“HOW DO YOU FEEL ABOUT THE ABORTION?”: PRE - TERMINATION OF PREGNANCY COUNSELLING IN THE PUBLIC HEALTH SECTOR IN THE EASTERN CAPE

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Abstract

Pre-abortion counselling, as an aspect of abortion provision, has received growing research interest in various contexts. Much of the research has primarily focused on whether abortion counselling takes place, the experiences of women and/or counsellors (usually through retrospective interviews and surveys), and the content discussed during the counselling session (often policy regulated). Such research has proven vital to addressing the various reproductive issues facing women seeking an abortion worldwide. However, little research has focused on how pre-abortion counselling as an everyday institutional practice is conducted at a conversational level in the medical setting.

By drawing on both conversation analysis and discursive psychology, this study explored how pre-abortion counselling was conducted in the public health sector in South Africa. The study involved recording the conversation during pre-abortion counselling and analysing it in terms of its content, in particular, the discourses drawn on by all parties involved, and its *structure* and *delivery*.

The data were collected from three public hospitals in the Eastern Cape of South Africa and involved the audio recording of pre-abortion counselling sessions as part of abortion services. In total, 28 counselling sessions were recorded: 21 were individual sessions, and 7 were group counselling sessions. At two of the sites, counselling was conducted by registered midwives who worked at the hospital. At one site, an external Christian organisation volunteered trained counsellors to counsel women at the hospital free of charge.

Using conversation analysis, counselling sessions were analysed in terms of the main projects. Seven key projects were identified: (1) Context setting, (2) History taking, (3) Establishing reason for abortion, (4) Presenting options, (5) Providing procedural information, (6) Obtaining verbal informed consent, and (7) Discussion of family planning. Each project is explored in terms of what discourses and subject positions featured when speakers were orienting to a specific project. This process highlighted how the conversational projects and their respective goals enable the deployment of certain problematic discourses and interactive/reflexive positionings.

Discourse analysis revealed a clustering of discourses around two central themes. In the first clustering, the discourses were primarily used to discuss the (1) *medically related issues underpinning the abortion procedure* [medical discourse, responsibilization discourse, risk

discourse, and discourse of support]. Talk using these discourses positioned women as patients needing medical intervention, responsibilised women for conceiving, playing an active role in their termination, and navigating all the psychological and physical risks "associated" with abortion. The discourse of support illustrates how support was spoken about in the interaction whereby patients were constructed as subjects who required support and nurses/counsellors as the ones who offered the support.

In the second clustering, the discourses (2) *focused on women and the foetus*. These discourses [reproductive choice, religious, pronatalist, and foetal personhood discourses] positioned women as being responsible for making a choice regarding their pregnancy and the consequences that may result. In addition, a religious discourse coupled with a pronatalist discourse was used to construct the pregnancy and motherhood as desirable and part of "God's plan", whereas the foetus was spoken about as a "gift from God". The foetal personhood discourse was used to construct the foetus as a living and functional human.

This research provides evidence of how abortion counselling is problematic at various levels. At a practical level, there is a lack of standardisation in the delivery of abortion counselling (e.g., variation in key projects, where the counselling is mandated, time taken, nurse/counsellor training, content and format – group vs. individual counselling). At a discursive level, the use of certain discourses works to render the counselling directive through : (1) awfulizing abortion by providing misinformation about the abortion procedure, foetus and post-abortion psychological distress, (2) chastising and responsibilising women for conceiving, (3) constructing abortion as immoral, the ending of life and not in line with God's plan, (4) constructing parenthood as the preferred choice, (5) delegitimising abortion as a resolution for pregnancy when compared to the other options (e.g., parenting or adoption), and finally (6) providing counselling that does not take into account the broader socio-political contexts. Recommendations for future research are put forward, and a call to move to a reparative justice framework is made by highlighting how it can be used to identify and understand reproductive injustices as they occur along four intersecting dimensions: (1) Individual material, (2) Collective material, (3) Individual symbolic, and (4) Collective symbolic.

Contents

List of table and figures

GLOSSARY OF TERMS USED IN THE THESIS

LIST OF ABBREVIATONS

African National Congress	ANC
Choice on Termination of Pregnancy Act	CTOP Act
Conversation analysis	CA
Counsellor	C
Discourse analysis	DA
Discursive psychology	DP
Department of Health	DoH
Nurse	N
Patient	P
Post-abortion syndrome	PAS
Termination of pregnancy	TOP
Pre-termination of pregnancy	PTOP

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Chapter 1: Setting the scene

1.1 Introduction

Research on abortion and abortion related topics have increased significantly over the last few decades and specifically, much attention has been focused on the experiential aspect of having an abortion (i.e., the patients' perspective). Research has looked at, *inter alia:* social stigma (e.g., Cockrill & Nack, 2013), mental-health wellbeing both pre and post-abortion (Fergusson et al., 2008; Major et al., 2009), abortion decision-making (e.g., Frederico et al., 2018), male partners involvement (e.g., Hanschmidt et al., 2016) and unsafe abortion particularly in low-income earning countries (e.g., countries located in sub-Saharan Africa, Latin America and South-Asia) (e.g., Rasch, 2011; Singh, 2006; Yogi & Neupane, 2018).

