and (at site 2) information around foetal development which was constructed through moralisation discourses, pronatalist discourses and a discourse of responsibilisation. Furthermore, that womxn took up these discourses and did not challenge this information may be part and parcel of not only the power relations that generally operate with the clinic space as a site of power (where healthcare providers' language use has the weight of scientific truth and fact) but also of liberal counselling practices where healthcare providers are positioned as educators and womxn as in need of education in order for womxn to be able to make a responsible decision.

Part of the liberal counselling practices that were described by healthcare providers was the exclusion of third-parties during the counselling as they would unduly influence womxn's abortion decisions. Excluding third-parties was also justified through recourse to liberal discourses where womxn were positioned as needing to take responsibility for their decision and thus attend the counselling unaccompanied. One healthcare provider acknowledged the challenge of maintaining liberal counselling practices in a resource-strained environment. Thus, she explained how the fragmentation of the services at site 1 meant that social workers, who were no longer at the facility at the time of data collection, were responsible for providing information on adoption while the nurses concentrated on abortion. I noted how in the absence of the social workers, the nurses' focus on abortion created some conversational trouble in the

implication that womxn in fact were not being given the full extent of information around their options, in other words that liberal counselling practices were being compromised. I also noted, however, that several womxn had found discussions around adoption to be distressing and/or emotionally difficult.

Pastoral counselling practices were also described by healthcare providers wherein they positioned themselves as guiding womxn on the correct path. Within this relation of power, healthcare providers, most notably the counsellors, had a duty to direct womxn towards continuing with their pregnancies. This was framed as being based on a concern for womxn's (and the foetus') well-being. The limits of pastoral counselling were acknowledged, however. As such, counsellors spoke about how information around the practical assistance offered by the NGO (such as nappies, food vouchers, clothes etc) and the fatal consequences of backstreet abortion was a necessary and justified tactic, within pastoral counselling practices, to guide womxn who were particularly stubborn in not heeding advice. Furthermore, these tactics were not constructed as manipulative but as necessary information that would assist womxn in making a responsible decision.

Womxn themselves referred to pastoral relations of power in the micro-narrative of 'I was guided'. Here, womxn spoke about being responsibilised by the healthcare provider to see the error of their ways in not preventing their unintended pregnancy. Within pastoral relations of power, however, womxn responsibilised themselves as having failed to prevent their pregnancies and positioned the healthcare provider as rightfully guiding them towards the correct path. As discussed in chapter 6, another example of this guidance was where one participant spoke about how during and as a result of the counselling she realised that abortion was harmful, risky and was therefore an unwise decision and subsequently changed her mind.

As discussed in the analysis chapters, sovereign/authoritarian relations of power between healthcare providers and womxn/clients were also referred to by both womxn and health service providers, although infrequently. In womxn's interview data, this was addressed in micro-narratives around waiting room interactions. Thus, in a micro-narrative of 'They are not the kindest people', constructed by a minority of womxn, one participant discussed how healthcare providers' show of authority, through needless shouting, resulted in fear around what healthcare providers would do next.

Healthcare provides' own accounts of sovereign/authoritarian counselling practices included talk on how LARCs were necessarily pushed onto womxn to minimise the prevalence of

unintended pregnancies and future abortions, which were both constructed as problematic. Gate-keeping tactics, where one healthcare provider described how determining womxn's medical/health fitness or unfitness for abortion necessarily formed part of abortion counselling practices, also referred to authoritarian power relations. These were justified through the construction of abortion as risky and potentially dangerous, even when conducted in a healthcare setting, and through a holistic health model where healthcare providers are required to attend to all of womxn's health needs, some of which (such as HIV, asthma, and high blood pressure) may exacerbate abortion complications and thus compromise womxn's fitness for abortion procedures. In relation to this, I noted how the likelihood that these health issues could equally problematise taking a pregnancy to term was not addressed.

3. Pre-abortion counselling practices that were described and constructed/accounted for by participants

In their micro-narratives and accounts of their experiences, participants described several pre-abortion counselling practices: information-giving practices, consent practices, administering of LARCs, implementation of a waiting period and third-party (non-)involvement in the counselling. These will be addressed here. Practices which have been suggested in the literature on abortion counselling but were absent in participants" talk will also be discussed.

Information-giving practices and consent practices were a dominant feature in participants' talk. Information-giving practices centred on unconfirmed and over-stated risks around abortion (infertility, cancer and psychological trauma), procedural information, foetal development information, and information around contraception. Information on the risks of abortion were accounted for by healthcare providers through positivist notions where factual information is seen as neutral and unharmful. Through a hero narrative, which was also relied upon to justify providing this kind of information, healthcare providers positioned both womxn and the foetus as in need of saving, thus necessitating this information. Graphic detail around the medical abortion procedure was accounted for by healthcare providers as necessary to reduce womxn's anxiety and thereby enable adequate self-preparation, and to save womxn and foetuses from abortion (in the case of the counsellors). The counsellors described information around foetal development as necessary to save the foetus by conscientising the pregnant womxn to the life for which she is responsible. Although womxn described this information as shocking, they also described it as educational. I argued that their responses suggest that the 'truth' of this information, and therefore the necessity of providing it, were taken-for-granted within the power relations that exist between healthcare provider and client. The provision of

information around contraception was constructed by womxn and one healthcare provider (Thembi, site 1) as useful and necessary for its educational value. Lastly, visual tactics also formed part of the information-giving practices that were described. Thus, the use of foetal models was justified by one healthcare provider (Heather, site 2) based on the accuracy of the models and the need to persuade womxn against abortion and in doing so save them and their foetuses. One womxn (Mpho, site 2) described the use of a photo depicting an aborted foetus and constructed this as necessary, despite its potentially traumatising effects. And Sbongiseni (site 2) described how detailed pictures describing the abortion procedure, which were posted on the walls of the waiting room, caused her distress and contributed to her decision to continue with pregnancy instead.

Significantly, the information-giving practices described by participants were not framed as being part of the consent practices that take place during counselling. In other words, womxn were not given the choice to opt in or out of receiving this information. From womxn and healthcare providers' interview talk, consent practices therefore centred exclusively on the decision of whether to go ahead with TOP or continue with the pregnancy. In line with liberal forms of government, healthcare providers spoke about how liberal counselling meant leaving this decision to womxn themselves. Womxn echoed this in their micro-narratives. However, participants' interview talk suggests that this decision (of whether to continue or terminate the pregnancy) was framed in such a way as to make abortion the irresponsible (because harmful) choice.

The coercive administering of LARCs to be taken post-abortion procedure was described and accounted for by one healthcare provider. Thembi justified this practice by speaking to the need to prevent future unintended pregnancies and future abuse of TOP services. Thembi also described parental involvement in the contraceptive part of the counselling. The decision to involve parents was made by Thembi and was justified through the need to bring the parent to account for their child's pregnancy and through the need to prevent repercussions that may arise from the parent not having been informed of the LARC that was administered.

At site 1, a waiting period was described by two womxn (Lisa and Zimkhitha) and the healthcare provider (Thembi) as having been implemented to get womxn to reconsider their decision to have an abortion. Lisa and Zimkhitha described this practice as centring on the healthcare providers' concern for womxn's mental health while Thembi justified this practice

based on an understanding that the purpose of pre-abortion counselling is to prevent future abortions.

Lastly, management of third-party (non-)involvement in the counselling was described by healthcare providers. The exclusion of third-parties was justified by Sam (site 3) as facilitating womxn's decision-making and enabling Sam's own effective communication with her clients, while Thembi justified this through a need to focus on and prioritise the client herself. Exceptions to this rule of exclusion were justified by Sam only in the event where including a third-party would enable effective communication. In contrast to Thembi and Sam, Heather and Chanelle encouraged the inclusion of the client's partner as this tended to lead to a decision against terminating the pregnancy.

3.1. Absent practices

Moore et al. (2011) argue that womxn's varying experiences of abortion counselling (that not all womxn need abortion counselling and that among those who do express a need for it, their needs differ) means that pre-abortion counselling should be voluntary and should be tailored to each womxn for those womxn who do request it. The results of their study, and work by Joffe (2013), suggest that counselling should differ in terms of the information and support that is provided to womxn. For example, while some womxn may want to have a discussion on the options available to them (referred to as 'options counselling'), many womxn arrive at an abortion facility already decided. Womxn who have already decided, therefore, do not have a need for options counselling and may just need procedural information. Some womxn may want support in the form of a reassurance that their decision is the right one (Moore et al., 2011). Brown's (2013) study suggests that some womxn may want to discuss the support that is available to them or not while other womxn may want emotional support after their procedure.

While healthcare providers in the present study spoke of liberal counselling practices which tailor information-giving practices to individual womxn based on womxn's health concerns and the circumstances of their pregnancy, participants did not describe receiving options relating to the provision of different kinds of information. Indeed, as already mentioned, consent practices revolved around the decision to continue with or terminate the pregnancy. Relatedly, although counselling should be voluntary according to the CTOP Act, womxn were not always made aware of this.

Ely (2007) and Joffe (2013) describe how an important practice in abortion counselling revolves around the normalisation of abortion by the healthcare provider, which is necessary to counter the guilt and remorse that womxn may feel *because of* the stigma around abortion and dominant constructions of abortion. Notably, in the present study participants' talk points to an absence of this practice. Instead, womxn and healthcare providers describe health service providers' problematisation of abortion.

4. Challenging normative discourses and power relations

As discussed in the theory chapter (chapter 2), an African feminist post-structural perspective calls for representations of the experiences of African people which acknowledge the complexities and variability of these experiences. It also calls for an attention to and a documentation of the small acts of resistances which African womxn may enact (Chilisa & Ntseane, 2010). In the present study, three small acts of resistance were noted.

In the first, some participants challenged normative discourses around the immorality and shame of abortion. Thus, one healthcare provider normalised and rationalised womxn's embodiment of happiness which I argued is significant in going against the normative expectation that womxn should not only feel sad and ashamed but should visibly embody this before, during and after having an abortion. Related to this, and equally important, was that some womxn constructed a micro-narrative of 'We were chatting/sharing stories' in which womxn described how their experiences of being together in the waiting room, sharing their stories about abortion, and feeling comfort, solace and strength because of these discussions, led to a normalisation of abortion where it was lowered to the level of the everyday. In discussing this micro-narrative, I noted how it started to challenge dominant constructions which problematise abortion. Importantly, for some womxn these conversations provided a counter discourse to the awfulisation of abortion, moralisation and pronatalist discourses drawn upon by healthcare providers in their counselling practices. To the extent that womxn also took up these discourses during interviews, experiences of these waiting room conversations may also have enabled womxn to not only begin to view abortion differently, but also may have mitigated against the shame, guilt, and emotional difficulty experienced by some of the womxn in the present study. This micro-narrative, then, underscores the need for spaces, like waiting rooms in abortion clinics but also public spaces, to be created so that discussions about abortion can take place openly. Clearly, the creation of these discussion spaces is necessary for the disruption of normative constructions around abortion. A micro-narrative of 'We were chatting/sharing stories' also underscores how dominant constructions of abortion play a

significant role in producing emotional difficulty (Kimport et al., 2011) and that the creation of discussion spaces may work to mitigate or alleviate these experiences, indeed, may work to enable entirely different experiences of abortion.

