Rhodes University — Department of Psychology

Research project cover sheet

To accompany a research project submitted for examination in partial fulfilment of the requirements for the Honours Degree in Psychology / Organisational Psychology

1. Information	
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Type of thesis	Systematic review
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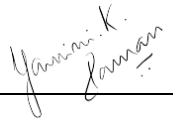
2. Declaration by supervisor

Either:

This project has been prepared under my supervision. I have read it carefully and believe that it meets the standards set out in the appropriate guidelines booklet in terms of academic content, clarity of research question, description of methodology, quality of analysis and ethical standards, as well as in terms of format, length, structure and referencing.

Signature and date:  20. Jan. 2021

Or:

This project has been prepared under my supervision using the guidelines set out in the appropriate guidelines booklet in terms of format, structure and referencing. However, I am not convinced that it meets the required academic standards with regards to academic content, clarity of research question, details of the methodology, quality of analysis, or ethical aspects.

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Abortion counselling in South Africa: a systematic review of the research

Systematic review submitted by

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Abstract

The purpose of this systematic review is to unearth themes, using a thematic analysis, from research written on abortion counselling in South Africa. The rationale behind this study is to contribute to a larger project that involves operationalizing guidelines for abortion counselling. Searches were conducted using Google scholar and Science Direct. A total of 17 articles were found to be of relevance to the study. Braun and Clarke's thematic analysis was applied to these articles. Six broad themes arose from the data namely: *experiences of women; nurses' responses to abortion and objection to abortion services; failed contraception and repeat abortions; counselling methods: one size does not fit all; contextualizing abortion narratives and difficulties nurses face in implementing family planning.* Overall, these themes were linked by a theme of ambiguity and contradiction in experiences. This was not only in-line with findings of other research in the field of abortion but further points to issues of standardization and deficits in abortion counselling guidelines. The lack of concrete guidelines may be linked with themes of nurses evaluating abortion seekers based on their own moral framework and values. Furthermore, deficits in counselling were found to be linked to barriers to access such as time constraints and structural issues. Lastly, counselling in almost all articles for analysis revealed that clinics and nurses treat counselling as synonymous with information sharing. This underlines that counselling guidelines are ambiguous and vague causing confusion between the difference between mandatory information sharing and non-mandatory counselling.

Key words: Abortion counselling, guidelines, contraceptive counselling, contradiction, information sharing, moral framework, South Africa

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Abbreviations

1. Abortion counselling (AC)
2. Termination of pregnancy (TOP)
3. Choice on termination of pregnancy act (CTOP)
4. Conscientious objection (CO)
5. Marie Stopes International (MSI)
6. Sexual health and reproductive services (SHR)
7. Street level bureaucrat (SLB)
8. World Health Organization (WHO)
9. Intimate partner violence (IPV)
10. International Pregnancy Advisory Services (Ipas)

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Chapter 1: Contextualising abortion in South Africa

1.1 Introduction

Much of the research conducted on abortion in South Africa revolves around the provision of abortion services. Specifically, the attitudes and experiences of health care workers (Harries, Lince, Constant, Hargey & Grossman, 2012; Harries, Stinson & Orner, 2009) and women's experience of abortion (Suffla, 1997; Orner, De Bruyn, Harries & Cooper, 2010). Similarly, much of the research around abortion takes on a public health approach and is aimed at understanding factors that lead to morbidity and inaccessibility (Varkey, 2000; Benson, Andersen & Samandari, 2011; Harries, Orner, Gabriel & Mitchell, 2007). However, another important element that forms part of the provision of quality abortion services is counselling. In this chapter I begin by providing a brief but global outlook of what constitutes quality abortion services; how abortion legislation exists on a continuum; and the World Health Organisation's (WHO) guidelines on abortion. I then elaborate on abortion legislation in South Africa; the choice on termination of pregnancy act (CTOP) guidelines; and ambiguities that exist due to a conflation of counselling and information provision. I underscore some of the barriers to access. Amongst others, this includes the dilemma of informed consent and issues around abortion stigma. Taking into consideration the topical global pandemic, I highlight some research that speaks to the effect of Covid-19 on [1]termination of pregnancy services (TOP). This is followed by research that offers suggestions to improve the quality of abortion services. I end this chapter with a section on contemporary research on abortion and abortion counselling (AC) in South Africa.

1.2 The global context

1.2.1 What constitutes a quality abortion

According to WHO a safe abortion is defined as a procedure that adheres to WHO's guidelines and standards and involves the following: provision of accurate information; non-directive counselling to ensure informed decisions; timely delivery of services; treatment of any complications (including those who have received unsafe abortions); contraceptive information; referrals; and information about other services that may be needed (WHO, 2012).

[1] There is contestation around using the terms abortion and termination of pregnancy interchangeably. This is because, arguably, all pregnancies end in a termination, making abortion a far less ambiguous term (Kavanagh & Aiken, 2018). For this reason, I will be using the term abortion for my own input. However, many research articles and legislation still use the term TOP and abortion interchangeably. Therefore, when citing research, the terms will remain the same as they are used in the articles.

Whereas an unsafe abortion is defined as "a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both" (WHO, 2012, p. 28). Hence, a quality safe abortion must include a physical examination, assessment of the patient's medical history and information and counselling services (WHO, 2012).

1.2.2 Abortion legislation internationally

The Centre for Reproductive Rights is an organization that tracks abortion laws and trends in real-time. Their data shows that abortion laws vary significantly across countries and sometimes even across states (Centre for Reproductive Rights, 2021). Certain countries prohibit abortion completely, such as Iraq, Angola and Egypt. Other countries allow abortions to take place only under certain circumstances such as if the pregnancy poses a risk to a woman's life, such as Mexico, Indonesia and multiple countries in Africa. Some countries allow abortions to preserve health. This in many cases means that abortions are only permitted in cases of impaired foetal health. These regulations preside in countries such as Colombia, Poland, Thailand and in certain countries in Central Africa. Other, more liberal regulations include performing abortions on the basis of broad socio-economic issues. This means that the economic situation and general environment of a woman is considered. Countries that follow these laws include India, Zambia and Finland. Finally, at the opposite end of the spectrum, reside the most liberal abortion laws that do not have restrictions on who or why an abortion should be performed, except possible limitations of gestational age. These countries include South Africa, China, the United States of America (USA) and multiple European countries such as the United Kingdom, Germany and France etc. However, abortion laws may also vary across states. An example of this can be seen in the USA. Despite many states having liberal abortion laws, 46 states do not perform abortions unless a woman's health or life is at risk (Guttmacher institute, 2020). Therefore, abortion laws appear on a spectrum ranging from oppressive laws (for example Angola) to more liberal laws (such as South Africa).

1.2.3 The WHO guidelines

The WHO (2012) guidelines on safe abortion states that an essential part of a quality abortion is the provision of information and counselling. The document states, that at minimum, a woman should receive information on the following: the length of the process; pain management; risks and complications; when to resume normal activities; follow-up care; and lastly what is done during and post- procedure (WHO, 2012). According to WHO (2012) the

purpose of pre-abortion counselling is to ensure that women have an opportunity to deliberate their decision free from external pressure. The guidelines go on to state that some women who seek an abortion have already made their decision, which needs to be respected; and so abortion clinics should not be "subjecting a woman to mandatory counselling" (WHO, 2012, p.36). In this way, WHO sees information and counselling as separate entities, where counselling is a voluntary option but certain kinds of information, as mentioned above, must be provided.

1.3 A history of abortion legislation in South Africa

Hodes (2013) states that during apartheid, a concern of the nationalist government was to curb the growth of the black population. On par with this, birth control was promoted amongst black and coloured communities (Guttmacher, Kapadia, Naude & de Pinho, 1998). However, abortion, another means of keeping the black population from increasing, was still seen as immoral in the eyes of a conservative government party (Hodes, 2013).

Under the A*bortion and sterilization* act (Act No. 2, 1975), abortions were only performed in extreme cases. For example, if the pregnancy posed a risk to a woman's life or if carrying the pregnancy to term would result in severe mental distress (*Abortion and sterilization* Act No. 2, 1975). In other words, a legal abortion could be performed based on the "psychiatric consequences" of carrying a pregnancy to term (Hodes, 2013, p.535). Although abortions were mostly prohibited, no measures were put in place to prevent illegal abortions in black communities (Hodes, 2013). Because of this, the number of illegal abortions performed reached "epidemic proportions" (Hodes, 2013, p.531) during the 1970's. The rise in clandestine abortions resulted in gynecological wards being overwhelmed by women presenting with incomplete abortions (Guttmacher et al, 1998). Furthermore, incomplete abortions require more resources such as longer hospital stays, blood transfusions and surgery (Guttmacher et al, 1998). The rise in maternal morbidity and the increasing stress placed on the health system by illegal abortions subsequently led to the lobbying of doctors, political parties and feminist groups to change the laws on abortion (Hodes, 2016; Guttmacher et al, 1998).