Focus at a policy and research level has homed in on the counselling aspect of abortion services. This has involved taking a closer look into what content is covered in abortion counselling (Gold & Nash, 2007), the different types of abortion counselling and what makes them distinct, the issue of optional versus mandated counselling (Baron et al., 2015) and the abortion counselling experience from the patients' perspective (Bridsey et al., 2016; Mavuso & Macleod, 2020a; Vandamme et al., 2013). This research thesis joins and contributes to the abortion counselling literature by investigating how pre-abortion counselling is conducted in everyday practice in the public health sector in South Africa.

In this chapter, I introduce the research study. This is done by providing a brief historical contextualization of research on abortion and abortion laws during apartheid and in post-apartheid South Africa. I then move on to outlining the rationale for this research thesis and providing the key research questions. Following this, the specifics relating to the context of the study are further unpacked with a brief description of the three hospitals from which data were collected. Finally, a thesis overview is provided; this identifies and describes the central aim of each chapter.

1.2 Contextualising abortion in South Africa

When considering the history of South Africa, many people refer to a time either during or after Apartheid[1]. The fall of apartheid in 1994 marked a significant turning point for South

[1] Apartheid (meaning separateness) was a system of institutionalised racial segregation that encouraged the repression of people of colour in order to benefit the White minority of the time (Alan, 1999). Apartheid as a

Africans in various facets of their life (economically, socially, culturally, constitutionally etc.). More specifically and in relation to abortion, the law regarding abortion was changed in 1996 in the new, post-apartheid South Africa. Below I provide a brief description of the legal context of abortion in South Africa during apartheid and post-apartheid.

1.2.1 Abortion in apartheid South Africa (experience and law)

During early apartheid (up to the 1970s), all matters pertaining to abortion were dealt with under Roman-Dutch common law. Under this legal framework, pregnancies could not be terminated upon request in South Africa. However, a termination of pregnancy (TOP) could be performed if medical professionals had grounds to believe that the continuation of the pregnancy endangered the life of the pregnant woman or would impact the woman's mental well-being. Medical professionals who performed the procedure beyond these criteria ran the risk of being prosecuted and fined by the state (Guttmacher et al., 1998; Hodes, 2016)

The experience of abortion at this point in South African history was very different for women of different races and class (Klausen, 2015). The South African government had drafted and implemented legislation that institutionally and structurally privileged White South Africans in several ways. White women seeking an abortion could approach a private practitioner and request an abortion under the premise that going through with the pregnancy would threaten her mental well-being. Upper and middle-class white women, who had the financial means, could fly to other countries where the criteria for abortion were less stringent at the time (e.g., England).

In comparison, women of colour, who were restricted economically, politically, socially and educationally, were generally low-income earners and experienced great difficulty seeking abortion services (Guttmacher et al., 1998). Women and families of colour, due to structural inequalities, seldom had the financial means to access safe abortion services, and even if they did, finding a doctor to perform the abortion was particularly difficult for women of colour (Bradford, 1991). Such circumstances resulted in women procuring clandestine abortions (e.g., back street abortion – discussed later), which were often performed by lay-practitioners, doctors who had not finished their medical training, or mid-wives (Guttmacher et al., 1998). Some women used herbal abortifacients (Bradford, 1991). However, even alternative abortion procedures required some financial resources. Women who could not afford clandestine

regime existed from 1948 to 1994, although planned racial segregation in South Africa started long before that – as early as 1815.

abortions would endanger their lives by attempting to perform their own termination of pregnancy by using a variety of objects and chemicals, such as knitting needles and certain detergents (Guttmacher et al., 1998).

1.2.2. The Abortion and Sterilization Act

During the 1970s, women's organizations such as the Abortion Reform Action Group (ARAG) and the medical establishment – who were seeking protection from performing technically illegal abortions — together lobbied for abortion reform in South Africa (Cope, 1993). In 1975 parliament passed the Abortion and Sterilization Act (Act No. 2 of 1975) which sought to grant women of South Africa greater access to safe abortion services by extending the criteria under which a legal abortion could be obtained. According to the Abortion and Sterilization Act (1975), an abortion could be performed under the following conditions:

(a) If the continued pregnancy endangered the woman's life
(b) If the continued pregnancy constituted a serious threat to a woman's physical or mental health
(c) When there was a serious risk that the child to be born would suffer from a physical or mental defect of such a nature as to be irreparably seriously handicapped, and
(d) The pregnancy was the result of unlawful intercourse such as rape, incest or with an "idiot or imbecile."