In what I argued was another small act of resistance, I noted how some womxn constructed a micro-narrative of 'Adoption is not an option'. Within this micro-narrative, womxn not only constructed adoption as a non-option, but also expressed frustration and disagreement with healthcare providers' construction of adoption as always already an option. The construction of this micro-narrative reveals how approaches to abortion counselling which presuppose that womxn need to be told or need to discuss their options with a healthcare provider may reproduce macro-level power relations which, as Foucault discusses, discard the knowledges that emanate from lay spaces while investing power and authority in academia and various 'expert' spaces. In other words, such approaches to counselling invisibilise how womxn may be experts of their own circumstances and may be best able to determine not only what their options may be, but also to determine what their informational needs are.

In the third instance, I argued that within a context of abortion stigma and provider opposition to performing abortions, Thembi and Sam's use of a hero narrative to construct an account of why and how they became involved in abortion work could be seen as a counter-narrative. By challenging the narrative in which *not* providing abortions is normalised and is constructed as moral, Thembi and Sam's involvement in abortion work and their re-construction of abortion work as moral work (that is, in saving the lives of womxn) is a small act of resistance.

5. An African feminist post-structural approach and narrative-discursive analysis

The findings discussed above (in the previous two sections) demonstrate the usefulness and potency of an African feminist post-structural approach used alongside a narrative-discursive analysis. An African feminist post-structural approach has enabled an understanding of the discourses and relations of power that frame and underpin pre-abortion counselling practices and participants' experiences thereof. By using this theoretical approach, the socio-culturally constructed/constituted nature of pre-abortion counselling practices and experiences of these practices has been shown up. In other words, this approach has made it possible to see that PTOP counselling is a social product, the naturalness of which is often taken for granted, and can therefore be produced differently. Like any other social practice, pre-abortion counselling is subject to change and indeed should be transformed when it does not serve those whom it is

meant to serve. This understanding of the situatedness of pre-abortion counselling and experiences thereof might otherwise not have been enabled through other approaches.

Integrating post-structural work on power and discourse with a narrative-discursive approach has visibilised how power operates. This has been made possible by a focus on individuals' (micro-)narrative construction. By exploring participants' narrative construction, the intersection between the social and the personal has been illuminated. That is, how the social acts upon individuals (through canonical narratives and discourses which constrain ways for thinking about social practices and limit opportunities for socially desirable subject positioning) as well as how individuals act upon the social (by purposefully drawing upon particular discourses and narratives to position themselves in particular ways and/or to account for their actions in particular ways) was made visible. Furthermore, an extended narrative-discursive approach has made visible ways of thinking about and experiencing pre-abortion counselling (as well as abortion decision-making and abortion more generally) which go against dominant understandings and has thus illuminated the divergences and convergences in participants' narrated experiences.

An African feminist post-structural approach demands a rethinking of what we understand about gendered and raced experiences. From this study, which adopted an African feminist post-structural approach, we see the variability and complexity of clients' and healthcare providers' experiences of accessing and providing abortion services. Starting from womxn's experiences, as opposed to predetermining an essence of experience, has enabled an understanding of abortion as an important part of reproductive decision-making in the Eastern Cape province of South Africa, the country and possibly the continent. Participants' varied and sometimes contradictory constructions of abortion, and the effects of these constructions when taken up in abortion counselling services, is important to highlight. This particular aspect of the analysis of womxn's and healthcare workers' interview data means that homogenised understandings, not only of gendered and raced experiences generally but also of abortion as it is practised in South Africa, need to be eschewed. By keeping the signifiers 'African' and 'womxn' open and unstable, we can make room for African feminisms which acknowledge the gendered systems which impose expectations of mothernormativity (Tamale, 2006) and stigmatise abortion, whilst also allowing room for both mothering and abortion to be part of (sometimes in interrelated ways) and absent in womxn's reproductive decision-making. The findings of this study mean that the work of feminist, particularly reproductive justice, activists living and working in South Africa needs to include ways of challenging raced, cultural and

gendered assumptions about womxnhood, motherhood and abortion if barriers to abortion access are to be eliminated, the CTOP Act is to be fully implemented, and womxn's reproductive autonomy is to be guaranteed. Participants' own descriptions of the circumstances that occasioned abortion means that we need to create the conditions necessary for abortion to be a viable and legitimate option in reproductive decision-making, whilst simultaneously understanding how inequitable gendered power relations may mean that abortion becomes a necessary means for womxn's reproductive autonomy, and that working towards the elimination of inequitable gendered power relations is necessary to enhance this reproductive autonomy.

6. Implications for TOP counselling service provision

Despite using the language of liberal discourses which emphasise 'choice' and individual decision-making, and which limit healthcare providers' role to information provision, pre-abortion counselling (as described by participants in this study) was pervasively ideological and therefore directive in two main ways. Firstly, healthcare providers' use of coercive practices to get womxn to take up LARCs post-abortion is directive in that neither womxn nor healthcare providers described that these discussions took place in a context of choice. In other words, while liberal discourses framed abortion as choice, albeit an illegitimate choice, not taking up contraceptives (LARCs in particular) was not framed as a decision that womxn *could* make. Secondly, even though the decision to have abortion was framed within liberal discourses which emphasise 'choice', the awfulisation of abortion, which includes information around the risks of abortion, information around foetal development, and the use of moralisation and pronatalist discourses, and a liberal discourse of responsibilisation all work together to undermine abortion as a legitimate, responsible and appropriate choice.

In relation to this, it is important to note that womxn narrated that the counselling was experienced as non-directive. This cannot be dismissed or ignored, as to do so would be to discard womxn's voices by privileging that of the researcher who alone 'knows' and who alone is an authority on womxn's experiences. Therefore, womxn's descriptions of pre-abortion counselling as non-directive must be understood, I argue, firstly within a context in which womxn also described distress, hurt/pain, and unresolvable conflict in response to the information they received around the so-called risks of abortion, the construction of adoption as a simple solution, information around foetal development, and graphic descriptions of the medical abortion procedure which was described by the healthcare providers as similar to birth.

Secondly, descriptions of non-directive counselling must be situated within the clinic as a site of power wherein TOP healthcare providers' language use is accorded the weight of scientific authority and truth (for example, risk around abortion and the awfulisation of abortion are likely to be taken as truth, not discourse) which closes down the possibility of challenging these 'truths'. Relatedly, Foucault (1976) in *The Birth of the clinic*, shows how these power relations within the clinic relate to how healthcare providers are invested with the authority, and are expected to carry out the obligation of safe-guarding the well-being of society. This well-being not only refers to the health of the population. It also refers to morality and socially constructed ideas around normative sexuality where, in the present study, unintended pregnancy and abortion were constructed as problematic. As Feltham-King (2016) notes, these all form part of the visible field of the clinic. Thus, as a guardian of people's well-being, the healthcare provider is also caught up and produced within power relations where they must act in womxn's best interests, whether by providing information (including the 'risks' of abortion) through liberal forms of government, morally guiding womxn on what is wrong or right through warning and shaming tactics (for example) described in pastoral power relations, or using force, coercion or gate-keeping tactics associated with the exercise of authoritarian power. Through the exercise of these formations of power, in which healthcare providers are also produced, womxn are thus incited to know, master and care for the self to be responsible, sexual subjects. And as this study shows, the responsible sexual subject knows what led to an abortion request to avoid making the same mistake, avoids unintended pregnancies by using contraception consistently and effectively, either parents or places the resultant child up for adoption in the event of an unintended pregnancy and, in the case of adolescent womxn, has sex with only one partner or does not have sex at all to protect themselves from psychological insecurities.

The micro-narrative of 'I was hurt' where some womxn spoke about the hurt they experienced in relation to receiving information about the risks of abortion and/or foetal development point to how counselling may produce harm or distress instead of mediating or preventing it. It points to the importance of excluding inaccurate information, such as the over-stated risks of abortion. I, along with my colleagues (Mavuso et al., 2017), have thus recommended that the 'standardised' part of abortion counselling should be limited to: the abortion methods available from which womxn may choose (if more than one is available), the side effects and complications associated with each method, the duration of the abortion, pain management recommended/provided by the healthcare staff, and follow-up and referrals if necessary.

Because womxn's and healthcare providers' accounts suggested that womxn generally did not have a choice in what kinds of information they were provided with, a micro-narrative of 'I was hurt' also points to the need for the voluntariness of abortion counselling (as stipulated in the CTOP Act) to be emphasised by healthcare providers so that abortion counselling *is* voluntary. Given how pre-abortion counselling may affect womxn in negative ways, mandatory counselling is certainly undesirable (Brown, 2013). Echoing Moore et al.'s (2011) argument for a 'cafeteria style approach' and Birdsey et al.'s (2016) call for client-centred counselling, a model of abortion counselling that is responsive to womxn's narratives of their lives should be developed. To do so, different kinds of counselling should be made available to womxn: decision-making counselling (for womxn who have not yet decided and would like assistance in talking through their options such as they may be), procedural counselling (where womxn can elect to hear more details about the procedure), and pre- and post-procedural counselling (where womxn may get emotional support prior to or after their procedure) (Mavuso et al., 2017).

In the introductory chapter I noted how the CTOP Act, as well as policy documents produced by the Western Cape Department of Health and Ipas, construct abortion as problematic, provisionally acceptable and in need of regulation (by referencing 'abortion culture'), and construct unintended pregnancy as a problem which may not be appropriately solved through TOP. In other words, while stipulating that counselling must be non-directive, directive counselling is in fact not only enabled but is justified by and through these documents when unintended pregnancy and abortion are problematised and pre-abortion counselling is legislated on this premise. Thus, while womxn's right to reproductive decision-making is enshrined in the CTOP Act, this is undermined, which is particularly problematic given that for some womxn, abortion decisions already take place in discursive, social and structural conditions which undermine reproductive freedom.

Also noted in the introductory chapter was how one of the activities that was included in the Values Clarification Workshops organised by Ipas reinforced the construction of abortion as provisionally acceptable. This is worrying as these workshops were intended to improve access to abortion services by transforming provider attitudes to abortion.