It was not until the transition into democracy that abortion laws began to change (Guttmacher, 1998). In 1995, ANC party leaders proposed that abortion be legalized as an act of protecting women's health (Hodes, 2016). This was an attempt to neutralize debates between pro-choice and pro-life activists (Hodes, 2016). In 1997 the *Choice of termination of pregnancy* (CTOP) *act* was instated. The act (Act No. 92 of 1996) states that woman can have a pregnancy

terminated up to 12 weeks, on request. If a pregnancy needs to be terminated at the 13-20 week period, this may be done if carrying the pregnancy to term would cause serious risk to the woman or the fetus; if the pregnancy was a product of rape or incest; if the pregnancy poses a threat to the socioeconomic status of the woman; and finally, if the pregnancy results in serious malformation of the fetus (CTOP Act No. 92, 1996). A pregnancy may also be terminated after 20 weeks if a doctor or trained midwife determines that the pregnancy is a threat to the woman's health or if the pregnancy would result in a severe handicap to the fetus (CTOP Act No. 92, 1996).

1.3.1 CTOP guidelines

Like the WHO guidelines, the CTOP states that counselling should be non-directive, voluntary and available before and after the abortion procedure (CTOP Act No. 92, 1996). The only mention of the kind of information that is required to be given to women seeking an abortion in the CTOP is that health practitioners should inform them of their rights under the CTOP act. Similarly, sparse information is given on abortion counselling.

1.3.2 The ambiguity of counselling and information

Counselling and information provision appear to have a complex and controversial relationship. The CTOP and WHO guidelines appear to have vague descriptions of what information and counselling services should consist of. Even though the WHO guidelines describe the minimum amount of information a woman should receive, this too, is open to interpretation. For example, it states that a health care practitioner should provide information on what "will be done during and after the procedure" (WHO, 2012, p. 35). Woodcock argues that withholding certain information, especially procedural information, could be seen as "paternalistic" (2011, p.497). What Woodcock means by this term is that when accurate medical information that could possibly be beneficial in a woman's decision-making process, is withheld from a woman, then this may be viewed as patronising or dismissive. Woodcock (2011) suggests that a woman should be asked about the kind of information that she would like to receive that would aid in her decision-making process. However, even the act of giving correct medical information can sway a woman's decision to have an abortion, as procedural information maybe experienced as intimidating (Woodcock, 2011). These uncertainties create an inconclusive abortion counselling environment with much of the guidelines left up to the interpretation of the individual health service provider. The vague guidelines presented in the

CTOP act and the international WHO guidelines open doors for dangerous counselling practices, such as coercion, and raise questions around consent (Woodcock, 2011).

1.4 Informed consent

As health practitioners do not have any national standardised guidelines with regards to abortion counselling, the variations in the information and counselling that clients receive in South Africa is vast (Vincent, 2012). In fact, counselling and information services have been used by anti-abortion activists, who work in health clinics or anti-abortion organisations, to further political agendas and their own religious beliefs (Hoggart, 2015). For example, pro-life activists in Britain after the 1980's, who were working with a religious agenda — sometimes even at abortion clinics — used counselling as an avenue to convince vulnerable women that having an abortion would lead to unhappiness and psychological distress. Counselling allowed nurses and health practitioners, who were part of abortion services, to construct abortion as "innately traumatic" (Hoggart, 2015, p.369).

1.5 Abortion Stigma and barriers to access

Despite the relatively liberal abortion laws in South Africa, illegal abortions continue to take place. Not only this, delays in seeking an abortion until the second trimester, a more complicated procedure, account for 20% of the legal abortions performed in South Africa (Harries et al, 2007). Moodley and Akinsooto (2003) argue that the liberalisation of abortion laws does not necessarily decrease illegal abortion rates or even contribute to more requests for legal abortions. Although, at a macro-level, abortion restrictions have been removed, at a micro level, factors such as culture, community, religion and education levels create serious barriers to a woman's access to a safe abortion (D'souza, 2013). In addition to structural barriers, such as inappropriate referrals and waiting periods, research conducted on the difficulties in accessing second trimester abortions in South Africa mention staff attitudes as a contributing factor. Harries et al (2007), found that staff members in the public health sector were sometimes openly hostile towards women trying to access abortion, where some would try and dissuade women from having an abortion during pre-abortion counselling sessions. Stigma and unwillingness of staff members to be involved in abortions and even apprehension to attend abortion training seminars due to fears about being accused of being 'immoral' by their communities, creates a serious barrier for women trying to access abortions (Harries et al, 2009). Not only this, a woman might avoid or delay seeking an abortion altogether due to stigma and general community disapproval (Sibuyi, 2004).

Abortion is situated in a climate of stigma, where health practitioners and communities can be judgemental and negative (Harries et al, 2007). This influences the provision of appropriate post-abortion care services, such a contraceptive counselling. Research shows that health care providers were often apprehensive to provide contraceptive counselling and were particularly judgemental towards younger women (Harries et al, 2009). Due to negative attitudes of health care providers pre-abortion counselling is similarly, comprised.

Currently, research on abortion counselling that perpetuates the notion that abortion is a traumatic and emotionally damaging procedure, still exists. For example, Baloyi, who explored the use of a narrative hermeneutical approach of abortion counselling, makes reference to women seeking an abortion as "victims or abortion suffers" (Baloyi, 2012, p.3). Vincent (2012) highlights that how we frame abortion counselling should be taken into close consideration. Currently, pre-abortion counselling sessions are constructed as a "confession" (Vincent, 2012, p.134) where a woman is expected to justify her reasons for seeking an abortion. Secondly, the current culture surrounding abortion results in the assumption that there are good and bad answers when answering questions around why one seeks an abortion. This space, where women need to justify their decisions and whose answers are subjected to scrutiny is an infringement on their autonomy that the constitution asserts (Vincent, 2012).

1.5.1 Conscientious objection and obstruction to access

The CTOP act does not have a clause regarding conscientious objection (CO). Instead, providers evoke the Bill of Rights to enact their "freedom of conscience" (McQuoid-Mason, 2010). CO is when a doctor or nurse refuses to perform an abortion procedure because it violates their religious or personal values/beliefs (Govender, 2016). Research finds that providers are not just using CO as a means of opting-out of performing abortions or being involved directly in the procedure but are using it at all levels of care (Govender, 2016). Providers have evoked CO to deny medications, ultrasounds or counselling (Govender, 2016; Harries, Cooper, Strebel & Colvin, 2014). A closer inspection of South African legislation reveals that CO can only be evoked when a provider wishes not to perform the actual abortion procedure. CO is therefore limited by the CTOP act in that providers cannot deny referrals or information to women seeking an abortion (Mcquoid-Mason, 2010). Refusal to provide referrals or information about abortion when a provider is unwilling to perform the procedure themselves is seen as a deliberate obstruction to access under the CTOP act (Mcquoid-Mason

& Dhai, 2003). Because of this, it has been suggested that many providers have actually obstructed access to abortion (an offence punishable by law) under the guise of CO. Research finds that the rate of CO is high, and this leads to fewer nurses being available to perform abortion services (Favier, Greenberg & Stevens, 2018). This in turn is a barrier to access for women. However, since providers cannot object to counselling or providing information this means that those who object to abortion are those most likely performing other tasks such as pre-abortion counselling (Harries et al, 2014). Research also finds that those providers who object to abortion have time during pre-abortion counselling sessions to dissuade women from having an abortion, often imposing religious beliefs (Harries et al, 2007).

1.6 Covid-19 and TOP services

A recent barrier to the access of abortion services is the global Covid-19 pandemic. The implementation of lockdown regulations has caused a variety of problems relating to reproductive health services (Church, Gassner & Elliott, 2020). Marie Stopes International (MSI), an organisation that works in 37 countries, states that without their services an estimated 2.7 million unsafe abortions would be performed across these countries and would result in 11,000 pregnancy related deaths (MSI, 2020). The pandemic has influenced the production of contraceptive medication and devices leading to a shortage, which can potentially lead to an increase in unwanted pregnancies (Mbatha & Mafuma, 2020). Other issues that arise from lockdown restrictions include restricted access to transport and an increase in intimate partner violence (Mbatha & Mafuma, 2020). South Africa has started to prioritize some medical services over others. For example, the beginning of lockdown regulations saw Gauteng minister of health state that only maternal health care services would remain open while elective surgeries would be limited (Mbatha & Mafuma, 2020). However, this has since been overturned. Activists and sexual and reproductive rights organisations warn that it is essential that reproductive services continue to remain operational as the livelihood of many depends on it (Mabatha & Mafuma, 2020). MRI (2020) states that abortion procedures are time sensitive and the restrictions due to Covid-19 will cause delays in access. An unexpected policy reform has taken place in response to these issues, namely the introduction of telemedicine. It was previously prohibited in South Africa, unless the provider and client had an already existing relationship. Telemedicine is now being promoted as a means of helping women adhere to social distancing restrictions (Stevens, 2020).