Paradoxically, the Act's specific conditions made it more difficult to have a legal abortion in South Africa. Although the Act provided more conditions for which a legal abortion could be performed, women would have to obtain approval from two independent doctors and, in some cases a magistrate's court (e.g., if a woman had been raped). Once approved, the abortion had to be performed in a state hospital, where all information regarding the abortion would be stored.

Research, although limited, which sought to investigate the impact of the 1975 Abortion and Sterilization Act, reveals that it failed to increase access to safe abortion services for women in South Africa. The failure of the Act is evident in the number of clandestine abortions that occurred between 1975 and 1996, which increased remarkably from 120 000 per year prior to 1975 to 250 000 per year thereafter (Rees et al., 1997). Research conducted by the Medical Research Council showed that in 1994, 44 686 women were admitted to public hospitals with incomplete abortions, and 425 died due to complications of the abortion. Although these

findings more than likely are an underestimate of the true incidence of clandestine abortions, incomplete abortions and maternal deaths reveal that unsafe abortion practices were, under the new Act, a serious reproductive health issue. This called into question the effectiveness of the Abortion and Sterilization Act and highlighted the inadequacies in the South African Health department and legislation to protect and ensure women's reproductive well-being.

1.2.3 Abortion in post-apartheid South

The abolishment of Apartheid in 1994 and the transition into democracy saw the new ruling party, the African National Congress (ANC), address the reproductive rights of women of all colours in South Africa (Mhlanga, 2003). According to Mhlanga (2003), the South African government at the time were responding to the recommendations, specifically those concerning reproductive rights and health that were made at the International Conference on Population and Development (ICPD) and the United Nations Convention on the Elimination of All forms of Discrimination against Women (CEDAW). By tackling the contentious issue of abortion in South Africa, the ANC government was making a concerted effort to liberate women from the restrictive Abortion and Sterilization Act.

The ANC declared its stance on abortion as pro-choice. It did this through the drafting of new national goals in the Reconstruction and Development Plans, which stated, "every woman must have the right to choose whether or not to have an early termination of pregnancy according to her own beliefs" (ANC, 1994, p. 50). This new goal set the foundation for the establishment of a new abortion law in South Africa.

With the call to change the Abortion and Sterilization act of 1975, both pro-choice and anti-abortion groups filled the public and political domain with heated debate (Macleod & Feltham-King, 2012). After much debate and struggle, the Choice on Termination of Pregnancy (CTOP) Act (Act no. 92 of 1996) was passed, which has been, and still is, described as among one of the most liberal abortion laws in the world (Roberts, 2007; Ipas 2008). The CTOP Act reads as a piece of transgressive and liberal legislation. It sought to address issues of gender inequality by extending women's reproductive rights by ensuring that abortion services are available and accessible to all women in South Africa. Additional services were also incorporated into the Act, such as abortion counselling, to provide women with the information and support they

may require to safely navigate their reproductive journey. The CTOP Act was implemented in February 1997 and later amended in 2004[2].

Foremostly, the CTOP Act recognized a woman's[3] right to make her own independent choices regarding her reproductive health and to be free from any form of coercion that may influence a women's sexual or reproductive life (Engelbrecht, 2005). In line with this, the CTOP Act enables all women of South Africa, irrespective of age (including minors) and race, to request an abortion during the first 12 weeks (first trimester) of gestation. A woman does not have to provide any reason(s) for requesting an abortion during the first 12 weeks of gestation.

After 12 weeks and before 20 weeks, an abortion can only be performed if a medical practitioner and pregnant woman involved are of the opinion that:

- If the pregnancy is not terminated, the woman's physical or mental health would be at risk
- There is a substantial risk that the foetus may suffer severe physical or mental abnormality
- The pregnancy is a result of rape
- If the pregnancy continues, the social and economic circumstances of the woman would be significantly affected.

After 20 weeks, an abortion may be performed once the patient has consulted with relevant medical practitioners who are of the opinion that continuing the pregnancy would:

- Endanger the woman's life
- Result in severe malformation of the foetus
- Pose a risk of injury to the foetus

The CTOP Act, in its complete written form, addresses and provides guidelines for the following: reproductive choice/self-determination, who can perform termination of pregnancy (TOP), facilities where a TOP can take place, minors, access to services, future family planning and abortion counselling. The CTOP Act, after its initial inception, led to a decrease in

[2] The amendment expanded access to abortion and allowed registered nurses/midwives to perform abortions up to the 12 weeks of gestation.

[3] It is important to note that it is not only cisgender women who access abortion services. Transgendered men, intersexed people and individuals who identify as gender diverse may also require these services. I also am aware that within the progress literature the term "pregnant people" is used. However, within the context of this study the sample consisted of cisgender women, I continued to use the word women as a descriptor.

abortion-related mortality and maternal morbidity across South Africa (Jewkes et al., 2005). However, concerns about the implementation of the Act soon surfaced and continue to exist today, with the provision of abortion services being unevenly distributed across geographical locations within the country (i.e., different provinces) and different income-earning statuses (Macleod et al., 2017).