Considering this, for counselling to be non-directive, abortion needs to be re-imagined as an appropriate way to resolve or regulate a pregnancy: it needs to be normalised as a common practice and discursive room needs to be created to allow abortion to be understood as a

legitimate option that womxn may want or choose *and* as something that may be dictated by womxn's circumstances. Unintended pregnancy should also be normalised on the basis that unintended pregnancies, including those that are continued to birth, are quite common with one out of two to three pregnancies being classified as unintended each year (Macleod, 2015). Furthermore, post-structural approaches to language and social practices should be applied to the pre-abortion counselling context to interrogate and make visible the socio-cultural nature of the content of pre-abortion counselling. When applied, the effects of using particular discourses, such as foetal personhood which positions womxn as already mothers, for example, will be made visible. In this way, notions of harm will be broadened to enable an understanding of the effect, intended or not, of providing information and of using language in particular ways. This will then enable counselling practices which prioritise and defer to womxn's own language use. Ultimately, critical attention to the content of pre-abortion counselling and *how* that content is relayed will be made possible as a result. These re-constructions should then be used to inform TOP legislation and policy documents, values clarification workshops and healthcare provider training around pre-abortion counselling. Indeed, Ely (2007) recommends that feminist counselling philosophies, which emphasis the normalisation of abortion, should underpin abortion counselling practices.

7. The absence of a reproductive rights discourse

Mazzei (2004) speaks about how silences that occur within data may be just as significant as what is spoken and thus deserves the researcher's consideration. As noted in chapters 5 and 7, there was a general silence around a reproductive rights discourse. In womxn's data, this silence was audible where womxn spoke about having to provide, during the counselling, a reason/reasons for their abortion decision. Not one womxn drew on a reproductive rights discourse to justify her decision. Instead, a few womxn constructed a micro-narrative of 'I didn't/don't have a choice' in which the decision to have an abortion was dictated by the womxn's circumstances. I suggested in chapter 5 that this micro-narrative reflects the dominant understanding of the awfulisation of abortion where abortion is constructed as a difficult decision that womxn are compelled to make. As such, it provides womxn with a positive subject positioning during the counselling while serving to construct the decision as *justified* as opposed to unnecessary. Indeed, one participant spoke about feeling that she needed to produce a valid reason.

In comparison, a reproductive rights discourse might have been perceived, by the womxn, as a challenge to the healthcare providers' authority. It is certainly possible that healthcare providers

might have perceived it this way had womxn taken up this discourse in the counselling session. It also is limited in that using such a discourse presumes 'choice' and does not enable an acknowledgment of the circumstances and conditions of womxn's lives which enable or constrain choice. It is also possible, however, that the silence around this discourse, at least in the womxn's data, may point to a lack of awareness that accessing abortion services is in fact a right that cannot be denied or obstructed by healthcare providers (for example, through gate-keeping tactics). In other words, that womxn *were* accessing abortion services cannot be seen as an indication of their awareness of this right, particularly as several womxn spoke about hearing informally from friends and people in their communities about where to access an abortion. Certainly, research by Macleod et al. (2014) conducted in the Buffalo City district suggest that knowledge of the CTOP Act is poor due to a lack of government-led advertising around abortion legislation and available services.

Notably, this silence around a reproductive rights discourse was also audible in healthcare providers' accounts of their motivations to become involved in abortion work. This is an interesting finding as other research conducted in South Africa has shown how healthcare providers have drawn on this discourse in this way (see Potgieter & Andrews, 2004). As discussed in chapter 7, nurses drew on a public health discourse and hero narrative to construct their involvement in abortion work as necessary to save lives lost to illegal abortion, while counsellors drew on career narratives which highlighted their counselling qualifications, personal qualities and love for the organisation as reasons for doing abortion counselling. Given that one nurse was silent around her own position on abortion and the remaining three healthcare providers all identified as religious and therefore against abortion, the absence of a rights discourse in justifying abortion service provision may be linked to the trouble it might have presented in the healthcare providers' discursive work. In other words, grounding their abortion service provision in the need to uphold womxn's right to access abortion services may have meant risking being positioned as 'pro-choice' which is stigmatised in a discursive climate of abortion stigma and which would go against their own explicit and implicit reflexive positioning.

In these ways, it appears that while a reproductive rights framework is useful for the advancement of liberal abortion legislation in democratic countries, and while it is necessary for abortion services to be made available, it may be of little use in womxn's negotiations within the interactive space of abortion services but also in terms of how healthcare providers who are against abortion may make sense of their involvement in abortion service provision. Given that

the absence of a reproductive rights discourse was noted in research on abortion decision-making conducted in South Africa (Mavuso, 2015) and Zimbabwe (Chiweshe, 2016), it would appear that a reproductive rights discourse has little traction.

8. The presence of 'I didn't/don't have a choice' micro-narrative

Given that this study did not focus on womxn's abortion decision-making, as my previous research did (see Mavuso, 2015), I did not expect even a minority of womxn to construct a micro-narrative accounting for and justifying the decision to have an abortion. While I was aware that womxn may nevertheless be called upon during the counselling to do this kind of work, and while I expected that womxn may, during their interviews with me and other interviewers, refer to having been asked to provide reasons, I did not expect womxn to feel compelled to do that kind of justificatory labour within the interview itself.

That womxn did so may reflect two things. Firstly, data were collected at the hospitals, where womxn had already been asked by healthcare workers to provide their reasons for abortion; this may have occasioned such a micro-narrative. Certainly, it is possible that womxn may have associated me and the other interviewers with the hospital and with the hospital staff, making this kind of work appear necessary. Secondly, as womxn themselves took up moralisation discourses around abortion, a micro-narrative of 'I didn't/don't have a choice' may reflect the discursive climate wherein abortion is highly stigmatised in South Africa. The result of this stigma may be that womxn are required to perform this justificatory labour and thus position themselves as unaccountable for the abortion, arising as it does out of a sense of compulsion as opposed to choice. This narrative of compulsion consequently enabled womxn to position themselves as less deviant and their abortion as acceptable.

9. Limitations of the study and recommendations for future research

As noted in the methodology chapter, 30 womxn and 4 healthcare providers were recruited in the study. While saturation of the data was reached in terms of the womxn's interview data, saturation was not possible regarding the healthcare providers' data because abortion services in the public healthcare system are often strained with few providers being responsible for running and maintaining the services. For example, at site 3, Sam was the only one working in the Womxn's clinic and at site 2, there were two nurses responsible for running the services, with the qualified counsellors doing the options counselling part of the services. Thus, despite the relative diversity in the 4 healthcare providers work experience, profession and in their

interview data, the low number of healthcare providers meant that comparative work across their interview data was limited, which is why the data were not analysed for the construction of micro-narratives. As shown in my analysis of the womxn's data in chapter 6, this kind of analysis enables the visibilisation of the kind of narratives that can be told and the various ways in which discursive resources can be put to work. Given that these low numbers of healthcare providers could not be avoided at the three sites visited, only visiting three sites proved to be somewhat of a limitation. As noted in the methodology chapter, however, to recruit from more than three facilities would have meant that data collected would have needed to take place over a much longer period to allow for the long process of approaching hospitals and requesting permission.

The finding that the content of the counselling (that is, information provision) and decision-making procedures (around contraceptives and pregnancy options discussions) were directive despite the language of 'choice' reportedly used during the counselling and that was used during interviews is problematic and goes against, while also being enabled by, the CTOP Act. This, along with the variability across sites in terms of the inclusion of foetal development information (at site 2 this was included whereas at sites 1 and 3 it was not) necessitates further research like this study, that should be conducted in each of the provinces to get a picture of the discursive and counselling practices that are carried out. From these data, it would be possible to get a sense of whether non-directive counselling is being conducted and how this is achieved, at least from the narrated experiences of womxn and healthcare providers. It would also be important to get a sense of whether other abortion facilities have an agreement with NGOs who are then responsible for conducting the 'options' counselling and what kind of discursive practices are employed therein. Relatedly, and noting the silence around a reproductive rights discourse in participants' interview data in the present study, future research conducted in other provinces could provide an idea of whether and how a reproductive rights discourse is useful for womxn accessing abortion services. Future research might also enable an understanding of when and how healthcare providers account for their involvement in abortion service provision using a reproductive rights discourse.

As stated in the methodology chapter, this study formed part of a larger study of which the South African component compromised of one other study in which recordings of the pre-abortion counselling sessions were obtained and analysed. The preliminary findings of the partner project mirror the accounts provided by participants in this study of the counselling practices engaged in. Thus, in addition to studies being conducted in other provinces on

womxn's and healthcare providers' narrated experiences of pre-abortion counselling, it would be useful for studies which seek to analyse recordings of the actual pre-abortion counselling sessions to also be conducted in different parts of the country.

In addition to the presented study being limited by recruiting from Eastern Cape hospitals, the study also only focused on public healthcare abortion facilities. While this was important to do as most of the South African population accesses these services, similar research that is instead conducted in the private sector in the Eastern Cape and in other provinces would allow for comparative analysis.

Given that one of the implications of the present study was that abortion and unintended pregnancy need to be re-imagined and that this should then inform healthcare provider training on pre-abortion counselling, research documenting what training currently takes place and whether this is uniform across the provinces would be vital. Such research would enable an understanding of whether the training, in its current format, replicates the problematisation of abortion and unintended pregnancy or departs from this. From this a judgment can be made about whether the training needs to be changed. Relatedly, research investigating the content of Values Clarification Workshops is necessary to determine the extent to which changes need to be made to reflect a re-imagination of abortion and unintended pregnancy, and in turn, a re-imagination of pre-abortion counselling in the South African context.

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Appendix 1: Womxn's interview schedule

1. Tell me as much as you want to about how the counselling went and anything else you feel is important. Begin wherever you want to.
2. a). What, if any, were your expectations of the counselling?
   b). How did these compare to what happened?
3. What was your experience of how information was provided during the counselling?
4. What was your experience concerning discussions on options about the pregnancy?
5. a). What aspects, if any, of your life did you discuss with the health service provider?
   b). How was that for you?
6. a). In the counselling, were there things that you wanted to say or ask about but did not?
   b). What were your reasons?
7. Tell me about your experience of being in the waiting room and anything else you want to say. Begin wherever you want.
8. What was your experience of interacting with the health service providers and other womxn while you were there?
9. While in the waiting room I observed [description of interactions between health service providers and womxn specific to each facility]. What were your own experiences?
10. What would you tell a friend about coming to the TOP clinic?
11. Is there anything else you want to add?