1.7 Counselling methods

Various methods of abortion counselling have been proposed, such as crisis-intervention models. Strydom and Humpel assert that pre-abortion counselling should be aligned with crisis-intervention and state that this is the "obvious model" (2009, p.222) that should be used. Faure and Loxton in their study on anxiety, depression and self-efficacy levels of women, in the context of a first trimester abortion, state that counselling is a "meaning building activity" (2003, p.36) with the purpose of helping women cope with complex emotions. According to Faure and Loxton (2003) abortion counselling should focus on a woman's strengths and incorporate problem-solving and coping strategies that can equip women to deal with the challenges posed by the abortion experience. They propose that self-efficiency is the mediating factor that can assist women in dealing with "psychological distress" (2003, p.36) linked to abortion. However, this study, like Baloyi's (2012), assumes that depression and anxiety of abortion clients is directly linked to the abortion itself, as opposed to the circumstances surrounding the abortion such as IPV, poverty and other socio-political factors. Studies such as these run the risk of repeating history by constructing abortion as "innately traumatic" (Hoggart, 2015, p.369) as mentioned in the above paragraphs.

The International Pregnancy Advisory Services (Ipas) is an organisation that aims to increase access to reproductive services globally. They aim to accomplish this though training programmes for health professionals (such as abortion providers), information and education campaigns and through advocacy for legal and safe abortions (Ipas, 2020). Ipas opts for a woman-centred approach to abortion services (Hyman& Castleman, 2005). This requires that health care providers first identify their own values and assumptions around abortion and then set these beliefs aside so that they can focus on the client's needs and values (Hyman & Castleman, 2005). The woman-centred approach is intended to create an environment of sensitivity and respect for women's decisions and it is upheld by a variety of practices such as values clarification workshops, co-worker feedback and anonymous client evaluation surveys (Hyman & Castleman, 2005). The client-centred approach appears to be a widely desired method for abortion provision and counselling seen in multiple local and international research studies (Mavuso, du Toit, Macleod & Stevens, 2018; Ipas, 2004; Macleod & Mavuso, 2019)

1.8 Research on women's experiences

Much of the contemporary research conducted on abortion counselling uses women's experiences of the procedure. It appears that most of the findings of these studies point to

contradictions in women's experiences. As mentioned in the above paragraphs there are multiple barriers to access as well as suggestions for improvement. However, women's experiences remain riddled with contradictions. Mavuso and Macleod's research on women's experiences of pre-abortion counselling revealed that some participants experienced the counselling as non-directive, empathetic and helpful ; while others found that the session created feelings of doubt around their decision to terminate their pregnancy; and some even described the sessions as "hurtful" (2019, p.4). One study found that all participants in the sample reported that during pre-counselling sessions they were treated with respect (Birdsey, Crankshaw, Mould & Ramklass, 2016). Harries et al (2007) found that not all respondents had negative answers concerning their experiences trying to access an abortion. Some respondents stated that staff were friendly and helpful (Harries et al, 2007). Contradictions existed sometimes within the same narrative of participants. Macleod and Mavuso (2019) describe possible explanations for these contradictions as reflections of power relations, where women may feel they need to give 'desirable' answers to researchers. Similarly, women's contradictions may reflect their own internal conflict as they too have likely internalised discourse surrounding abortion as immoral (Macleod & Mavuso, 2019).

Birdsey et al (2016) found that certain counselling practices were not meeting participant's needs. Specifically, group-based counselling and the health promotion content of the clinic's counselling program was found to fall short for women seeking other kinds of support (Birdsey et al, 2016). The overall suggestion of the study for the improvement of abortion counselling was for clinics to take into consideration that women seeking an abortion have varying counselling needs, where some only require basic information while others may require a greater amount of social support (Birdsey et al, 2016).

1.9 Suggested measures for the improvement of abortion services

Within the thread of improving abortion services, Harries et al suggest values clarification training as a means of increasing the access to quality abortions (2009). Research has found that values clarification workshops do have promising prospects for improving abortion services. In 2002 Ipas initiated 22 value clarification workshops with different stakeholder groups. Findings from 188 interviews revealed that 70% of the participants reported behavioural and attitude changes. In addition, 93% reported increased empathy and compassion for women seeking abortions (Mitchell, Trueman, Gabriel & Block, 2005).

Suggestions to combat the problems that arise from "the informed consent dilemma" (Woodcock, 2011, p.495) includes using a client-centred approach. Mavuso et al (2018) suggest that information provided, in order to establish consent, need not contain graphic procedural information or information about the developing foetus. They go on to describe various counselling options a woman can choose to receive. This includes decision making (options) counselling; additional procedural information; pre-procedural counselling, which involves emotional support; as well as post-procedure counselling (Mavuso et al, 2018).
WHO describes a quality abortion as one that is not only medically safe but also provides a clinical environment "that respects a woman's dignity, guarantees her right to privacy and is sensitive to her needs and perspectives" (2012, p. 64). Therefore, to ensure a quality abortion, abortion services must offer appropriate counselling and information to women, at a level that does not distort informed consent.

Another important element that can be included in the provision of abortion services is counselling for intimate partner violence (IPV). Birdsey et al (2016) found that many women in their sample were seeking an abortion, while currently experiencing or with a history of IPV. Therefore, recommendations are made that counsellors must prepare for this, and that training sessions of health providers should include intervention training for IPV survivors (Birdsey et al, 2016).

In this way, barriers women face regarding access to helpful counselling services go beyond individual counselling practices into the realm of historical, political and social inequality that results in normative presuppositions around a woman's bodily autonomy.

Chapter 2: Research design and methodology

2.1 Introduction

The research design used in this study will be a systematic review design. A systematic review design involves analysing a large body of information and/or research, in order to identify patterns and themes, to answer specific questions on what existing research and information reveals about a certain topic (Roberts et al, 2006). The research methodology section of this research project will outline the methodology of the study. This will include the research question, a description and motivation behind the inclusion and exclusion criteria, a description of the process of data collection, tables showing the data collection process as well as the procedure for data analysis (thematic analysis). Finally, the methods of maintaining the reliability, validity and ethical standards of the systematic review will be included.

2.2 Research Question

What are the themes that emerge from abortion counselling research conducted in South Africa?

2.3 Data Collection

The data was collected from Science direct and Google scholar. Only two hosts were used, as a preliminary search revealed that most sites contained the same articles and most articles found on other hosts could also be found on Google scholar. I began the data collection process by searching for papers that were directly related to the research topic. This involved two specific searches where an advanced search was used so that the search results only consisted of articles that had the search terms in the title. The first search used the search term "abortion counselling South Africa". The advanced search was set so that "abortion counselling" had to be present in the article titles. This was then made more specific by using the terms "pre-abortion counselling" and "post-abortion counselling". Once again, using an advanced search, searches were filtered so that only articles with these words in the title appeared as results. It was found that these terms did not need to be followed by "South Africa" as the search results were few and articles about South Africa could be easily identified.

The second search was conducted because the search terms (in the first search) did not yield an adequate number of research papers. Different ordering and wording of the search terms were used to gain access to all the possible research on abortion counselling present in the

databases. This included: “counselling for abortion”, “kinds of abortion counselling”, “abortion counselling methods” and finally “counselling for women seeking an abortion”.

The third and final search was a general one, as all research papers that mention abortion counselling also needed to be included in the study. Therefore, another broad search was conducted using “abortion in South Africa” to access papers that mentioned abortion counselling, even if it was not included in the title. This is done because research conducted on abortion counselling alone, in the South African context, is not enough to provide a clear picture of how abortion counselling is understood. For example, research papers conducted on barriers to access of quality abortions may have sections that pertain to abortion counselling. The terms that were used in each search are outlined in Table 1 below

Table 1

Search 1: specific	Search 2: specific (different wording)	Search 3: general
“Abortion counselling” “Pre-abortion counselling” “Post-abortion counselling”	“counselling for abortion” “kinds of abortion” counselling” “abortion counselling methods” “counselling for women seeking an abortion”	“Abortion in South Africa”

In summary, the first two searches were specific. An advanced search was used so that only articles with the search terms in the title were revealed. The final search was more general in that abortion counselling did not have to appear in the title. Moreover, two additional articles were found in the reference lists of other articles and were included into the study. The number of research papers collected for this systematic review amounted to 17.

2.3.1 Inclusion Criteria

The articles collected from the databases are subjected to a filtering process to determine if they are relevant to the study (Braun & Clarke, 2006). The inclusion and exclusion criteria allowed me to determine which articles were related to abortion counselling in South Africa.

Having a specific set of criteria narrows the search and allows one to come up with a manageable number of articles for analysis.