There are still multiple barriers that persist. Service provision is still limited (Macleod et al., 2017), accompanied by delays and long facility queues (Trueman & Magwentshu, 2013). Out of the 505 sites designated by the government to provide abortion services across the country, only 264 (53%) are operational and providing abortions (Amnesty International, 2017). The DoH's failure to regulate conscious objection (Amnesty International, 2017) has resulted in some service providers and facility managers citing personal objection as a reason for refusing services (Trueman & Magwentshu, 2013). A study in 2013 conducted in Cape Town reported that 45% of the sample did not receive the abortion they sought (Harries et al., 2015). A related study in 2016 found that out of those denied abortion care, 20% were turned away for advanced gestational age and another 20% because the clinic did not have the staff to perform abortions for that day (Harries, 2016).

1.2.4 Abortion counselling in law and policy

Concerning counselling, section four of the CTOP Act stipulates that "the State shall promote the provision of non-mandatory and non-directive counselling, both before and after the termination of pregnancy" (CTOP Act No. 92 of 1996). However, the CTOP Act did not provide any information regarding who is responsible for providing the counselling nor any standardized model for training nurses and social workers who can provide the counselling. Furthermore, the Act fails to address what information should be included in the counselling session.

The Western Cape Department of Health in 2000 published a termination of pregnancy policy, guidelines and protocols document. According to the document, counselling should include the following aspects:

> Assuring the client of confidentiality, listening to the reasons for the TOP request, discussing the available alternative to TOP (i.e., adoption or keep the baby), allowing the client to express her views, feelings, and concerns, giving details for the termination of pregnancy, ensuring that the client understands that once the Misoprostol has been taken, there is no turning back. The procedure must be completed, the available and

suitable contraceptive methods for her use post-TOP, respect and support the client's decision without being judgemental" (Western Cape department of health, 2000, p. 13).

The Western Cape Department of Health in 2016 published revised policy guidelines and protocols for choice on termination of pregnancy service. In relation to counselling, little is added other than stating that "counselling should cover all aspects" (p. 9), "Counselling done to determine gestational age" (p. 11) and including a copy of the "Best practice in comprehensive abortion care" from the Royal Obstetricians and Gynaecologists (Western Cape Department of Health, 2016). The issue with such vague guidelines is that they are open to interpretation and do not provide any direct guidance in how to perform counselling in practice. As such, it is likely that abortion counselling practices are not standardized across the province.

The Justice Alliance of South Africa, according to its website, is an organisation committed to fighting for justice and upholding the highest moral standards in South African society (Justice Alliance of South Africa, 2007). In 2007, the organisation proposed an amendment to the CTOP Act. The proposed amendment provides clarification, in the organisation's opinion, on certain elements of the existing Act that they consider to be vague and responsible for creating confusion in practice. With regard to counselling, the proposed amendment by the Justice Alliance puts forward guidelines for how PTOP counselling should be conducted. It states that women should be counselled in a manner which provides the opportunity for discussion. More specifically, PTOP counselling should include:

(a) Sufficient information, imparted either by electronic pictures or coloured diagrams and photographs, to enable the woman to understand the existing stage of development of the unborn child
(b) Involve a discussion of the extent of the risks involved in continuing the pregnancy, as set against the risks involved in having an abortion. The latter must be explained in the light of the latest medical science at the time, and must include explanation of the following risks:
    (i) The increased risk of breast cancer following an abortion
    (ii) The risk of depression and associated symptoms after a period of years
    (iii) The risk of difficulties in conceiving, and bearing children in the future.

(c) The available alternatives to abortion, and in particular, the ways in which the State and other agencies will support the mother and child, particularly in the case of the child being born disabled (Justice Alliance, 2007)

The guidelines proposed by the Justice Alliance are problematic and clearly serve a particular political and moral agenda. It is indeed, as the literature suggests, important for a patient to be provided with the necessary space to discuss their situation. However, the guidelines use terminology and propose the sharing of information that is not empirically supported. For example, they use the word 'child' instead of the medically appropriate term foetus. The guidelines focus on the notion of risk, in this case, pitting the risks of continued pregnancy against the risks involved in having an abortion. Framing the situation in this way highlights only the negative elements of each possible option, which could exacerbate any negative emotions the patient might be already experiencing. The proposed amendment suggests that counselling should address the risks of continued pregnancy and abortion, but only the (contested) risks of abortion are presented – risks associated with continued pregnancy are left unaddressed. Research has shown that pregnancy is often riskier than abortion performed under safe conditions (Raymond & Grimes, 2012). Federal statistics from the United States of America from 1998 through to 2005 show that the risk of death from "childbirth was approximately 14 times higher than that of abortion" (Raymond & Grimes, 2012, p. 216).