Translated questions:

1. Ngicela ukuthi ungitshele yonk' into oyifunayo nge-counselling: ihambe kanjani futhi noma yini ebalulekile kuwe. Qala noma kuphi.
2. a). Phambili yokufika la ekliniki, bowucabanga ukuthi icounselling ibezuhamba kanjani?
   b). Le nto oyicanbangayo iyafana na nendlela icounselling ihambe ngayo?
3. Indlela unesi wakhetha ukunika i-information phakathi kwe-counselling ikuphathe kanjani?
4. Indlela yokukhuluma ngama-options ikuphathe kanjani?

5. a). Ukhulumile kanjani ngempilo yakho?
6. b). Ikuphathe kanjani yokukhuluma ngezizinto?
7. a). Bezikhona izinto ozungafuni ukukhuluma ngazo, noma imibuzo oyignafuni ukubuza phakhathi kwe-counselling?
   b). Ngitshele ngezizathu zakho.
8. Ngitshele ukuthi ukulinda e-waiting room ikuphathe kanjani futhi noma yini ebalulekile kuwe. Qala noma kuphi.
9. Kubenjani ukuba nabanye abantu wesifazane futhi nokuhlangana/khuluma namanesi lapha e-waiting room?
10. Mina ngesikhathi ngaya e-waiting room ngibonile ukuthi [description of interactions between health service providers and womxn specific to each facility]. Kwenzenjani mawulinda laphaya?
11. Uma utshela umngani ngokuza kwakho ekliniki, uzomtshela ini?
12. Ikhona enye into oyifuna ukukhuluma ngayo na?

Appendix 2: Healthcare providers' interview schedule

1. a). How long have you been working in TOP?
   b). What is it that motivated you to do this kind of work?
2. Tell me as much as you want to about your experience of providing counselling and anything else you feel is important. Begin wherever you want to.
3. What do you see as the purpose of the counselling?
4. In your view, what is your role in the counselling?
5. a). What kinds of information do you normally provide during counselling?
   b). Under what circumstances, if any, might the information be different?
6. a). Does it make a difference to your experience of counselling if there is a third party (the womxn's relative, partner, friend etc.) present?
   b). In what way?
7. a). Are different resolution of pregnancy options something that you would discuss in these sessions? Why is this?
   b). How would you initiate these kinds of discussions?
8. Tell me about examples of counselling sessions that stand out for you.
9. Tell me about your experience of the waiting room dynamics between health service providers and womxn. Begin wherever you want to.

Question for short reflection discussion:

1. a). Which, if any, consultations over the past two days stood out for you?
   b). What were the challenges?
   c). What aspects of the counselling went well?

Translated questions:

1. a). Uyenza lo msebenzi ngesikhathi engkakanana?
   b). Ngitshele ngezizathu zakho zokuyenza lomsebenzi?
2. Manje ngicela ukuthi ungitshele yonk' into oyifunayo nge-counselling: ihambe kanjani futhi noma yini ebalulekile kuwe. Qala noma kuphi.
3. Ucanbanga ukuthi yingani i-abortion counselling iyenzekwa?
4. Ucabanga ukuthi yini umsebenzi wakho phakathi kwe-counselling?
5. a). Ngitshele nge-information oyinikayo phakathi kwe-counselling?
   b). Yini isimo ezoshintsha i-information oyinikayo?
6. a). Indlela yokuyenz' i-counselling iyashintsha na uma kukhona omunye omuntu? Ngicabanga manje ngomndeni, noma umngani noma isithandwa.
   b). Ishintsha kanjani?

7. a). Phakathi kwe-counselling ukhuluma ngezindlela ezihlukene zokulungisa isimo so-pregnancy? Yingani?
   b). Mawukhuluma ngezindlela, uqala kanjani?
8. Ngitshele ngesibonelo nge-counselling.
9. Ngitshele ngezizinto ozibonayo phakathi kwamanesi nababantu wesifazane e-waiting room. Qala noma kuphi.
10. Kukhona enye into oyifuna ukukhuluma ngayo na?

Question for short reflection discussion:

11. a). Kukhona ama-consultations ungangitshela ngayo?
    b). Yini izinto ezihambeke kanzima?
    c). Yini izinto ezihambeke kahle?

Appendix 3: Womxn participants' consent form

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[Date]

Dear service user/ *Msebenzisi wenkonzo obekekileyo*

I am Jabulile Mavuso from Rhodes University. I form part of a research team interested in exploring how pre-termination of pregnancy consultations are conducted in Termination of Pregnancy clinics in South Africa. This study is important in terms of helping us understand these sessions better and in terms of improving these services. Permission to conduct this research has been obtained from the Eastern Cape Department of Health and [insert hospital name].

Ndingu Jabulile Mavuso osuka e-Rhodes University. Ndingomnye wabantu abanomdla wokuphanda ngendlela i-counselling yenziwa ngayo phambi kokuba umntu akhuphe isisu kwikliniki apha eMzantsi Afrika. Oluphando lubalulekile ngoba lusinceda sazi ngcono ngecounselling kwaye sifumane iindlela zokunyusa izinga lwenkonzo yempilo. Igunya lokwenza oluphando silufumene kwisebe Lwezempilo lase-Mpuma Koloni Dora Nginza Hospital.

I invite you to participate in this study. If you agree to participate in the study your participation would involve the following:

1. Allowing us to audio or video record the consultation session; and/or
2. Speaking to us about your experience of the consultation session. If you prefer to participate in only **one** of these, this is fine.

Ndiyakumema ukuba uthathe inxaxheba koluphando. Ukuba uthe wavuma ukuthatha inxaxheba kulophando, inxaxheba yakho izawuquka oku kulandelayo, ukuba:

1. *Imvume yokuba sishicilele] i-counselling sisebenzisa iteyipi rekhodi okanye i-video rekhodi; kwaye*
2. *Usixelele ngamava akho nge-counselling.*

Ukuba ukhetha ukwenze into ibenye, kulungile.

This is how the research will work:

1. The pre-termination of pregnancy consultation that you will have with the health service provider will either be audio or video (including audio) recorded. The

researcher will switch on the recording device(s) and will exit the room. She will not be present when you have your consultation with the health service provider. Once the researcher has exited the room, the consultation session will begin. After the consultation is completed, the researcher will come in and switch the recording device off. The researcher will show you where the off switch is for the recording equipment. If at any stage of the consultation you wish to withdraw from the study you can simply press the off button on the recording devices. In such an instance all previous recordings will be deleted by the researcher after the consultation.

2. The interview you will have with the researcher after the consultation with the health service provider will be audio-recorded. The health service provider will not be present during this interview. You will have a chance in this session to speak about your experience of the consultation. You will not be asked to speak about the reasons for your decision or any other aspect of your life, unless you specifically want to speak about these issues.

Oluphando luzohamba ngoluhlobo:

1. I-counselling ozakuyifumana kumongikazi izakushicelelwa kwi-teyipi rekhodi okanye i-video rekhodi. Umphandi uzolayita iteyipi okanye i-video rekhodi alandele ngokuphuma kwigumbi. Umphandi akazobakho xa ufumana i-counselling kumongikazi. I-counselling izoqala xa umphandi ephumile kwigumbi. Xa ugqibile ukuthetha nomongikazi, umphandi uzokungena kwigumbi acime –ivideo okanye iteyipi rekhodi. Umphandi uzokubonisa icinywaphi iteyipi okanye i-video rekhodi ukuze ukwazi ukuyicima xa uziva ukuba awusafuni ungenela oluphando. Kwimeko enjalo umphandi uzocima lonke ushicelelo kwiteyipi okanye i-video rekhodi.

2. Emva kokuthetha nomongikazi kwi-counselling uzobanodliwano ndlebe nomphandi kwaye kuzosetyenziswa iteyipi rekhodi. Umongikazi akazubakho koludliwano ndlebe. Uzawufumana ithuba lokuthetha ngamava akho nge-counselling. Akuzobuzwa ngezizathu ezibangele ukuba uthathe esigqibo sokuza ekliniki okanye ngobomi bakho ngaphandle kokuba wena uyafuna ukuthetha ngayo.

Please understand that your participation in this study is completely voluntary and you are not being forced to take part. Although we would really value your participation, the choice of whether to participate is yours alone.

Sicela uyazi ukuba ukuthatha inxaxheba koluphando kuxhomekeke kuwe kwaye akekho umntu ozakunyanzela. Nangona singayivuyela inxaxheba yakho koluphando, sonke isigqibo sesakho kuphela.

If you choose to, or choose not to, participate in this study, the services you receive will not be affected in any way whatsoever. If you agree to participate, you may stop at any time and discontinue your participation. If you withdraw at any stage, this will not affect the services you receive at the Termination of Pregnancy clinic.

Isigqibo sokuthatha okanye ukungathathi nxaxheba koluphando, asizo chaphazela uncedo ozalifumana. Ukuba uyavuma ukuthatha inxaxheba koluphando, uvumelekile ukuba uyeke nanini na. Ukuyeka kwakho akuzuchaphazela inkonzo ozifumanayo apha eklinikhi.

In order to protect you, we will not be recording your name for the purposes of this research. Instead, we ask that you make up a name, called a pseudonym. You can sign the consent form with this name, if you wish.

Ukuze sikhusele wena, igama lakho lokwenyani alizokusetyenziswa kule-research. Kodwa sizokusebenzisa igama ozithiyilelo koluphando. Ungatyikitya ifomu yemvume ngeligama ukuba uqwenela ukwenza njalo.

We will, however, ask that you please provide your age. Only the researchers working on this study will have access to this information.

Kodwa sizakucela usixelele iminyaka yakho. Ngabaphandi kuphela abazokubona ezinkcukacha.

The recordings of the consultation sessions and of the interview with the researcher will be kept in a safe place and will only be accessed by researchers on the project. The video recordings will not be used in any publications or presentations. This is to protect you so that nobody but the researchers is able to identify you. The purpose of the video recordings is to give the researchers a better picture of the consultation.

Iteyipi rekhoda okanye i-video rekhoda ezishicilele icounselling kunye nodliwano ndlebe zizogcinwa kwindawo ekhuselekileyo apho ingabaphandi bale-research kuphela abafikelelayo. I-video rekhodi ezishicilelweyo azizopapashwa. Injonga kukhuselela igama lakho. Injongo ze-video rekhodi kukunika umphandabaphandi] umfanekiso ocacileyo ngecounselling.

The health service providers will not have access to your interview material and will not be told what you specifically said about the session.

Oomongikazi abazokuboniswa okanye baxelelwe ngodliwano ndlebe nokuthethileyo malunga ne-session ye-counselling.

If, at any time in the process you feel upset, you may end your participation. For example, you can turn off the recording during the consultation and you can ask for the interview to stop. In addition, the researcher will provide details of a counsellor should you feel that you would like to make use of these services.