1. As the research aims to understand current abortion research, the study will include peer-reviewed journal articles to ensure that the data is valid and reliable. These research papers would best describe the picture of abortion counselling in South Africa.
2. The study will only include qualitative research. This is because this research paper is qualitative in nature and the method of analysis (thematic analysis) is a qualitative research method (Braun & Clarke, 2006).
3. The systematic review will only include research published between 1997 (the year abortion was legalized in SA) to the present (2020).
4. The review will include any research article that discusses abortion counselling; even if abortion counselling was not the primary focus of the research (meaning even if it did not appear in the title of the research).
5. The study will include research that utilizes data drawn from women's and health practitioner's perspectives/experiences of abortion counselling.

2.3.2 Exclusion Criteria

1. The research will exclude non-peer reviewed research, unpublished research, legislation documents and other organisation guidelines/reports.
2. The review will exclude quantitative research papers as there are not many research articles on abortion counselling that are quantitative and the method of analysis for this research paper (thematic analysis) is more synonymous with qualitative data.
3. The research will exclude any research written before 1997.
4. The systematic review will exclude research that is not conducted in South Africa.

The tables below outline the number of results each search yielded and how many articles were selected based on the inclusion and exclusion criteria. Generally, the first search term of each search would yield most of the possible articles. For this reason, articles that were present in the first search and re-appeared for other search terms were excluded. This means only new articles that did not appear under any prior search terms are listed below. The "0" values seen in the tables do not necessarily mean that no articles concerning abortion counselling were found but that the search term did not yield any *new* articles that had not been found under prior searches. In addition, although numbers appear in the column titled "articles after inclusion and exclusion criteria" not all could be selected for analysis. This is because some

articles met the criteria but could not be accessed. In total, 15 articles were selected from the searches and two additional articles were found in the reference lists of other articles. Table 4 provides a summary of the articles chosen for analysis.

Table 2: Google Scholar

Search type	Search term	Number of results	Articles after inclusion and exclusion criteria	Number of articles selected for research
Search 1	Abortion counselling in SA	3	3	3
	Pre-abortion counselling	8	3	2
	Post abortion counselling	12	0	0
Search 2	Counselling for abortion	6	1	0
	Kinds of abortion counselling	0	0	0
	Abortion counselling methods	1	0	0
	Counselling for women seeking an abortion	0	0	0
Search 3	Abortion in South Africa	110	12	8
Total		140	19	13

Table 3: Science Direct

Search type	Search term	Number of results	Articles after inclusion and exclusion criteria	Number of articles selected for research
Search 1	Abortion counselling in SA	7	1	0
	Pre-abortion counselling	4	1	0
	Post abortion counselling	5	0	0
Search 2	Counselling for abortion	31	2	0
	Kinds of abortion counselling	1	0	0
	Abortion counselling methods	3	1	0
	Counselling for women seeking an abortion	1	0	0
Search 3	Abortion in South Africa	57	6	2
Total		109	5	2

Table 4: Summary of articles for analysis

Article number	Author(s) and date	Title	Design and methodology	Points about AC
1	Harries, Stinson & Orner (2009)	Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa	-Qualitative -interviews -Thematic analysis	Pre/post abortion counselling including contraceptive counselling needs improvement. Counselling is needed for clients and providers
2	Vincent (2012)	Shaking a hornets' nest: pitfalls of abortion counselling in a secular constitutional order–a view from South Africa	-Qualitative -Review	AC has been used in many contexts to infringe on the right of abortion and women's bodies AC is framed as a confession Women are expected to justify their decision to have an abortion during AC sessions.
3	Birdsey, Crankshaw, Mould & Ramklass (2016)	Unmet counselling needs amongst women accessing an induced abortion service in KwaZulu-Natal, South Africa	-Qualitative -semi-structured and in-depth interviews -Thematic analysis	Limited understanding of what clients need from AC. Biomedical and health content did not seem to meet needs of clients. AC should be tailored to the client. Group-based to optional one-on-one is a solution. More support and training are needed for clients experiencing IPV
4	Mavuso & Macleod (2019)	Contradictions in women's experiences of pre-abortion counselling in South Africa:	-Qualitative -interviews	Pre-AC may help women understand their decision to terminate a pregnancy. Participants wanted non-directive

		Implications for client-centred practice	-Taylor and Littleton's (2006) Narrative-discursive lens	empathetic counselling. Counselling was sometimes negative and followed an anti-abortion discourse
5	Mavuso &Macleod (2019)	Resisting abortion stigma in situ: South African women's and healthcare providers' accounts of the pre-abortion counselling healthcare encounter	-Qualitative -Semi-structured interviews -African feminist post-structural approach	Woman described counselling as helpful. AC was seen as healing in that counsellors normalised abortion as a routine health service
6	Harries, Orner, Gabriel &Mitchell (2007)	Delays in seeking an abortion until the second trimester: a qualitative study in South Africa	-Qualitative -In-depth interviews -Grounded theory approach	In some counselling sessions providers imposed religious beliefs and gave inappropriate referrals. Women not aware of time restrictions
7	Strydom & Humpel (2009)	An examination of the importance of pre-abortion counselling	-Qualitative -Survey procedure Single system design	Pre-AC is akin to crisis intervention. This kind of counselling prevents "impulsive decision-making" (p.222)
8	Harries, Cooper, Strebel & Covin (2014)	Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study	-Qualitative -In-depth interviews -Thematic analysis	Conscientious objection influences abortion provision. Some providers who objected usually assisted with pre and post counselling instead of medical procedure

9	Orner, De Bruyn, Harries & Cooper (2010	A qualitative exploration of HIV-positive pregnant women's decision-making regarding abortion in Cape Town, South Africa	-Qualitative -In-depth interviews -Grounded theory	AC contained mixed messages for participants. Some nurses were described as supportive and informative others were described as careless and judgemental. Points to stark variations in pre and post AC services even within the same facility. Some women had concerns specific to their HIV status and this should be incorporated into counselling
10	Baloyi (2012)	The use of narrative hermeneutical approach in the counselling of abortion patients within an African context	-Qualitative - Review	A Christian approach can add value to counselling. A narrative approach can be tailored to each individual
11	Röhrs (2017)	The influence of norms and values on the provision of termination of pregnancy services in South Africa	-Qualitative -Semi-structured interviews	Nurses divide clients into worthy and unworthy based on their own perceptions and values
12	Harries & Constant (2020	Providing safe abortion services: Experiences and perspectives of providers in South Africa	-Qualitative	Difficulties in post abortion contraceptive counselling include lack of resources, time and private spaces

13	Jonas, Roman, Reddy, Krumeich, van den Borne & Crutzen (2019	Nurses' perceptions of adolescents accessing and utilizing sexual and reproductive healthcare services in Cape Town, South Africa: A qualitative study	-Qualitative -descriptive study -Group discussions -Thematic analysis	Nurses are generally supportive of adolescence during contraceptive counselling but become frustrated at repeated requests for TOP
14	Müller, Röhrs Hoffman-Wanderer &Moult (2016	"You have to make a judgment call". –Morals, judgments and the provision of quality sexual and reproductive health services for adolescents in South Africa	-Qualitative -In-depth interviews -street-level bureaucracy	Individuals can consent to contraception from the age of 12 but the age of consent is 16 and requires mandatory reporting. This creates "contradictory obligations" (p.1) and counselling becomes complex
15	Harries, Lince, Constant, Hargey & Grossman (2011)	The challenges of offering public second trimester abortion services in South Africa: Health care providers perspectives	-Qualitative -In-depth interviews -Thematic analysis	Repeated abortions frustrated providers. Some suggested sterilization as a contraceptive solution. Others advocated for wider contraceptive counselling and family planning citing that repeated abortions were due to deficits in contraceptive promotion and counselling
16	Orner, de Bruyn & Cooper (2011)	'It hurts, but I don't have a choice, I'm not working and I'm sick': decisions and	-Qualitative -In-depth semi-structured interviews	There is a need to integrate sexual reproductive counselling during the abortion process with HIV

		experiences regarding abortion of women living with HIV in Cape Town, South Africa	-Grounded theory techniques	counselling. Specifically, follow-up care needs to be increased
17	Sullivan, Harrison, Harries, Sicwebu, Rosen & Galárraga (2018)	Women's reproductive decision making and abortion experiences in Cape Town, South Africa: A qualitative study	-Qualitative -Questionnaires, in-depth interviews, expert interviews, participant observations -Thematic analysis	Women found they received different information from different nurses and different counselling procedures at different facilities. Women did not know what questions to ask during counselling. Contraceptive choice was sometimes influenced by women's partners. The partners of the women thought using contraceptives was suspicious and implied infidelity.

2.4 Thematic Analysis

The data collected (i.e. the research articles on abortion counselling) was analysed using Braun and Clarke's method of thematic analysis (2006). A thematic analysis was used, over any other qualitative method, as it best met the demands of the research question. Thematic analysis can uncover patterns and themes across large sets of data (Braun & Clarke, 2006) and this is in line with the aim of the research to understand the current state of abortion counselling in South Africa. However, this research will also not fall into the trap of describing themes and patterns as innate to the data itself. Braun and Clarke (2006) stress that the researcher has an active role in the analysis of these themes and should not deny their own theoretical standpoint and values in relation to the research. For this reason, not only will the themes and patterns of the data be set forth, but the reasons behind why I, the researcher, have chosen to discuss those themes will be elaborated on.