The guidelines also propose that the risks be explained considering the most recent medical science, with the proposal suggesting that abortion can lead to an increased risk of breast cancer, depression and other associated symptoms, and problems with future fertility. In light of the most recent studies, however, the above risks have not been empirically and conclusively proven as real risks (see Deng et al., 2018; Gerdts, 2016; Horvatht & Schreiber, 2017; Rowlands, 2011) and instead should be regarded as anti-abortion literature. Citing unsubstantiated risks in abortion counselling has been critiqued as a strategy to dissuade women from having an abortion, and ultimately threaten a woman's reproductive rights (Bryant et al., 2014; Vincent, 2012).

Although the Justice Alliance lobbied for the above amendments, they were ultimately unsuccessful. In 2008 the CTOP Act was amended and in reference to counselling, stipulated that "The State shall promote the provision of non-mandatory and non-directive counselling, before and after the termination of a pregnancy" (Choice on Termination of Pregnancy Amendment Bill, No. 1 of 2008).

In 2019 the South African DoH published national clinical guidelines for the implementation of the Choice on Termination of Pregnancy Act. In this document section 3.2 is dedicated to abortion counselling. It covers various aspects, including counselling standards (such as non-directive, non-mandatory, person-centered, and interactive approaches) and counselling topics (ranging from decision-making counselling to pre-TOP counselling, post-TOP counselling, and counselling on post-TOP complications). Some of the insights and findings from this thesis, as discussed in chapter 2, have contributed to the development of this section in the guidelines.

1.3 Rationale for this research

Abortion and abortion counselling continues to be a contentious topic of investigation in various disciplines (Brown, 2013; Hoggart, 2015). One of the most controversial issues relating to pre-abortion counselling is how it may work to dissuade women from exercising their right to choose an abortion, or in other words, how it is conducted in a directive/biased manner (Dervious & Russo, 2000; Mavuso & Macleod, 2021; Medoff, 2009: WHO, 2010). This concern is a common one which is shared by activists and (feminist) scholars alike.

Exploring pre-abortion counselling is important for many reasons. Firstly, in terms of abortion provision, it is an aspect where decision-making, experiences of pregnancy, family planning and realities related to gendered assumptions within the specific socio-cultural context (i.e., understandings of motherhood) are made relevant and discussed. Conversations about these issues within a public health space cannot be assumed to be neutral and always in the best interests of women and their reproductive rights. It is for this reason that researching pre-abortion counselling can also assist in exploring how political agendas (e.g., anti-choice) may enter into the pre-abortion counselling interaction, dictate what information is shared, and ultimately what type of counselling experience the patient receives – one which is aligned with

reproductive justice[4] and the CTOP Act or one which serves an alternative anti-abortion agenda. Secondly, there are few guidelines for conducting abortion counselling in South Africa and guidance for abortion care workers is important. Thirdly, studying abortion counselling can highlight which aspects are beneficial and which are not; ensuring the abortion counselling is conducted in a supportive and patient-centred fashion is important for the well-being of those who "chose[5]" this reproductive route.

Many of the studies exploring pre-abortion counselling have employed retrospective[6] methods using interviews or questionnaires; reviews of previous research with women and health-service providers who conduct counselling have also been published (Bender & Geirsson, 2004; Beja & Leal, 2010: Birdsey et al., 2016; Brown, 2013; Ely, 2007; Gould et al., 2013;). Although research based on retrospective methods has generated invaluable insights into women's and nurses'/counsellors' experiences of providing counselling, no study, to the author's knowledge, has sought to analyse how the interaction of pre-abortion counselling unfolds in everyday interaction at the level of talk.

Acknowledging that talk and language are the primary vehicles for healthcare communication, I take pre-abortion counselling as a predominantly conversational activity where medical professionals, patients and third-party members (e.g., parents, partners, friends) exchange information through talk. Analysing actual real-life counselling sessions at an exploratory level would not only fill a "gap" in the research literature but could also prove invaluable in collecting and identifying rhetorical practices which are problematic and also instances of potentially empowering and/or supportive talk. If there is a concern that pre-abortion counselling may be directive/biased in some way or another, then this calls for an investigation of *how* the interaction, as a primarily communicative one, is conducted in everyday practice. As such, this study seeks to address the "gap" in the literature and provide some of the first insights regarding the format, timing, content (i.e., discourses) and structure (i.e., overall organization) of pre-abortion counselling sessions conducted in public health settings in South Africa.

[4] Reproductive Justice can be defined as "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (Sister Song, 2006). See further discussion in Morison (2021).

[5] I have inserted chose in inverted commas to illustrate that many who undergo abortion feel that it was not a choice, but rather the culmination of various personal and social situations (Mavuso et al., 2018).

[6] After pre-abortion counselling has been conducted. Although the data generated are valuable, the research still relies on participants' recall and not actual interactions.

1.3.1 Research questions

The over-arching research question of this thesis is:

How is pre-abortion counselling conducted in the public health sector in the Eastern Cape, South Africa?

To assist me in exploring the talk of pre-abortion counselling, I proposed the following research questions:

1. What is the overall conversational structure of a pre-abortion counselling consultation?
    a. What are the key phases/projects that take place?
    b. How do these key phases/projects unfold during the pre-abortion interaction?