Ukuba awuziva kakuhle unalo ilungelo lokuyeka ukuthatha inxaxheba koluphando nanini na. Umzekelo ungacima iteyipi rekhodii okanye i-video rekhodi xa ufumana i-counselling okanye ucele udliwano ndlebe ukuba malupheliswe. Kwaye umphandi uzokunika inkcukacha zecounsellor ukuba uziva ufuna uthetha nayo.

If you have a person with you (for example, partner, parent, friend, relative) who will participate with you in the consultation session, they must also give their consent to participating in the research. If this person does not want to participate, but you do want to, then we will simply delete the section of the recordings where she or he is speaking.

Ukuba uhamba nomntu (iqabane, umzali, sihlobo, isizalwane) ozawube ekhona kunye nawe kwi-counselling kufuneka naye lo mntu asinike imvume yokuthatha inxaxheba koluphando. Ukuba lo mntu uhamba naye akafuni ukungenela uphando kodwa wena uyafuna, sizokucima kwi-teyipi rekhodi indawo ebethethe kuzo ngela xesha le-counselling.

In addition to the above, one of our researchers will be observing the interactions that take place between service providers and women in the waiting room. Notices about these observations have been put up in the waiting room area. Please communicate with the researcher if you would like her to not include any of the interactions you have with the health service providers in her observations.

If you have any questions about this study, please feel free to ask me. In addition, if there are questions that you feel I have not answered, or if you have concerns about the research, you may contact Prof Catriona Macleod, the principal researcher, at Rhodes University by calling her on 046-603-7329.

Kwaye, omnye wabaphandi uzojonga isimo okanye iindibano nokwenzekayo phakathi koomongikazi namanenekazi kwigumbi lokulinda. Izaziso ngoluphando zibekiwe kwigumbi lokulinda. Ndicela uthethe nomphandi ukuba awufuni ayibandakanye koluphando inthetho nendibano yakho nomongikazi. Ukuba unemibuzo ngoluphando, ndicela undibuze khululekileyo. Kwaye ukuba awanelisekanga okanye unengxaki ngoluphando, ungaqhagamshela u-Prof Catriona Macleod, okhokela uphando e-Rhodes University, kule nombolo 046-603-7329.

If you have a complaint about any aspect of this study, you may also contact the Rhodes University Ethical Standards Committee by calling 046-603-8055 or e-mailing ethicscommittee@ru.ac.za

Ukuba unengxaki okanye unesikhalazo malunga nayiphi na indawo koluphando *ungaqhagamshela* ***i-Rhodes University Ethical Standards Komiti*** *(ikomiti ejongene nemigaqo ye-ethics eRhodes University) kule nombolo* 046-603-8055 *okanye kule meyile* ethics-committee@ru.ac.za

(THE ABOVE SECTION IS TO BE KEPT BY THE PARITICPANT)
(*Ezi zigaba zibhalwe ngasentla zigcinwa ngumntu othatha inxaxheba koluphando*)

TERMINATION OF PREGNANCY CONSULTATION RESEARCH PROJECT/
UPHANDO NGE-COUNSELLING XA UMNTU EZOKUKHUPHA ISISU

WOMAN PARTICIPANT CONSENT FORM/ *IFOMU YEMVUME YAMANENEKAZI ATHATHA INXAXHEBA KOLUPHANDO:*

I hereby agree to participate in this research project that seeks to explore how pre-termination of pregnancy consultations are conducted in Termination of Pregnancy clinics in South Africa. Please tick to indicate your response in the below box.

Ndiyavuma ukuthatha inxaxheba kuphando malunga ne-counselling efumaneka phambi kokhupha isisu kwiklinikhi ezincedisa ngokhupheni isisu apha eMzantsi Afrika. Ndicela utikishe i-box yempendulo yakho apha ezantsi.

I agree to the following:/ *Ndiyavuma kokulandelayo*	Yes/ *Ewe*	No/ *Hayi*
1.1.The pre-termination of pregnancy consultation session that I will have with the health service provider being recorded. 1.1 *I-counselling endiyifumanayo kumongikazi phambi kokukhupha isisu izoshicelelwa kwirekhodi* . 1.2.If you answered yes to the above question, please indicate with a tick how you would prefer the consultation to be recorded 1.2. *Ukuba impendulo yakho ithe ewe kulo mbuzo ungasentla, sicela tikishe i-box ukhethe indlela ushicelelo ufuna lwenziwe ngayo* Video recorded/ *I-video Rekhodi* ☐ Audio recorded/ *Iteyipi rekhodi* ☐		
An interview with the researcher after the pre-termination of pregnancy consultation session. *Kudliwano ndlebe nomphandi emva kwendibano ne-counselling ephambi kokukhupha isisu.*		
The audio recording of the above-mentioned interview. *Kushicilelo ngeteyipi rekhoda kolu dliwano ndlebe lungasentla.*		

I understand that I am participating freely and without being forced in any way to do so. I understand that at any point if I wish not to continue I can withdraw from participating in the study without any negative consequences.

Ndiyaqonda ukuba ndizingenele ngomoya okhululekileyo koluphando kwaye kange ndiyanzelwe. Ndiyaqonda ukuba naninina ndingayeka koluphando xa ndifuna kwaye akukho sohlwayo okanye iziphumo ezibi xa ndithe ndayeka.

The purpose of this study has been explained to me, and I understand what is expected of my participation. I have kept a copy of the written explanation given to me.

Injongo yoluphando ndiyicaciselwe kwaye ndiyayazi indima ekufuneka ndiyidlalile *koluphando. Ndizingcinele ikopi yenkcukacha zoluphando endithe ndayifumana.*

I have received the telephone number of a person to contact should I need to speak about any issues that may arise due to participating in this study.

Ndiyinikiwe inombolo yefowuni yomntu endinokuthetha naye xa kukho ingxaki ngenxa yokuthatha kwam inxaxheba koluphando.

I understand that this consent form will not be linked to any recording, and that the conversation recorded will remain anonymous and video recording confidential.

Ndiyaqonda ifomu yemvume ayidibenanga ne-video rekhodii okanye iteyipi rekhodii. Kwaye incoko ezishicelelweyo zizohlala ziyimfihlo.

I understand that no personally identifying information will be released in any form. I understand that these recordings will be kept securely in a locked environment.

Ndiyaqonda ukuba igama lama kunye nelendawo alizosetyenziswa. Kwaye ndiyaqonda irekhodii ezishicelelweyo zizawugcinwa kwindawo efihlakeleyo nekhuselekileyo.

I understand that if I do not want any of the conversations I have with health service providers in the waiting to form part of the research I will communicate this to the researcher.

Ndiyaqonda ukuba andifuni indibano yam nomongikazi kwigumbi lokulinda ifakwe koluphando ndizokuxelela umphandi.

My pseudonym is:/ *Igama endizithiyileyo ngu:* _____

I am _____ years old/ *Ndinemiyaka e-* _____

I am currently (please tick where appropriate) /*Ndenza ntoni ngoku (khetha i-box)*

Employed/ ☐

Ndiyaphangela

Unemployed/ ☐

Andiphangeli

Still in school/ ☐

Ndiyafunda

_____ _____

Signature of participant/ Date/ *Umhla*
Utyikityo lo thatha inxaxheba koluphando

_____ _____

Signature of the researcher/ Date/ *Umhla*
Utyikiyo lowenza uphando

Where relevant, third party consent (partner, parent, friend, relative, acquaintance or any other person accompanying the woman)/

Xa kukho umntu wesithathu (iqabane, abazali, isihlobo, isizalwane, umntu ohamba ne nenekazi)

The information shared with the person I am accompanying has also been shared with me. I understand the purpose of this study, and I understand what is expected in terms of data collection.

Ndixelelwa inkcukacha zophando njenge nenekazi endihamba nalo. Injongo yoluphando ndiyicaciselwe kwaye ndiyayazi indima ekufuneka ndiyidlalile koluphando.

I agree to the following: /*Ndiyavuma kokulandelayo*	Yes/ *Ewe*	No/ *Hayi*
1. The sections of the recording of the pre-termination of pregnancy consultation where I speak may be used for the study. 1. *Into endiyithethileyo kwi-counselling eshicelelweyo kwirekhodi inosetyenziswa koluphando.*		
2. The sections of the interview with the researcher after the pretermination of pregnancy consultation session where I speak may be used for the study. 2. *Into endiyithethileyo kudliwano ndlebe nomphandi emva kwecounselling inosetyenziswa koluphando.*		

I am the _____ (state your relationship with the participant).

Ndigu/Ndisi_____(xelela ukuba nihlobene njani)

_____ _____

Signature of third party/ Date/ *Umhla*
Utyikityo lo mntu wesithathu

_____ _____

Signature of researcher/ Date/ *Umhla*
Utyikityo lomphandi

ADDITIONAL AGREEMENT BETWEEN WOMAN YOUNGER THAN 18 AND RESEARCHERS CONCERNING PARENTAL OR GUARDIAN CONSENT: TO BE OBTAINED AFTER THE CONSULTATION BUT BEFORE INTERVIEW

ISIVUMELWANO NE NENEKAZI ELINGAPHANTSI KWEMIYAKA ELISHUMI ENESIBHOZO (18) NABAPHANDI MALUNGA NEMVUME YOMZALI: IMVUME IFUNYANWA EMVA KWECOUNSELLING KODWA PHAMBI KODLIWANO NDLEBE.

In addition to the agreement signed above, I confirm that I have spoken to the health service provider about the possibility of consulting with my parent or guardian about my decision to terminate my pregnancy.

Ngaphezu kwesivumelwano esityikitywe ngasentla, ndiyavuma ukuba ndithethile nomongikazi malunga nokuthetha nomzali wam ngesigqibo sam sokukhupha isisu.

I confirm that/ *Ndiyavuma ukuba*:	Tick only one option/ *Tikisha ibenye qa*
1. I have chosen not to consult my parent/guardian about my decision and that I would like to continue in my participation in the research *1. Ndikhethe ukungamxeleli umzali wam ngesigqibo sam kwaye ndiyafuna ukuqubekha ngophando.*	
2. I have decided to consult my parent/guardian about my decision and feel that I would like their consent to participate in the research *2. Ndikhethe ukumxelela umzali wam ngesigqibo sam kwaye ndifuna ukucela ivume kumzali ungenela oluphando.*	
3. My parent/guardian has accompanied me to the clinic and gives his/her consent for me to participate in the research. *3. Ndikhatshwe ngumzali wam ukuza apha ekliniki kwaye undinike imvume yokuthatha inxaxheba koluphando.*	
4. My parent/guardian has accompanied me to the clinic and does not give his/her consent for me to participate in the research. 4. *Ndikhatshwe ngumzali ukuza apha ekliniki kwaye akavumi ukuba ndithathe inxaxheba koluphando.*	

If you have chosen to No. 2 above, please let us know how we can contact your parent/guardian. If they do not provide their consent, we will delete the recordings of your consultation session and interview.