Thematic analysis involves unearthing themes in the data. A theme can be described as a pattern of response present throughout the data that is important to the research question (Braun & Clarke, 2006). In order to outline the themes in a data set Braun and Clarke (2006) set out a series of steps that can achieve this. These steps, which were followed in this research, are outlined below.

2.4.1 Familiarising with the data

This step involved familiarising myself with the data through repetitive reading. It is not only a method of familiarising oneself with the content of the data but reading actively so that preliminary impressions, themes and patterns are identified. This helps guide the researcher into the next step of coding. Apart from reading through each article a couple of times, I also pursued reading them actively by highlighting extracts that stood out and that appeared to repeat themselves across various articles.

2.4.2 Coding

The initial stage of coding involved picking out the raw data that was interesting to the research question. This is a way of consolidating the raw data into meaningful units. In the case of this research, coding was done to draw out specific themes relating to abortion counselling. At this stage the coding was exhaustive, and any potential themes were highlighted, as these themes could always be narrowed later on. Coding was performed by using different colour highlighters for different codes. For example, I used a yellow highlighter for any reference to

the type of approach or the background of the clients. Some of the codes were: different cultural backgrounds; cultural context; differential client needs; crisis intervention; and intensive psychosocial counselling. This led into the next step and the generation of the theme titled: Counselling methods: one size does not fit all.

2.4.3 Themes

During this stage, codes were sorted into themes. The codes were analysed and were considered as to how they could be condensed into over-arching themes. During this phase of the analysis the relationship between codes, sub-themes, and over-arching themes was considered. Codes that did not appear to fit into any of the themes were discarded.

2.4.4 Reviewing themes

At this stage the themes determined in the previous step were refined. The raw data or codes that were placed under each theme were assessed to determine if they were coherent with the theme. This involved asking if the codes that were grouped together were accurately described by the theme, and vice a versa. It is during this stage that one needs to decide if particular theme names should be discarded or changed. For example, originally a group of codes namely, limited method choice; rushed; lack of time; lack of privacy; injectable contraceptives etc was named "difficulties surrounding family planning". However, at this stage the name of this theme was changed to "Difficulties nurses face in implementing family planning services" as the codes related more to nurse's difficulties with implementing family planning rather than women's difficulties with access to family planning. At the end of this stage, a comprehensive set of themes and an understanding of how they related to one-another was established.

2.4.5 Refining the themes

At this stage the themes were refined and redefined. This involved identifying the essence of the over-arching themes. This was done through a series of drafts and discussions with my supervisor. This step usually involves describing each theme and how it relates to the overall "story" that the data conveys and how it relates to the research question. This was done by writing up a draft of my analysis. I then received feedback on the analysis and themes after a discussion with my supervisor. During our meetings we discussed how I had related my themes and how themes could be divided into sub-themes, and what themes needed to be re-named. For example, the yellow codes (mentioned in section 2.4.2) that made up the theme "Counselling methods: one size does not fit all" originally had a sub-theme called *IPV and HIV*

in my first draft. However, while writing up the second draft it was decided that this sub-theme would make more sense as a theme in and of itself and was re-named "contextualizing abortion narratives".

2.4.6 Writing up

This final stage involved providing evidence, or extracts, from the data that confirmed the prevalence of the theme. The evidence needed to be provided in a way that allowed me to tell the story that the data was conveying and describe how the themes answered the research question. The next chapter engages with this step in detail.

2.5 Reliability and validity

According to Long and Johnson (2000) reliability can be defined as the consistency of the researcher in applying analytical methods. They define validity as the precision and accuracy of the researcher in applying these methods as well as if the data accurately describes the findings and if these findings are successful in answering the chosen research question. Previous discussions on the credibility of systematic reviews revolved around the notion that the credibility of the review is determined by the credibility of the studies it analyses (Garside, 2014). However, Popay et al (2006) state that the credibility of reviews does not necessarily determine the credibility of the systematic review, rather a focus should be put on the audit trail that explains why certain studies were included or excluded. Therefore, the reliability of this study was ensured through clear descriptions of why certain research papers have been included as stated under section 2.3.1 and 2.3.2.

In addition, Smith and Noble's (2015) strategies to ensure valid and reliable research were followed. Their strategies relevant to this systematic review are listed below:

"1. Accounting for personal biases which may have influenced findings".

2. "Acknowledging biases in sampling and ongoing critical reflection of methods to ensure sufficient depth and relevance of data collection and analysis".

3. "Meticulous record keeping, demonstrating a clear decision trail and ensuring interpretations of data are consistent and transparent".

4. "Establishing a comparison case/ seeking out similarities and differences across accounts to ensure different perspectives are represented".

5. "Demonstrating clarity in terms of thought processes during data analysis and subsequent interpretations".

6. "Engaging with other researchers to reduce research bias" (Noble & Smith, 2015, p.2)

In order to ensure step 6, the systematic review analysis was reviewed by and discussed with my research supervisor. Overall, the reliability and validity of the study was ensured through a process of ongoing reflection throughout the research project as well as a transparent outline of the method and research process. Notes were made on the areas that the research articles were conducted and the formats of research. Similarly, a research diary was kept in which I recorded personal biases and research challenges. For example, after reading multiple articles on CO and articles on nurses who moralize abortion, I developed a bias towards nurses in reproductive health care services, believing that all nurses objected to abortion. This bias was written down along with a reminder that this was not an accurate or fair assumption. Furthermore, this bias was disputed by following point 4. I ensured that the articles for analysis contained data on nurses who did moralize abortion and articles that contained data to the contrary.

Chapter 3: Analysis and discussion

3.1 Introduction

The chosen analysis for this systematic review is a thematic analysis. This is because the research question concerns uncovering themes of abortion counselling research in South Africa. The previous chapter provided examples of how initial codes became themes (under section 2.4.2 and 2.4.3). This chapter covers the remaining steps of Braun and Clarkes analysis, that is the description of themes and an exploration on how these themes and sub-themes are linked. The analysis ends with a discussion on the links between the themes and subsequent recommendations. In total 6 themes emerged from the data.

3.2 Themes

In the sections below, I discuss the themes and outline why they have been chosen as such. Each theme is followed by a deeper discussion on the significance of the theme for abortion counselling in South Africa.

Theme 1: The experiences of women

This theme was chosen as eight of the 17 articles for analysis have a focus on women's experiences of abortion counselling and women's experiences of abortion services in general. This theme is split into two sub-themes: namely, women's experiences of the abortion clinic environment; and then more specifically their experiences of abortion counselling.

Sub-theme 1(a): Experiences of the overall environment

Although this theme does not relate directly to counselling it can be argued that the environment of the clinic may influence women's experiences of the counselling session. The extracts below point to how the clinic environment can have a negative and positive impact on women's experiences of TOP services.

"Women described difficulties in navigating the health care system, which affected their abortion care-seeking and attempts to learn and gain health information" (Sullivan et al, 2018, p.1173)

"she was disturbed by anti-abortion demonstrators outside of the clinic" (Harries et al, 2007, p.6)

"The waiting rooms… the hard chairs. It's cold and inhospitable for everyone who is sitting there getting cold and you're in pain… I just feel things could be a little … more comfortable for us" (Sullivan et al, 2018, p.1169)

"you feel like they are just looking at you, they're just looking at someone who is a cheapskate, who doesn't have any morals" (Harries et al, 2007, p.5)

The clinic environment seems to 'set the stage' or 'tone' for the counselling session in that women arrive at clinics with preconceptions and their own constructions on what abortion means for them. These preconceptions may be exacerbated by the clinic environment. The extracts above highlight that the clinic environment can further construct abortions as immoral, innately traumatic or shameful and in doing so perpetuate the internalisation of stigma. This hostile environment is created firstly by the difficulty navigating the system in the first place (as highlighted by the first extract) the difficulty to access already implies that women are unwelcome, and this confusing system may ward off potential abortion seekers. Secondly, if a woman does find her way to a clinic, she may be met with anti-abortion protestors outside the clinic (extract two) this can solidify feelings of shame before women even enter counselling sessions. Thirdly, the environment inside the clinic has been described as "cold", "hard" and "inhospitable" (extract three). This is coupled with stares from providers and those who work at the clinic that have been described as judgemental. In this way, the environment of the clinic makes women feel unwelcome and solidifies feelings of shame. Before counselling has even begun women feel that they are being told, although not in words, that they should not be seeking an abortion.

However, if the clinic is welcoming then women may feel comfortable and especially, feel able to talk freely and openly in counselling sessions. For example, the extract below highlights an ambience which contrasts with the hostile environment that is described in the extracts above.