2. What information is requested and provided by women (and/or third party if present) and the health care provider during the consultation?
    a. How is the information that is requested and provided by the woman (and/or third party if present) and health care provider delivered in conversation?

3. What reflexive and interactive subject positions are located/made available within the counselling conversation?

4. What discourses are drawn on when women, healthcare providers and third parties take up or offer particular subject positions?

This research not only adds to the global literature on pre-abortion counselling but also, more importantly, provides insights into how pre-abortion counselling is conducted in South Africa. In addition, a study of this nature, which poses these types of questions, uses the empirical data of real-life interactions to ground analytical claims that could very well have the potential to contribute to the development of abortion provision and (in)directly affect women who access these services (Hoggart, 2015).

This study also seeks to make theoretical and methodological contributions. At a *theoretical* level, I have conceptualized pre-abortion counselling as a discursive event, which is simultaneously an instance of language, an instance of discursive practice and an instance of social practice (Fairclough, 1992), and as such, I am interested in the talk that features during

the interaction. A methodological objective of this study is to provide an empirical account of the content of pre-abortion counselling. More specifically, I am interested in the (1) conversational structure of the interaction (i.e., how the session begins and progresses) as well as the actual (2) content of the counselling. In relation to the content, I am interested in what discourses, subject positions and other rhetorical devices are deployed in the session and how they are used within the interaction.

At a *methodological level,* this study is one of the first, to the researcher's knowledge, to use actual real-life audio recordings of pre-abortion counselling taking place in everyday interaction. Methodologically, I also drew on the analytical strengths of discursive psychology (DP) and conversation analysis (CA) to explore how pre-abortion counselling is performed in interaction. My objective was not to create a new analytical approach but rather to demonstrate how these two approaches can co-exist in a study and can be used to illuminate different elements of pre-abortion counselling (this is demonstrated in the analytical chapters of this thesis). At a theoretical level, I highlight how the premises of discursive work and of conversation analysis can be used in complementary ways to illustrate how the *structure* and the *content* of talk can be used to understand the overall *process* of pre-abortion counselling, from its commencement to its conclusion.

1.4 Context of the Study

The study was conducted on pre-abortion counselling services in three public hospitals in the Eastern Cape, South Africa. The Eastern Cape has the third highest population out of South Africa's nine provinces and, according to census data collected in 2011, is the poorest province as indicated by its high levels of poverty and unemployment (45,8%) (STATS SA, 2016; STATS SA, 2018). In addition to this, Black women have been described as particularly vulnerable when it comes to unemployment, with a reported rate of 34.2%.

In terms of population, "Black Africans" make-up the majority of persons living in the Eastern Cape at 86,26%; "Coloureds" (8.26%) and "Whites" (4.73%) are the second and third largest population groups. In terms of first language distribution in the Eastern Cape, isiXhosa (77.6%), Afrikaans (10.4%) and English (5.5%) are the most dominant. Nationally, isiXhosa has the second-highest proportion of first-language speakers.

The sites where data were collected are public health facilities. The public health system within South Africa continues to be a national issue, with some describing public healthcare as "dysfunctional" (Coovadia et al., 2009, p. 817; Malakoane et el., 2020; Maphumulo & Bhengu,

2019). It is characterised by long working hours for medical professionals, infrastructure issues, inadequate resources and a shortage of medical professionals (Manyisa & Aswegen, 2017). The current system's operations are affected by the country's history of colonial subjugation, racial discrimination and apartheid dispossession and by recent failure in management, poor access to resources/funding and weak implementation of internationally admired policies (Coovadia et al., 2009; Manyisa, 2016; Maphumulo & Bhengu, 2019).

With the fall of apartheid in 1994, the government transformed the health system into an integrated and comprehensive national service, making health-care access for all a constitutional right (Harries et al., 2011). However, despite changes, many barriers and challenges exist today, including the vast distances patients travel, travel costs (especially from rural areas), payments for care, long queues and waiting times, and poor infrastructure (Manyisa & van Aswegen, 2017).

1.4.1 Description of the three data collection sites

Research *site 1* is an abortion clinic in a government-funded large hospital located in an urban area (3.5km off the coast) in the Eastern Cape. It was established in 1881 and is also used as a teaching hospital for tertiary education. The abortion clinic is primarily accessed by Black[7] and Coloured[8] populations and, on average, offers abortion-related services to 10 patients per day.

Site 1 had four nurses and two independent counsellors working at the TOP ward at the time of data collection. There were two Black nurses who could speak both isiXhosa and English to patients. The other two nurses were Coloured; one could speak English and Afrikaans, whereas the other spoke English, Afrikaans and isiXhosa. The two independent counsellors who worked at this site were associated with a Christian organisation and offered their counselling services to the ward free of charge. The counsellors had undergone formal training and presented themselves as lay counsellors.