Ukuba ukhethe inombolo yesibini (2) ngasentla, ndicela usixelele ukuba singamfumana njani umzali wakho. Ukuba umzali wakho akafuni uthathe inxaxheba koluphando sizokucima ushicelelo lecounselling nodliwano ndlebe kwirhekodi.

_____ _____

Signature of participant/ *Utyikityo* Date/ *Umhla lothatha inxanxheba*

_____ _____

Signature of researcher/ *Utyikityo lo mphandi*

Date/ *Umhla*

If you have chosen No. 4 above, your parent/guardian should sign the following/ *Ukuba ukhethe inombolo yesine (4) ngasentla, umzali/omele umzali kufuneka atyikike okulandelayo*:

I have read and agree to all the conditions of participation contained in the letter of information and consent form provided to my daughter/custodian, and hereby consent that she may participate in the research.

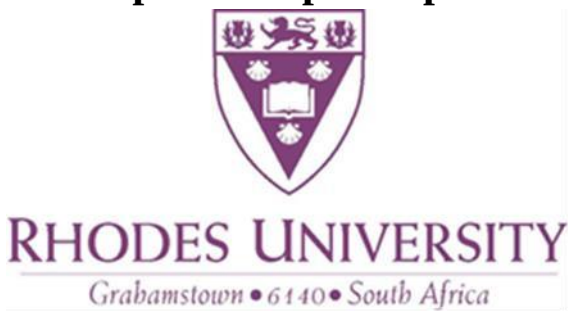
Ndizifundile inkcukacha kwaye njengomzali/omele umzali ndiyavumelana nemigaqo ebekiweyo kwileta enekcukacha nefomu enikwe intombi yam malunga nokuthatha inxaxheba. Ndiyavuma ukuba angathatha inxaxheba koluphando.

_____ _____

Signature of parent/guardian/ *Utyikityo lo mzali/omele umzali*

Date/ *Umhla*

Appendix 4: Healthcare provider participant consent form



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[Date]

Dear service provider/ *Mongikazi/Mongi obekekileyo*

I am Jabulile Mavuso from Rhodes University. I form part of a research team interested in exploring how pre-termination of pregnancy consultations are conducted in Termination of Pregnancy clinics in South Africa. This study forms part of a larger study in which we hope to compare, in the future, how pre-termination of pregnancy consultations are conducted in Britain with those conducted in South Africa. As you may know, in Britain abortion may only be performed if it is recommended by health service providers, while, of course, in South Africa a woman may request an abortion up to 12 weeks of gestation. In addition, the social acceptability of abortion and length of time in which abortion has been legal is very different in the two countries. We believe that these differences will have implications in terms of how the pre-termination of pregnancy consultations are conducted. With your assistance, we hope to be able to understand best practices around pre-termination of pregnancy counselling in the two countries and to assist in developing ideas on how to improve this aspect of care. Permission to conduct this research has been obtained from the Eastern Cape Department of Health and [insert name of hospital]

Ndingu Jabulile Mavuso osuka eRhodes University. Ndingomnye wabantu abanomdla wokuphanda ngendlela i-counselling eyenziwa ngayo phambi kokuba umntu akhuphe isisu kwikliniki yokukhupha isisu apha eMzantsi Afrika. Oluphando luyinxalenye yophando olubanzi esinqwenela ukulithelekisa kwixa elizayo nophando olwenziwa eBritane kunye nolwenziwa eMzantsi Afrika malunga nendlela i-counselling eyenziwa ngayo phambi kokuba umntu akhuphe isisu. Xa ujonga eBritane ngumongikazi/ngumongi onegunya sokuthatha isigqibo ukuba umntu angakhupha isisu. eMzantsi Afrika iyohluka ngoba inenekazi liyakwazi ukukhupha isisu nanini na phambi kweeveki eziyi-12 (ezingamashumi amabini) enzima. Kwaye xa uthelekisa la mazwe mabini, kwezomthetho ayohluka amaxesha apho umthetho wokukhupha isisu wathi wavumeleka. Kwaye ukwamkeleka kokhupha isisu ekuhlaleni kohlukile kula mazwe mabini. Siyakholelwa ukuba ezizinto zohlukanisa la mazwe mabini xa kuthethwa ngokukhupha isisu zinegalelo kwindlela i-counselling eyenziwa ngayo phambi kokuba umntu akhuphe isisu. Ngoncedo lwakho siyathemba ukuba sizawukwazi ukufumana ulwazi ngendlela ezisemgangathweni ezinosetyenziswa kwi-counselling kula mazwe mabini. Sinenjongo yokuncedisa ukufumana amacebo anoyusa izinga lokunikezelo lonyango. Ingunya lokwenze oluphando silifumane kwiSebe LezeMpilo apha eMpuma Koloni kunye Dora Nginza Hospital.
We invite you to assist us in the following way/ *Sicela usincede ngokulandelayo*:

1. By allowing us to record the pre-termination of pregnancy consultation sessions that you conduct during the day.

1. *Ngosivumela sishicelele indibano ne-counselling oyenzayo imini yonke.*

2. By speaking to us in an interview conducted at the end of the day about your experience of the various consultation sessions. In this session the researcher will ask you about what aspects of the consultation sessions you felt went well and what challenges you encountered with specific women or specific situations.

2. *Ngokuthetha nathi kudliwano ndleba, ekupheleni kwemini, ngamava akho okwenza lo msebenzi we-session ezahlukeneyo ze-counselling. Kolu phando, umphandi uzakubuza nge-zinto ozibona ukuba zihambe kakuhle kwii-session ze-counselling kunye nezinto ezibe ngumceli-mngeni kuwe xa ubu-counsellisha inenekazi/amanenekazi athile okanye ngenxa yemeko yalo/yawo.*

Data for this study will be collected in the following ways/ *Ulwazi koluphando uzawuqokelelwa] ngezindlela zilandelayo:*

1. The pre-termination of pregnancy consultations that you provide will be either audio or video (including audio) recorded. The researcher will switch on the recording device(s) and will exit the room. She will not be present during the consultation. Once the researcher has exited the room, the consultation session will begin. After the consultation is completed, the researcher will come in and switch the recording device(s) off.

1. *Sizoshicelela ngeteyipi rekhoda okanye sisebenzise i-video rekhoda xa usenza icounselling yaphambi kokukhupha isisu. Umphandi uzoyilayita iteyipi rekhoda okanye i-video rekhoda alandele ngokuphuma kwi-gumbi le-counselling phambi kokuba iqale i-session. Xa ugqibile ukwenza i-counselling umphandi uzakungena acime iteyipi rekhoda okanye i-video rekhoda.*

2. The interview you will have with the researcher at the end of the day about the consultation sessions will be audio-recorded.

2. *Udliwano ndlebe ozawuthi ubenalo nomphandi ekupheleni kwemini malunga nesessions oye wanazo emini luzawushicilelwa kusentyenziswa iiteyiphi rekhoda.*

3. Interviews with individual women about their experiences of the consultation.
3. *Udliwano ndlebe nenenekazi ngalinye ngezimvo zalo malunga ne-counselling.*
4. Observations of interactions in the waiting room.

4. *Sijonge nesimo okanye indibano phakathi koomongikazi namanenekazi kwi-gumbi lokulinda.*

Please understand that your participation in this study is completely voluntary. If you agree to participate, you may stop at any time and discontinue your participation.

Sicela uyazi ukuba awunyanzelekanga ukuba uthathe inxaxheba koluphando. Ukuba uyavuma [ukuthatha inxaxheba koluphando, uyakwazi ukuyeka naninina.

In order to protect you, we will not be recording your name for the purposes of this research. In addition, the research is being conducted at a number of sites. While a general description of the sites will appear in the research (e.g. located in a town or city, offering first trimester only or also second trimester abortions), the names of the actual sites or the town/city in which they are located will not be revealed. We ask that you make up a name, called a pseudonym. You can sign the consent form with this name, if you wish.

Sinenjongo yokukhusela, asizokusebenzisa igama lakho koluphando. Kwaye oluphando lwenziwa kwindawo ezahlukileyo (umzekelo – idolophu ethile enikezela ngenkonzo zokukhupha isisu ukusuka kwinyanga ezinthathu zokuqala okanye ezintandathu). Xa sithetha ngendawo enikuyo igama le ndawo okanye idolophu ekuyo alizokusetyenziwa xa sipapasha uphando. Sicela uzithiye igama esinolisebenzisa koluphando. Ungatyikitya ngeligama kwifomu yemvume eyazisiweyo xa uqwenela ukwenza njalo.

The recordings of the consultation sessions and of the interview with the researcher will be kept in a safe place and will only be accessed by researchers on the project. The video recordings will not be used in any publications or presentations. This is to protect you so that nobody but the researchers is able to identify you. The purpose of the video recordings is to give the researchers a better picture of the consultation.

Iteyipi rekhoda okanye video rekhoda ezishicelelweyo ze-counselling kuye nodliwano ndlebe zizobekhwa kwindawo ekhuselekileyo apho ingabaphandi kuphela abazawufikelela. I-video rekhodii ezishicelelweyo azizopapashwa okanye zisetyenziswe xa kunikwa intetho. Injongo kukhusela igama lakho ukuze kungabikho nabani na ozawukwazi ukuba wabelane ngeziphi na wena izimvo. Injongo ze-video rekhodii kunika umphandi umfanekiso acacileyo ngecounselling.

Please note that this research is NOT an evaluation of your performance (good or bad) as a health service provider. No feedback on how you, specifically, conducted the sessions will be provided to the management of the facility. When feedback is provided, it will be in form that makes it impossible for management or any other parties to identify specific individual health service providers.

Sicela uyazi ukuba oluphando asizojonga umgangatho womsebenzi wakho ukuba mhle okanye awumhlanga njengomongikazi. Asizonikezela nkcazelo kumphathi wakho ngendlela owenza ngayo i-counselling. Ukuba sinikezela inkcazelo kumphathi, igama lo msebenzi alizovela

kwaye sizawuqinisekisa ukuba umphathi akanandlela yokwazi ukuba zeziphi na izimvo zakho kanye kanye.

Please also note that, for similar reasons of confidentiality, we will not be able to share what individual women said about their specific consultation. You will, however, have access to the over-arching findings of the research.