"Zintle described how "chatting" with others in the waiting room removed the discomfort and conflict around her decision making her feel "at ease"… importantly, for Zintle, this

experience produced the knowledge that abortion may not be as wrong as she thought" (Mavuso & Macleod, 2019, p.9)

The extract shows that the casual environment outside of the counselling session can have positive outcomes. Casual conversations in waiting rooms are a way in which information and empathy is shared between women. In this way clients are providing, what ideally, the environment and clinic staff are supposed to provide. The extract reveals what, in women's experiences, makes abortion services welcoming. Firstly, the use of the word "chatting" implies that the interaction was casual and therefore women did not feel under pressure to speak. Secondly, the casual chatting most likely mitigates the "cold" and "hard" environment and instead can make one feel "at ease". In a way, the casual chatting between women going through a similar experience can un-do the feelings of shame and stigma created through the clinic environment. It appears that the clinic environment, including potential anti-abortion protestors outside, creates an environment of 'us versus you'. However, when women sit in waiting rooms and have these casual interactions the environment changes into 'we are with you'. If the clinic environment is supportive then women will feel supported. If women feel "at ease" then it is more likely that they will utilise the counselling session to their advantage.

Sub-theme 1(b): Experiences of AC

In the extracts below it appears that women's experiences with counselling were often described in terms of the information received. The information provided included overstated risks of abortion such as misinformation around the risk of infertility, being told not to opt for abortion and being told to choose adoption instead. The first extract underscores several difficulties encountered by women within the abortion counselling space.

"participants perceived multiple barriers to improving family planning services in the public sector, including limited contraceptive choice, overemphasis on condom promotion, little or no pre- and post-abortion counselling, and problems with access to family planning services such as restricted clinic opening times and contraceptive services not always being available at abortion sites" (Harries et al, 2011, p.204)

"Nndipha described how (mis-)information provided during the counselling about the risk of infertility, coupled with this pregnancy having been her first, was experienced as

distressing…distress is produced through discourses which construct the decision to have an abortion as one to be ashamed of" (Mavuso & Macleod, 2019, p.6).

"some of the women spoke about the hurt they felt during the counselling because of the (overstated) risks of abortion or being encouraged to opt for adoption" (Mavuso & Macleod, 2019, p.6)

"One third of women reported that the information given during counselling was not sufficient and just over half of all women reported that the information given was not relevant to their personal situation" (Birdsey et al, 2016, p .475)

"Pre-abortion counselling was also seen by some as judgemental rather than informative: "We need abortion counsellors who will talk to you and explain what's going to happen, to make sure you want to continue with your decision or not. Not counsellors that will tell you not to terminate your pregnancy". (Orner, de Bruyn & Cooper, 2011, p. 787)

It seems that pre-abortion counselling has become synonymous with providing information, which is required by law to acquire confirmed consent. Women need to be informed of their rights and be given basic information on what an abortion involves ensuring that women are consenting to the procedure. In the second and third extracts, the information given during counselling consisted of talk around 'risks'. Although almost all medical procedures require providers to disclose the risks of the procedure the extracts around abortion counselling often use the terms "misleading" and "over-stated" when referring to information on risks. In the fourth extract women found that the information they received was irrelevant or insufficient. The overstated risks and inadequate amount of information given to women raises concerns over informed consent. Incorrect information, especially medically inaccurate information, can dissuade women from opting for an abortion. Not being given relevant or enough information could also influence women's decision-making processes. Finally, the last extract explicitly shows that women seeking an abortion desire information to help with their decision making. This means that these questionable information sharing practices are especially problematic for those women who have not yet made their decision to have an abortion. The lack of concrete guidelines on what information should be provided in order to obtain informed consent may lead providers to relay biased information to abortion seekers. Lastly, the

judgemental attitude of providers can also dissuade women, and just as false information does, it could make women question their decision.

The information in these extracts was perceived in general as misleading or lacking. There was not much mention of counselling that addressed emotions or decision making. It appears that counselling around options was not an objective practice of simply stating all the options other than abortion but an avenue for nurses to insert their preferred option (adoption or no abortion). However, some women's experiences of counselling included some positive experiences such as described in the extract below.

"some participants experienced the counselling as healing or beneficial" (Mavuso & Macleod, 2019, p. 4)

This section contained 6 extracts, where 3 of these were from the same author. This also underscores the need for more research into women's experiences of abortion counselling and information sharing.

Theme 2: Nurses responses to abortion and objection to abortion service provision

Research on abortion and abortion counselling utilize client and provider perspectives as data. While the first theme (and sub themes) focused on the former; this theme focuses on the latter. Overall, the provider perspectives in the research articles follow patterns of a "moralizing service provision" (Muller, Rohrs, Hoffman-Wanderer & Moult, 2016, p.74). Once again, this theme has two sub-themes: conscientious objection; and justifying abortion.

Sub-theme 2(a): Conscientious objection

The CTOP policy states that providers can choose not to participate in the procedure, on grounds of conscientious objection. As an outcome of the Act, many nurses chose to utilize this right either due to their moral or religious beliefs (as highlighted in the first extract) or sometimes even because they are uncomfortable with the procedure (as highlighted in extract 2).

"operate by innovating ways of service provision that were congruent with their moral framework" (Muller et al, 2016, p.74)

"Providers who were uncomfortable with abortions limited their involvement to less contentious services such as pre and post abortion contraceptive counselling" (Harries & Constant, 2020, p.81)

This objection to be involved in abortion services limits nurses to counselling (because this is required by law). In this way it appears that counselling services can be seen as a way of 'opting out' of the procedure — as seen in the extracts highlighted below — thereby significantly decreasing the number of providers available to perform procedures.

"providers described that they would help with ultrasounds and pre abortion counselling…they preferred not to assist in the procedure itself" (Harries et al, 2009, p.6)

"others restricted their involvement to tasks solely relating to pre abortion care such as counselling or referral" (Harries et al, 2014, p.4)

However, one of the articles indicates that providers have used conscientious objection to remove themselves from abortions services completely, including pre and post abortion counselling.

"some providers went further and absented themselves from the entire process" (Harries et al, 2014, p.4)

This could mean that those responsible for providing information and emotional support are those who disagree or moralize TOP services (and use the session as an opportunity to pass on their values). This could have consequences for the women who seek these services as the values of the nurses who counsel them may seep into the counselling session. This is not always the case, however, as some research has found that some nurses are able to separate their personal views on TOP from their work.

"despite personal or religious beliefs prohibiting TOP involvement, some providers were able to separate personal values from professional conduct" (Harries et al, 2009, p.6)

However, it is still concerning that those who object to abortions are those usually involved in providing information to women who are seeking these services, as well as counselling the

clients. This could provide one explanation as to why nurses in these research samples choose to relay information to women that over-emphasizes emotional and physiological consequences of abortion procedures.

Sub-theme 2(b): Justifying abortion

In addition to the finding that providers tend to moralize abortion services this extends into a theme of justification. To elaborate, many articles found that the level and quality of care that women receive is sometimes dependent on their ability to provide the 'right' reason for wanting to access TOP services. As mentioned in sub-theme 2(a) it has been found that nurses have inappropriately used CO to avoid participation in all aspects of abortion service provision, even counselling. However, when nurses do conscientiously object to the procedure and instead limit their participation to counselling only, their moral stance on the procedure has the potential to seep into counselling sessions, where women end up needing to justify their decisions.

"street-level bureaucrats (SLB's) make moral judgments about their clients to distinguish 'worthy' clients from 'unworthy' clients." (Muller et al, 2016, p.75)

"The sub-themes of 'forced pregnancy' and 'vulnerable patients' were also mentioned by other participants supportive of TOPs….In the view of this participant, the circumstances of the pregnancy (rape), the social circumstances (lack of resources) and the trauma of the client (vulnerability) clearly made this patient 'worthy' of support" (Rohrs, 2017,p.41)

"almost all providers in research undertaken in South Africa perceived an unintended Pregnancy due to rape or incest as a legitimate reason to obtain an abortion…women who were pregnant due to rape or incest would deserve more compassion and support…Similarly, health care providers were found to be more understanding and supportive toward a woman seeking an abortion due to fetal abnormality as this was perceived as a legitimate medical reason" (Harries & Constant, 2019, p.82).

"They (nurses) reported to have some empathy the first time the girl requests a termination of pregnancy, and use the worst-case scenario as explanation warranting her to seek termination of pregnancy" (Jonas et al, 2019, p.89)

The extracts above highlight what providers consider 'good' or 'legitimate' reasons to seek an abortion. Firstly, providers appear to consider the circumstances of the pregnancy such as rape or incest as an appropriate reason to seek an abortion. Secondly, fetal abnormalities were also considered a legitimate medical reason to seek an abortion. Thirdly, they consider the social circumstances of the women, this could include lack of resources needed to take care of a child. Most of these extracts consider an abortion legitimate especially if it appears out of the woman's control. Providers also appear more empathetic to first-time abortion seekers. If providers perceive there to be legitimate reasons for abortion, then this must mean they perceive there to be illegitimate or a 'wrong' reason to seek an abortion. It also appears that nurses perceive repeat abortions, and failure of contraceptive use as illegitimate reasons to seek an abortion. These points are further elaborated on in theme 3 below.