One of the significant issues at this site was a language barrier between counsellors and patients. The counsellors could only counsel in English, and as such, patients who could not speak or understand English were turned away (from counselling). To address the language

[7] For the purposes of this thesis race/racial categories are understood as being socially constructed rather than a biological essence but also having real effects on peoples' lived experiences.

[8] "Coloured" is a racial category that is used to describe individuals with mixed ancestry (Adhikari 2005), often described as mixed race. The term 'mixed race' is a contested category but continues to be used in official documentation, particularly with regard to equity issues.

barrier issue, counsellors would request patients' cell phone numbers so that they could be contacted later when an isiXhosa counsellor could be arranged. Counselling at site 1 was optional and was conducted by independent counsellors.

Site 2 is situated in a different city from the other two research sites. It is situated in a township[9] in the Eastern Cape. It is a government-funded hospital and serves as a tertiary teaching hospital. This hospital is primarily accessed by Black populations. Site 2 was the busiest out of all the sites from which data were collected, and as such, most of the counselling sessions recorded come from this site.

Site 2 had three nurses who worked at a Women's clinic that provided TOP services at the time of data collection. Two of the nurses were Black, spoke isiXhosa and were mainly responsible for facilitating the pregnancy ultrasounds. There was one nurse who conducted counselling at this site. She was coloured and fluent in English and Afrikaans. Throughout the data, it was also apparent that she knew a few isiXhosa terms, such as "thatha" (take). All the counselling sessions that were collected from this site were conducted in English.

At site 2, all the nurses shared the work amongst themselves. The shared responsibility contributed greatly to this site's efficiency. Not only was this site the busiest, but they also would provide TOP throughout the day. In contrast, sites 1 and 3 would not take any new clients after late morning. Counselling at this site was mandatory. Both individual and group counselling were offered at this site. In most cases, the nurse would ask which format patients would prefer and then allocate them accordingly.

Much like sites 1 and 2, site 3 is a large government hospital. It is situated in a township and serves as a tertiary teaching hospital. This site is accessed by mostly a Black population. Three nurses who worked at this site at the time of data collection were all black and fluent in isiXhosa. All the counselling sessions were conducted in isiXhosa. At this site, doctors assisted the nurses with scans and performing the TOP surgical procedure. The doctors who assisted were mainly Indian, White or foreign doctors.

The nurses at this site divided the responsibilities amongst themselves. One nurse was responsible for collecting patients' history. Another was responsible for providing pre-abortion counselling. The third nurse acted as an assistant nurse. At site 3, the nurses shared that they

[9] Townships are underdeveloped urban areas in South Africa that were designated for persons of colour during the Apartheid era (1948 – 1993/4). The Apartheid government demarcated outlying areas as townships so that residents could provide their labour to the closest city or town.

had not undergone any formal TOP training and had learnt on the job. Counselling at this site was mandatory. Counselling sessions were either individual or group, depending on the number of patients on the day.

Procedurally, abortion was divided into two major types – medical and surgical abortion. Patients who were in the first trimester, up to nine weeks, of their pregnancy were given medical abortion, which involved the patients being given a series of tablets (i.e., Misoprostol and/or Mifepristone) which would trigger contractions and expel the foetus. This procedure could be carried out at home and only required medical intervention if complications occurred.

After nine weeks and up to 20 weeks of pregnancy, the only available option for patients in these sites is surgical abortion. Depending on the site and resources available, this is carried out using either the dilation and evacuation (D&E) or manual vacuum aspiration (MVA) method.

It's worth emphasising that the course of events varied significantly among the different sites. Individuals seeking abortion services experienced differences in the care they received, which were tailored to their specific circumstances. These variations were influenced by factors such as the stage of pregnancy (e.g., first trimester versus second trimester), the availability of resources and appointment slots on that particular day, and the location where participants received counselling.

For instance, at site 1, participants were encouraged to pause and reflect on their decision, possibly returning home to deliberate further. In contrast, at sites 2 and 3, participants were more likely to have their abortion procedure performed on the same day without extended deliberation.

1.5 Thesis overview

The next chapter (Chapter 2) reviews the literature on pre-abortion counselling. The chapter starts with a brief history of pre-abortion counselling both globally and within the South African context. I then proceed to address the different types of pre-abortion counselling, or rather what is often covered in these sessions. More specifically, I delineate options-counselling, procedural and pre-procedural counselling, and contraception counselling. In doing so, I seek to also highlight key elements that counsellors may need to address in sessions, such as the management of third parties. My focus then shifts to the approaches that have been adopted to guide pre-abortion counselling. Here, I attempt to provide a balanced description of

and engagement with the three documented approaches (Crisis intervention, pastoral counselling and patient-centred counselling) by focusing on South African and international literature. I then highlight some of the contentious aspects of abortion counselling, such as the issue of bias/directive counselling through the dissemination of (mis-)information and mandatory counselling. Finally, I develop a case of why pre-abortion counselling, as a communicative activity, needs to be studied in situ at the level of talk.