Sicela wazi ukuba, ngezizathu ezidibene nelungelo le mfihlo, asizokwazi [ukwabelana nawe malunga nezimvo zenenekazi ngalinye malunga nendibano kunye ne-counselling ethile eliyifumeneyo. Kodwa sizokuxelela ngeziphumo zophando ngokubanzi.

I am attaching the information sheet that will be given to potential woman participants for your perusal.

Ndidibanise iphepha elinenkcazelo ezakunikezelwa kumanenekazi abonakalisa umdla wokuthatha inxaxheba koluphando ukuze uzijongele.

If you have any questions about this study, please feel free to ask me. In addition, if there are questions that you feel I have not answered, or if you have concerns about the research, you may contact Prof Catriona Macleod, the principal researcher, at Rhodes University by calling her on 046-603-7329.

Ukuba unemibuzo ngoluphando ndicela uzive ukhululekile ukundibuza nantoni na. Kodwa ukuba awanelisekanga ndicela uqhagamshalene no Prof Catriona Macleod, okhokhela oluphando eRhodes University kulenombolo 046 683 7329.

If you have a complaint about any aspect of this study, you may also contact the Rhodes University Ethical Standards Committee by calling 046-603-8055 or e-mailing ethicscommittee@ru.ac.za

Ukuba unengxaki okanye isikhalazo malunga noluphando ungaqhagamshela i-Rhodes University Ethical Standards Committee (ikomiti ejongene nemigaqo ye-ethics eRhodes University) kule nombolo 046 603 8055 *kwaye uthumele imeyile kwi-* ethicscommitte@ru.ac.za

(THE ABOVE SECTION IS TO BE KEPT BY THE PARITICPANT)
(*EZI ZIGABA ZIBHALWE NGASENTLA ZIGCINWA NGUMNTU OTHATHA INXAXHEBA KOLUPHANDO*)

PRE-TERMINATION OF PREGNANCY CONSULTATION RESEARCH PROJECT/ ***UPHANDO NGE-COUNSELLING XA UMNTU EZOKUKHUPHA ISISU***

HEALTH SERVICE PROVIDER CONSENT FORM/ ***IFOMU YEMVUME EYAZISIWEYO KAMONGIKAZI/MONGI:***

I hereby agree to participate in this research project that seeks to explore how pre-termination of pregnancy consultations are conducted in Termination of Pregnancy clinics in South Africa. Please tick to indicate your response in the below box.

Ndiyavuma ukuthatha inxaxheba kuphando malunga ne-counselling efumaneka phambi kokhupha isisu kwiklinikhi ezincedisa ngokukhupha isisu eMzantsi Afrika. Sicela utikishe ibox yempendulo yakho

I agree to the following/ *Ndiyavuma kokulandelayo:*	Yes *Ewe*	No *Hayi*
1.1 The recording of the pre-termination of pregnancy consultation session that I will conduct with various women. 1.1 *Ushicelelo lwe-counselling endiyenzayo namanenekazi phambi kokhupha isisu.* 1.2 If you answered yes to the above question, please indicate with a tick how you would prefer the consultation to be recorded. 1.2 *Ukuba impendulo yakho ithi ewe kulo mbuzo ungasentla, sicela tikishe ibox ukhethe indlela ushicelelo ofuna lwenziwe ngayo.* Video recorded/ *I-video Rekhodii* ☐ Audio recorded/ *Iteyipi rekhodii* ☐		
An interview with the researcher about these sessions at the end of the day. *Kudliwano ndlebe nomphandi nge-counselling ekupheleni kwemini.*		
The audio recording of the above-mentioned interview. *Kushicilelo ngeteyipi rekhoda kolu dliwano ndlebe lungasentla.*		

I understand that no personally identifying information will be released in any form. I understand that these recordings will be kept securely in a locked environment.

Ndiyaqonda ukuba igama kunye nelendawo, elinothi lenze kube lula ukwazi ukuba kwaziwe ukuba izimvo zezam, alizosetyenziswa. Kwaye ndiyaqonda irekhodii ezishicelelweyo zizogcinwa kwindawo efihlakeleyo nekhuselekileyo.

I understand that I am participating freely and without being forced in any way to do so. I understand that at any point if I wish not to continue I can withdraw from participating in the study without any negative consequences.

Ndiyaqonda ukuba ndizingenele ngomoya okhululekileyo koluphando kwaye kange ndiyanzelwe. Ndiyaqonda ukuba naninina ndingayeka koluphando xa ndifuna

The purpose of this study has been explained to me, and I understand what is expected of my participation. I have kept a copy of the written explanation given to me.

Injongo yoluphando ndiyicaciselwe kwaye ndiyayazi indima ekufuneka ndiyidlalile koluphando. Ndizingcinele ikopi yenkcukacha ezibhaliweyo zoluphando endiyinikiweyo.

I have received the telephone number of a person to contact should I need to speak about any issues that may arise due to participating in this study.

Ndiyinikiwe inombolo yefowuni yomntu endinokuthetha naye xa kukho ingxaki ngenxa yokuthatha kwam inxaxheba koluphando.

I understand that this consent form will not be linked to any audio or video recording, and that the conversation recorded will remain anonymous.

Ndiyaqonda ifomu yemvume ayizukusetyenziswa ukujonga ukuba izimvo ezishicilelwe kwivideo rekhodii okanye iteyipi rekhodii zezikabani na. Kwaye incoko ezishicelelweyo zizohlala ziyimfihlo.

My pseudonym is/ *Igama endizithiyileyo ngu*:_____

For how many years have you been providing termination of pregnancy services/ *Sekulithuba elingakanani na unikezela ngenkonzo zokukhupha isisu*: ____

_____

_____

Signature of participant/
Utyikityo lothatha inxaxheba koluphando

Date/ *Umhla*

_____

Signature of researcher/
Utyikityo lowenza uphando

_____

Date/ *Umhla*

Appendix 5: Xhosa transcript

Chapter 6

Extract 1

I: ok (1) e::m bese (.) ngokubona kwakho (.) ingaba umongikazi uthethe njani nawe xa bekuthethwa ngendlela ezingathathwa ngesisu?

Zipho: yoh like undiexplainele ngento yonke /*ja*/ uthethe kamnandi (.) undicacisele ngento yonke wathi it's up to mna uba ndiyenze (.) but undicacisele kakuhle shame /ok/ mm

Extract 3

Balisa: icounselling went well (.) and then I see:: by doing counselling *neh* /mm/ out of my own decision /mm/ it helped me because (.) in such a way that I didn't know that (.) how bad it is to do an abortion it's a bad thing or it's a good thing (.) /mm/ uyabo (.) by:: getting counselling it was (.) something that makes me at least (.) powerful /mm/ mm-mm

CR: as if like ungenza isigqibo ngoku to make =

Balisa: = ewe to make my own decision /mm/ just because ke ekugqibeleni (.) bendiyicinga lento (.) kudala like ndingayazi ukuba ndiyenze okanye ndingayenzi /mm/ bendithandabuza but at least ngoku ndiyifumene icounselling before (.) ndinikwe amayeza nentoni na /mm/ endiyicingayo ukuba (.) you have to do your own decision ekugqibeleni kengoku icounselling nayo yandinceda

Extract 4

Likhona: = so bavele ke bandibriefela bandicacisela yonkinto /yonkinto/ babe besithi noba ndingabe ndiyayenza ke (.) ndiyenze at my own risk /at your own risk/ ewe =

Extract 6

CI: ingaba ikhona enyinto onqenela ukuyithetha okanye ukuyongeza (.) sesishwankathela nje?

Nziweni: *ja*:: ndingatsho ndithi (.) ukwenza iabortion (.) it's not a (.) good thing /mm/ at all /mm/ uyabona (.) asiyinto entle le (1) so us womans (.) or (1) ukuze sisave imiphefumlo (.)

yabantwana bethu okanye singakhoni ukumitha (.) singathi siprevente (.) sicwangcise then nangoku sowucwangcisayo usebenzise icondom /mm/ uyabona (.) that's what I can say

Extract 11

I: ok ok (.) ngokubona kwakho (.) ingaba umongikazi uthethe njani nawe xa bekuthethwa ngendlela ezingathathwa ngesisu?

Nokubonga: (1) uthethe kakuhle /mm/ uthethe kakuhle akhange (.) akhange ndiyilindele mhlambi uba angathetha olwahlobo (.) but ke ngumntu ocounsellishayo nyhani /*ja*/ uye wandibonakalisela mna intoba ngumntu okwanzi ukucounsellisha umntu /mm/ onengxaki /mm/ uthethe kakuhle

Extract 17

Lisa: […] eqale wandinika i-information about le-abortion /mm mm/ bandinike idate /mm/ abafuni (.) into yabo (.) abafuni ukuve bayenze (.) uze namhlanje uyenze namhlanje /mm/ because after that (.) xa uphuma nge-gate unga regretta uthi no (.) bendingafuni ukwenza lonto nje

Extract 18

Lisa: *ja* that is <u>why</u> I came here (.) I thought ku-<u>easy</u> /mm/ njengoba abantu besitsho cause (.) if you can notice people talking things many things ukuba /mm/ iright nje lento ayikho nzima

Extract 20

CI: ok (2) ndicela undixelele kangangoko unako icounselling ihambe njani (.) kwaye zeziphi ezinye izinto ozibona zibalulekile kuwe (.) ungaqala noba kuphi na

Nowu: (.) u::m ok I found (.) the counselling very <u>useful</u> (.) in terms of ukuba (.) Basixelele ukuba i-risks zolento esiyenziyo nokuba and (.) sixelele ngelento ukuba (1) *i*-contraceptives like in the [inaudible] (.) ukuba which ones should we use and (.) that we should use them (.) because (.) we know ukuba [interruption] we know that the:: the:: (.) the abortion is not right and what not (.) *ja*

CI: ok (.) oh uzive njani xa kusithiwa i-abortion akulunganga?

Nowu: u::m we::ll (1) I don't know how I <u>felt</u> actually [laughs] u::m I guess I I don't know (.) i::t it's quite <u>sad</u> neh but ke (.) because (.) you don't have a choice (.) *ja*

Extract 21

CI: xa usithi izinto ebezithethwa yicounsellor mhlambi ezezi (.) ebezikoyikisa zenze uba ugcine sewuba uyazidoubta uba uyayenza lento noba awuyenzi (.) zeziphi mhlawumbi (.) eyona yona mhlawumbi uye wabona uba 'ha-a uyabona ke le (.) ndathuka nyhani'?