The patterns of moralizing abortion coupled with conscientious objection; and requiring women to justify themselves explain why many of the articles mention that women received misinformation, judgment and religious advice during counselling sessions. Furthermore, the theme of justification shows that the purpose of abortion counselling has not been made clear in guidelines or in clinics. It appears that the abortion counselling format has been set up as an interview where women are expected to explain themselves. This may not only dissuade women from attending counselling sessions but perpetuate unhelpful labels for TOP seekers as worthy or unworthy of empathy. These extracts point to a wide-spread problem of inadequate guidelines for nurses. When there are gaps in policy, training or guidelines it is expected that the practices of AC become open to interpretation and open the doors for nurses to fill in the gaps using their own system of values and beliefs.

Theme 3: Failed contraception and repeat abortions

In contrast to the last extract of sub-theme 2(b) this theme outlines issues around repeat abortions. In theme 2(b) it was found that nurses are more likely to be more empathetic when a woman is coming for a first-time abortion. However, this empathy seems to diminish when a woman seeks an abortion for the second or third time around.

Much of the experiences and opinions of nurses on contraceptive counselling revolved around issues of using abortion as a contraceptive method or women who had failed to use contraceptives. Most nurses cited 'repeated abortions' as a source of frustration. However, nurses had varying opinions on why this occurs. Some placed the blame on women for being

irresponsible with their contraceptive use, while others saw it as an issue of under resourced reproductive services.

"Providers suggested that the availability of abortion services "encourages people not to use family planning". While other providers attributed the rise in repeat abortions to the failure of contraceptive services to address women's diverse family planning needs" (Harries & Constant, 2020, p.82)

"when the girl returns the second time for termination of pregnancy or the third time, the nurses reported that they actually do not feel sorry or empathize with her anymore as it shows that she is not responsible and that she is using abortion as a contraceptive method" (Jonas et al, 2019, p.89)

" A woman who returned for a second or third time was identified as coming for a 'repeat abortion' and in turn was seen as sexually irresponsible…the relationship between failed or no contraception was linked to concerns with the 'break down' in current family planning services including adequate family planning counselling" (Harries et al, 2009,p.7)

"seeking an abortion more than once was indicative of using abortion as a contraceptive method and was key to providers' frustrations towards women seeking later abortions…a senior medical superintendent expressed an underlying discomfort with abortion, particularly second trimester procedures, suggesting an aggressive promotion of family planning, including more permanent methods such as female sterilization, as a feasible alternative" (Harries et al, 2011 p.204)

"Other providers suggested that there should be more focus on broader reproductive health services, especially contraceptive services, rather than expanding abortion services as improving family planning services was preferable to abortion and ultimately 'women needed to take more responsibility in using contraception" (Harries et al, 2011 p.204)

This theme links with the previous theme of justification. Nurses may change the way they treat abortion seekers who come for a second or third abortion because to providers there is no real justification for this. An abortion is no longer seen as out of a woman's control, but an

active choice made by women. In other words, providers believe that women have chosen to use abortion as a contraceptive method instead of being what they term 'sexually responsible'.

These extracts also highlight the various contradictions in opinions between providers. Not only do nurses blame women for repeated abortions, they may also change their level of care based on this perception. Nurses who see repeated abortions as a failure on the part of reproductive health services still remained frustrated. Interestingly, nurses appeared to immediately label abortion seekers as irresponsible or blasé if they returned for a second or third abortion as this meant they were using abortion as a contraceptive method. Nurses did not appear to consider that 'repeat abortions' may not always be due to sexual irresponsibility but other socially located issues such as IPV; long distance travel for contraceptive care; and partners' dislike of contraceptives, as this implied infidelity for some (Sullivan et al, 2018)

Furthermore, nurses who were frustrated and blamed women for being irresponsible with their contraceptive use solidified the theme around deservingness and justification. One abortion is seen as acceptable because it is not seen as a women's fault. However, more than one abortion sometimes meant women were not deserving of provider empathy. The changes in nurses' attitudes according to their understanding of a woman's deservingness results in non-standardized services where women may not be receiving the same quality of counselling if they require a second or third abortion.

In addition, it is interesting to note that most articles that discuss using "abortion as contraception" placed the burden of contraception on women alone. The responsibility of safe sex tends to fall on the woman's shoulders as does contraceptive failure. Providers who feel this way may be ignoring the bigger picture. That is, male partners should also be held accountable for failure to use contraception, especially condoms. It is not unheard of that some men refuse to use protection and women are sometimes not in the position to refuse sex if this occurs, in fear of violence or abandonment.

Theme 4: Counselling methods: one size does not fit all

Many of the articles for analysis state that counselling took place but did not further describe the format of the counselling. This links to theme one in that contradictions in women's experiences of counselling exist because there is no specified format. That is, the format of

counselling differs across clinics and between individual nurses. This theme outlines the varying formats of counselling and therefore highlights the lack of standardization.

Of the articles for analysis no two methods of counselling used or explained were the same. The articles suggest that women's needs are diverse and therefore AC needs to address these varying needs. For example, some women have already made their decision and do not feel the need for additional counselling, while some women may be facing difficult situations such as IPV. Furthermore, some women may be surrounded by support whereas others have no support from family or friends.

"Patients who are objects of this article are from different cultural backgrounds makes it important to attend to their problems differently and individually…the narrative approach would be able to give participants an opportunity to tell narratives within the context of their own particular language and cultural context" (Baloyi, 2012, p.2)

"the different steps during crisis intervention taken into consideration, the process of pre-abortion counselling with its contextual aspects can be implemented successfully in the interests of the pregnant woman who finds herself in a crisis" (Strydom & Humpel, 2009, p.222)

"Women seeking induced abortion services may have differential counselling needs with some requiring more intensive psychosocial counselling than others who have adequate social support…it is recommended that the abortion counselling take into consideration differential client needs" (Birdsey et al, 2016, p.477)

"Given that abortion seekers have varying needs…call for client-centered counselling, a model of abortion counselling should be developed that is responsive to the narratives clients tell of their lives…different kinds of counselling should be made available to abortion seekers" (Mavuso & Macleod, 2019, p.7)

It is clear from the extracts that many different counselling methods exist. The researchers in the first two extracts advocate for certain counselling methods (i.e. narrative and crisis intervention approaches) because they believe these methods take into consideration the culture and context of women. However, the latter two extracts (taken from more contemporary

articles) show a shift in thinking. That is, no counselling method is objectively better for all women. The efficacy of counselling is determined by whether the chosen method is determined by the needs of client. In this way, nurses need to become attuned to the needs of their clients as no one method will be of the same benefit to all women. Furthermore, as per the CTOP ACT, women may choose not to receive counselling and this needs to be respected and upheld by nurses.

Theme 5: Contextualizing abortion narratives

Many articles pointed to specific social and health issues that TOP seekers were facing, such as IPV and HIV and aids.

"Clients who were uncomfortable with the group format of the counselling reveled a number of relational and personal challenges which they expressed a desire to discuss further… four women reported sexual and/ or physical abuse" (Birdsey et al, 2016, p.475)

"respondents who had abortions and those who did not both reported sometimes being coerced into unprotected sex with male partners" (Orner et al, 2010, p.48)

"women spoke about having to cope with all of this 'with nobody to help' them, and were reluctant to disclose to others HIV-positive status, pregnancy, and notably, abortion-related intentions" (Orner et al, 2010, p.50)

"some women were able to discuss their decision to have an abortion with their boyfriends, yet others were afraid to discuss their decision because of fear of being abandoned" (Harries et al, 2007, p.8)

"Socioeconomic hardship was repeatedly raised as a prime reason for abortion… but these challenges were often deepened and more complex when coupled with HIV" (Orner et al, 2011, p. 786)

"Others cited relationship concerns, including lack of trust, like a cheating partner who did not want anything to do with her pregnancy or an alcoholic partner who would not be a trusted father" (Sullivan et al, 2018, p.1170)

As mentioned in the previous theme, women have varying counselling needs and it becomes evident from this theme that it is due to varying circumstances. The extracts above underscore the complex situations that women seeking abortions find themselves in. It is unclear how these issues are incorporated into counselling. Extract 1 (theme 5) highlights that women who were experiencing IPV found that the counselling did not address this specific need. This links to subtheme 1(b), extract four, in which women expressed that the information relayed during counselling did not feel relevant to their particular situation. IPV or lack of partner support is an important factor to consider in abortion counselling. For some women, a counsellor may be the only support they have. As seen in extract three and four of this theme, some women might feel uncomfortable discussing certain information as they may feel ashamed or it may be an issue that is surrounded with stigma in their communities. For example, women who are HIV positive face their own set of unique circumstances such as increased stigma and anxiety around health. Therefore, abortion counselling need not only address the abortion procedure itself, but it may be beneficial for counsellors to make it known that issues of IPV and HIV are open for discussion *if* the client so wishes. Furthermore, since multiple women across different studies bring up HIV and IPV it becomes clear that these are issues that women want addressed or need support for. This finding supports suggestions made by Birdsey et al (2016) for better integration of IPV and HIV support services into reproductive health care services as it has become clear that they are intertwined.

Theme 6: Difficulties nurses face in implementing family planning services

This theme covers issues around lack of resources and the challenges that nurses face in being able to provide reproductive health services. Reasons cited for the difficulties that health providers face include lack of resources; and confusion around laws, policies and guidelines.

"providers recognized the difficulties with family planning services including limited method choice, and lack of time to provide comprehensive counselling, and a private space in which to counsel women" (Harries & Constant, 2020, p.82)

"providers often had to talk to women "on the run" or they were too rushed to provide comprehensive post abortion contraceptive counselling and was easier to continue giving injectable contraceptives" (Harries et al, 2009, p.7)

"Confused by the contradicting policies and guidelines, nurses reverted to their own moral judgements and the inherited routines of care in stretched facilities. For example, several nurses emphasized abstinence as primary educational message, despite provisions in the CA that all children aged 12 and above have the right to access contraception" (Muller et al, 2016, p.74)

"nurses' decisions around the implementation of SHR services attempted to straddle the schism between policy, the reality of providing services in over-burdened, under-resourced clinics, and their own moral framework" (Muller et al, 2016, p. 75).

Theme three described how nurses tend to view women who come for repeat abortions as sexually irresponsible. However, within the same theme some nurses saw the rise in repeat abortions as a product of failing family planning services. Therefore, theme six highlights structural or macro issues that play a role in delivering quality reproductive health. A flawed reproductive health system leads to inadequate contraceptive services which in turn leads to a rise in repeat abortions. A lack of resources such as limited contraceptive options, a lack of private counselling rooms and time constraints are not ideal working conditions for nurses. Furthermore, extract 4 in this theme reiterates the point in subtheme 2(b) which underscores how ambiguous policies and guidelines result in nurses having to rely on their own moral value systems. Because of this, services become inconsistent and may be one of the reasons why women have contradictory experiences when accessing abortions.

3.3 Discussion

One pattern that emerges from all the themes is that of ambiguity and contradiction. Contradictions are evident in the extracts from women and providers. Many women at the same clinic had varying experiences of the counselling, and the clinic environment, ranging from negative to positive. When I considered how it is possible that women displayed contrasting experiences at the same clinic and across clinics, I looked to nurses experiences of counselling. Firstly, if women have contradicting experiences, then one of the possible reasons might be that the counselling methods being offered by providers is different. Secondly, if women have these contradicting experiences then it is likely (as identified in the literature as well) that women have varying counselling needs. Counselling at the clinics either meets those needs or does not, thereby explaining the spectrum of negative and positive experiences. It is interesting to see that counselling sessions do not appear significantly varied across research paper

findings. This means it is not necessarily the counselling that is different, but the usefulness or perceptions abortion seekers have of the counselling. This is because almost all the articles for analysis describe counselling more as an information sharing practice rather than what one would traditionally consider 'counselling'. Therefore, differences in counselling are not necessarily expressed in format but are nuanced. This could be in the way nurses treat women or what information they choose to share or leave out.

The question then arises as to why counselling is not standardized and why nurses conduct themselves in different ways. One of the possible reasons found in theme two and three show that nurses can place their own value judgements on women and counsel in a way that follows their own value systems. Furthermore, nurses who object to providing an abortion on moral or religious grounds are also likely to be the ones providing pre-abortion counselling. Just as TOP seekers have varying counselling needs, providers have varying reasons for working as abortion providers. The contradictions and ambiguities present in my findings show that providers may utilize their own value systems when conducting counselling because there are no standardised counselling guidelines to turn to. Uncertainty around counselling guidelines is exacerbated by structural barriers. Many of the findings of the research articles make mention of issues such as burnout, lack of access to private counselling spaces and time constraints. While it is convenient to blame nurses for the negative and sometimes hurtful experiences women have experienced as a result of counselling; one cannot dismiss the lack of support structures available to nurses themselves and that nurses too experience stigma (within the community and from colleagues) for the choosing to provide abortions. It must also be acknowledged that women have also described positive counselling experiences and found nurses helpful and supportive. Ultimately many providers probably find themselves trying to do their job in a system that is not ideal.

The lack of guidelines and standardization has far reaching consequences not only for women and nurses but on the perception of abortion in general. Owing to a lack of clear guidelines, and providers conscientiously objecting to the procedure leads to misinformation and stigma. TOP seekers are exposed to this misinformation and may spread this information to other women. Furthermore, women who already arrive at clinics having internalized abortion stigma, such as feelings of shame, may have these feelings further validated by providers and the clinic environment. This creates a cycle of stigma.

Perceptions of abortion and abortion seekers was a widespread theme in the articles for analysis, especially that of justification and worthiness. It was found that 'repeat abortions' was an issue commonly brought up by nurses. This label influences how providers treat TOP seekers. This points to the failure of reproductive health care services. Research articles on abortion reveal a pattern of how women are asked to explain their reasons for seeking an abortion. While this information and statistics may have use from a public health perspective, it is not ideal from a standpoint of the reproductive rights of women and in a country that has one of the most liberal laws on abortion.

Overall, the articles for analysis focused on nurses and TOP seekers perspectives. Not many of the articles mention the format or the kinds of information shared in the counselling sessions. In this way, what happens in AC sessions remains blurred. It appears that women are not offered a choice in the kinds of information, counselling and sometimes even the contraceptives they receive. Counselling services did not appear to be equipped to address issues of HIV and IPV. Even though the type of counselling was found to vary it could also be said that the types of counselling being offered are not distinctive enough. This is because women have varying needs and one standard information session cannot address the needs of all women. Finally, the construction of counselling as equivalent to information sharing is problematic.

3.4 Conclusion to the analysis

In this chapter, Braun and Clarke's (2006) fifth and sixth steps of a thematic analysis were elaborated on, namely the refining of themes (2.4.5) and writing up (2.4.6) of the report. While this systematic review was limited in the number of articles that were used as data, one thing that becomes clear is the need for more research in the area of abortion counselling in South Africa. I elaborate on this in the next and final chapter of this research. I highlight some of the limitations of this study and offer some recommendations based on this review of South African literature.

Chapter 4: Limitations and recommendations

4.1 Limitations

One limitation of the study was that articles on abortion counselling are inundated in the Western Cape. Of the 18 articles for analysis, 11 of these articles were conducted in the Western Cape, two in the Eastern Cape and one each for North West province and KwaZulu Natal. This means that the findings of this systematic review are circumscribed by the settings of the research articles. The articles chosen for analysis were open access. Therefore, it is possible that more research exists based in other provinces but were not accessible for this research project. Furthermore, due to time constraints the number of articles in this systematic review was only 17.

Another limitation was with regards to finding articles that spoke to the research question. Not many articles were written about abortion counselling specifically but rather abortion services. This means that many articles only contained a small section on abortion counselling or mentioned it in passing. This, however, is a finding in and of itself as it points the lack of concrete abortion counselling research in South Africa. Once again, only peer-reviewed articles were included in the study

4.2 Recommendations

It follows that the first recommendation is for the implementation of standardized guidelines for providers on counselling and contraceptive counselling. It is crucial that the training should be focused on strategies of modelling counselling to women's specific needs. This is because although standardized guidelines need to be created to ensure all women receive the same level of care, counselling also needs to meet the needs of TOP seekers. Providers need to be prepared to adapt to different situations and be attentive to TOP seekers specific social circumstances, whether it be IPV, HIV, lack of family support or emotional distress. There needs to be comprehensive guidelines that address varying needs of women. Furthermore, the articles found in this study mainly concerned women's and provider perspectives of current AC practices. It is suggested that more research be conducted on AC strategies and methods. Since IPV and HIV were common discussion points for women in these studies more research is needed to determine how HIV and IPV services can be incorporated into reproductive health care services.

In addition to comprehensive guidelines and training, reproductive services need to push for value clarification workshops. From my findings it is clear that these workshops should address issues of justification, 'repeat abortions' and conscientious objection. It could also be beneficial to introduce evaluation cards into TOP services. For example, women could receive a card before or after the TOP process where they have the option to write about their experiences of the counselling and the kinds of information they received. This would be a way of ensuring standardization and ensure that no misinformation or hurtful counselling practices are occurring within clinics. It could be useful, because with this information, deficits in the system could be tracked and addressed where need be.

Finally, the articles for analysis featured contraceptive counselling as a weak link in reproductive health care services. It appears that sexual responsibility is solely being placed on women's shoulders. Although not always possible, it may be beneficial to include women's partners into contraceptive counselling and education. What's more, nurses complained of limited contraceptive choice and lack of time which resulted in instances of women receiving the injection and not coming back for the next. Perhaps the use of automated text message reminders could be explored.

Chapter 5: Reference list

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