Nziweni: (1) u::h ezifana nezi ubana (.) xa una twelve weeks (.) up and above /mm/ twelve weeks /mm/ seyingumntu (.) ngumphefumlo uyabona /mm/ so (.) xa uyokwenza kengoku (.) phayana le abortion (.) unikwa lapilisi yokulunyiswa /mm/ ukhupha umntu umntwana (.) but oseligazi but inyawo zikhona /mm/ izandla uyazibona zikhona (.) /mm/ then (1) indoyikisa njani (.) umkhupha esaphefumla /mm/ u::h funeke umlindile futhi athi pass out (.) wena mzali wakhe /ujongile yonkinto/ ewe ujongile yonkinto (.) so zezinye izinto ezivisa kabuhlungu ezo

Extract 22

CR: […] oh ok ke sisi enkosi (.) so then iexperience yakho of i-information unesi provided to you during icounselling (2) ubuziva njani the time ebekuxelela i-information during the counselling? (1)

Balisa: like before kaloku ndi::yenze icounselling neh /mm/ mna bendizixelele ukuba haysuka wethu andikhathali noba kuthiwani na kungathangani but unesi uye wandixelela intobanangaba (1) like ayincedi into ubane uzokwenza the same mistake each and every now and again umane usithi awukhathali at least iDora iyayenza i-abortion /mm/ that is not a solution uyabo /mm/ you have to prevent ungumntu /mm/ njengoba uye wandixelela ukuba (.) you have to prevent and if ubanangaba awupreventi (.) iingxaki ezinjena ziyakwazi ukuthi gqi nanjani na uyabo (.)so ndizawucontinuisha ndimane ndisenza iabortion ogqiba ndibone uba ndithini

Extract 30

Yolanda: […] so:: I will ask them (1) tshomi just sit down uzixelele (.) ukubana ndenza into eright na /mm/ and then you have to also forgive yourself (1) you know (2) and u::h (.) I think (.) you also have to pray (.) yoh before yonke into (.) you have to pray ask God for guidance (.) /mm/ ask God for istrength (.) you know because /mm/ yonke lento ineeda istrength /mm/ ewe singahleka sithini /yes/ but ukhubone deep down /mm/ akumandanga /mm/ so:: (.) I'd tell them *ja* you have to be certain (1) pray (1) and then (.) forgive yourself /mm/ and go for counselling /mm/ (2)

Extract 33

CI: ok sisi ndicela undixelele uba (.) ok (.) i- (.) ndicela undixelele kangangoko ufunayo ukuba icounselling ihambe njani […]

Nikibha: [laughs] kaloku ngoku bebendicounsellor pha (.) ndiye ndaxelelwa intobana (.) one (.) lento ndizawuyenza inakho ukungalungi inakho ukulunga (.) just because (.) ekugqibeleni ndinongaphindi ndibenabo abantwana (.) okwesibini ndinga mhlambi ndingane cancer yesibeleko just because kuzawube kuqhuzulwa into esabambeleleyo (.) engenkajingi (1) so (1)

Extract 34

I: […] u::m so e::h now when you came what (.) u::m (.) before you came here /*ja*/ what were ama-expectations (1) for i-counselling?

Lisa: […] ngokuya bendifunda (.) ndifunda ezi-high school ntoni ntoni (.) ndafunda nge-abortion ukuba i-abortion ayikho right /*ja*/ cause abortion (.) uyayenza ngoku uyasuka umntana but (.) for the future (.) ungangabinabo abantwana /*ja*/ for the rest of your life (.) okanye and you get married (.) ungabafumani abantwana kanti yinto owawuyenze /*ja*/ ngoku wawusese tertiary or when you were still young

Extract 36

I: ok ok (.) so manje (.) can you say a bit more about iroom lokulinda (.) this waiting room /like/ iexperience yakho beyinjani?

Lisakhanya: yoh a ibi- [laughs] I couldn't experience nothing neh (.) but neh id that (.) kubekho omnye umama aneh (.) *ja* lo mama and undixelele ukuba (.) yena umntana wakhe wamzala njani and stuff (.) kwakutheni and yonke lonto neh (.) so wabe endicenga uba hayi maan why ungayiyeki lento uyabo (.) because mna ndakwazi ukumelntuka umntanam neh (.) for i9 months (.) which is wayengazanga ngothandwa yayingeyinto like wayeyilindele yena (.) yayi (.) just a rape neh /o::h/ then kengoku (.) at least mna neh (.) mna ndiyakwazi (.) I mean at least mna umntanam neh (.) uzawube esiza whereby utatakhe ezawumthanda and stuff nje ngothando neh (.) so andikwazi like umgcina neh (.) andikwazi serious andikwazi shame (.) because of isituation at home neh (.) it's like (.) nam ndiyafuna ukumgcina neh (.) but isituation yasendlini ayitsho /mm/ *ja*

Extract 37

CR: […] so ngoku I would like to know i-experience yakho of i- i- i-waiting room (.) and i-interaction xa nithetha (1) beyinjani?

Thembakazi: […] siyabuzana ukuba wena unangaki wena ungangaki /ok/ kutheni uqala ukuza ngoku /ok/ like sibuza izinto enzinjalo /ok/ then bangangekho abantwana (.) why uzathi uqala nomntana bese ucinga ngo-aborta izinto ezinjalo /ok/ so umuntu anika i-reasons zakhe uba why

Chapter 7

Extract 3

CI: mm (.) ngokubona kwakho ingaba uzive njani ngethuba umongi okanye umongikazi ekunika ulwazi kwicounselling?

Nowu: um I was actually very happy (1) I (.) I don't know I was very happy (1) cause I think (.) sometimes being advised (.) it's not about ukuba uyaqumba awuqumba but (.) being happy that (.) you know ukuba (.) lento obuxelelwe uyafunda (.) you learning from something ja

Extract 8

CR: oka::y (.) ok thank you /[laughs]/ and the::n (.) what would you tell a friend em xa eza apha to the Women's Clinic?

Thembakazi: *tjo* (.) though I'm not against i-abortion and though I'm not like (1) judging people /mm/ but (.) co- coming here is not (1) I don't feel it's like a (.) a good thing (.) but i-situation yomuntu iyamu (.) isa kwindawo akhange aklinidele /mm/ like me (.) akhange ngicinge I would end up here /mm/ so I would just (2) tell her (1) and (.) support her /mm/ ukuba you can go:: then you will find support at least usister usupportive /mm/ (1) uyakwazi uku:: (1) feela ukwenze ufeela kwe::(.) like ubufike ubambikile and then uyancokola (.) /ok/ ayisusa le tension into bana you are going to do something (.) uyabo

Extract 9

I: okay then just to speak about (.) the options (.) if there were options given to you (.) what was the:: how did you experience that (.) that part of the conversation (.) part of the counselling=

Thombulelo: =that part of the options? /*ja*/ (.) it was u::m (4) it was like u::h (3) they don't wanna they don't want me to do the termination (1) /ok/ *ja* it was like she didn't want me to do it /mm/ and I have no reason for me to do it /mm/ a::nd I can just keep the baby /mm/ and give it out (.) give it up for adoption /ok/ (and u::h just like make it ok) /ok/ *ja* so the option was like (.) she was trying to do that

I: ok (.) and h- how did you experience that what what how did you feel about that?

Thombulelo: mm (2) I felt (.) I felt like changing my mind at first /mm/ because I it was like I (.) like I (1) some (.) it felt so::me like I so::me how can I put this konje (2) like indenze ndafuna ubanosizi = /=mm-mm mm-mm/ do you understand /mm-mm=/ =as in like (.) to think about what I'm going to do and how wrong it is /o::hh/ *ja* /how wrong it is=/ (that's why *ja*)

Extract 10

Lisa: le uye waphinda wandinika more information about ela phepha wathi (.) ezinye zezinto (.) ezizeza physical damges is that (.) for ifuture (.) ndingangabinabo abantwana /mm/ abanye abantu baye bathi (.) ngokuba eye wambona la mntwana ingapheli la image abenala image so umntu abone ngamanye amaxesha enengxaki /mm/ engqondweni /mm/ *ja* so (.) ndifumene lo information /ok/ yiyo le eye yandenza ndangathi ndiya kwi-doubts

Extract 15

CI: ok (.) eyonanto ikuthusileyo yileyoba kuthiwe kulento uyenzayo uyenza at your own risk?

Likhona: ewe ndabe ndicaciselwa ukuba (.) abantu abenza lento (.) babane cancer /mm/ so mna bendingayazi /mm/ yenyinto endothusileyo /mm/ ndabe ndisithi andina choice kulento (.) ndiyafuna ukuyenza (2)

Exrtract 17

Nandipha: ok (.) ndiye ndangena kwicounselling (.) ndacollector iform yam [interference] kwicounselling /ewe/ kodwa (.) ndi ndi (.) ndiye (.) into endihluphile phofu ayindihluphanga as such (.) ibiyinyani /mm/ eyoba (.) ndiyaqala *mos* mna ukukhulelwa /mm/ ngoku sendisenza iabortion /mm/ uba (.) what if ibiliqanda lam lokugqibela eli /mm/

Extract 24

CI: […] ndicela undixelele ubuziva njani ngela xesha ubulindele ukuthetha nomongikazi kwigumbi lokulindela (1) ungaqala noba ngeyiphi na into

Nikibha: yhu hayi bendisoyika wethu /ok/ and then bendingazi uba izawuba lixesha elingakanani [interruption from nurse]

Extract 25

CI: […] ndicela undixelele ubuziva njani ngelaxesha ubulindele ukuthetha nomongi okanye umongikazi kwigumbi lokulindela (.) ungaqala nokuba kungeyiphi (.) ngela xesha ubuhleli pha (.) ulinde ukubizwa (.) ubuziva njani (.) andithi uthe ubuqala ukuzapha?

Likhona: hayi bendothukile kuba bendingayazi ukuba inoba kuzawuthiwani (.) bendingayazi ukuba kukho nento zecounselling /mm/ bendingazi

Extract 26

CI: […] so ngelaxesha ubu interacter with other (.) namanye amanenekazi uye wa (.) bowuziva njani?

Lindokuhle: (1) yoh (1) kuyoyikeka ndikuxelele /hm/ *ja* (.) kuyoyikeka /mm/ because uzawukwenza lento so (1) awukho comfortable (1) uba nervous

CI: kodwa mhlambi i- (.) ifeeling yokuthi (.) oh hayi akumna ndodwa kunabanye balapha (.) mhlambi ibikuthoba ukusaba oku

Lindokuhle: [inaudible] =

CI: awuthi xa usuka ekhaya uqonde ukuba yheyi (.) ingathi yimina ndedwa (.) kodwa uma usufika apha ubona uba (.) huh-uh (.) andindodwa uyabona (.) baninzi abantu abakwisituation endikuyo

Lindokuhle: ja but u::h (.) ifeeling onayo wena wedwa /mm/ yeyakho wedwa