Chapter 3 is concerned with outlining the theoretical framework that I used in this study. I introduce the paradigm from which I worked, which is social constructionist. I provide a summary of this before introducing the two approaches this study utilized to explore talk within pre-abortion counselling. The first of these is *Discursive Psychology* (DP). I discuss the origins of DP, its theoretical underpinnings, as well as key concepts such as discourse(s) and subject positions. I then proceed to conceptualize pre-abortion counselling as a "discursive event", which is an instance of language produced through discursive practices which simultaneously produce social practices (Fairclough, 1993). The second approach is *Conversation Analysis* (CA). I provide a brief history of CA and focus specifically on its interest in analysing talk in institutional activities. In doing so, I document how institutional interaction is conceptualized within the CA literature and identify key concepts such as activities, projects (i.e., the primary objective participants are working towards as they engage in talk and interaction) and overall conversation structure. I close off the chapter by discussing how analytical insights from DP and CA can complement each other and reveal different aspects (micro and macro level) of the talk which takes place during pre-abortion counselling.

Chapter 4 provides the procedures that were followed for data collection and analysis. I begin the chapter by restating my aim for the study and my proposed research questions. I proceed to describe the exploratory qualitative design that was taken for this study. This includes a discussion of sampling (including inclusion criteria), recruitment and the data collection procedures. The descriptive statistics of participants, format, number and length of counselling sessions are presented. What follows next is an account of how I conducted data analysis, the DP and CA components. I close the chapter by drawing attention to some of the ethical considerations (e.g., including minors) in the study as well as providing a brief reflexivity section where I reflect on my positionality in relation to the topic and research processes.

Chapter 5 is my first analytical chapter and is concerned with the conversation analytical component of the study. This chapter outlines the structure of pre-abortion counselling as well

as well as identifying seven key projects that constitute the interaction. These key projects are: (1) context setting, (2) history-taking, (3) establishing the reason for abortion, (4) presenting options, (5) providing procedural information, (6) obtaining verbal informed consent, and (7) discussions about family planning. Each project is analysed by looking at the actions that are used to introduce, manage and conclude them.

Chapter 6 is the second analytical chapter but the first that focuses on the discourses that feature in pre-abortion counselling. In this chapter, I present discourses that are in some way related to the abortion procedure. The first of these was a medical discourse. I explore how it was deployed to construct 'patienthood', the abortion procedure (e.g., medical and surgical) and service providers as experts. I then move on to illustrate how women were positioned as irresponsible for conceiving and responsibilised for family planning in a sexual relationship – this was accomplished through a discourse of responsibilization. Related to both, I highlight the risk discourse, which I argue contributes to the awfulisation of abortion through constructing it as risky both physically (e.g., future infertility, breast cancer, death) and psychologically (e.g., post-abortion syndrome). In closing, I explore a discourse of support.

Chapter 7 is an analytical chapter that focuses on discourses that are concerned with women, abortion and the foetus. The first of these is a discourse of choice which is used to emphasize the autonomy of decision-making. Also, within this discourse, notions of regret and morality are mentioned in relation to choosing abortion. The morality of abortion often included the deployment of a religious discourse which was used to construct the foetus as "gifts from God" and pregnancy as part of God's divine plan. I also examine a pronatalist discourse which was used to construct motherhood as a preferred choice, children as bringers of joy and fulfilment, and children as wanted subjects. Within this chapter, I highlight the use of a foetal personhood discourse, which, as the name suggests, is talk that is used to confer independent personhood upon the foetus. I identify how through description and imagery (i.e., images of the developing foetus), the foetus is personified into a baby and how this construction works to reinforce the religious and pronatalist discourses.

Chapter 8 provides a concluding discussion of the study, where I summarise some of the key findings. As guided by my research questions, I focus on the structure (i.e., overall organization structure, different projects) and the content (i.e., discourses, subject positions) of pre-abortion counselling, as analysed in this study. I discuss how the discourses identified and analysed from the pre-abortion counselling interaction are problematic and how a variety of discourses

are drawn on to render the counselling biased and directive. I then put forward an argument for future researchers and research to adopt a reparative justice framework. This framework is based on an understanding that reproductive injustices occur on multiple intersecting dimensions, namely (1) Individual material, (2) Collective material, (3) Individual symbolic and (4) Collective symbolic — these are unpacked in detail and considered in light of the data analysed from this study but also of the contextual realities in which pre-abortion counselling in South Africa takes place. I end the chapter and thesis by discussing some of the limitations of the study and putting forward recommendations for future research.

Chapter 2: Unpacking pre-abortion counselling

2.1 Introduction

As already mentioned briefly in the introductory chapter, there is much literature that explores abortion care, both globally and within the South African context. There is widespread consensus amongst medical professionals, activists and patients that abortion counselling should be an integral component of voluntary abortion care (Moore et al., 2011) and research on the topic continues to grow.

Pre-abortion counselling remains a hotly debated and controversial topic, especially when the content of counselling is founded on "problematic assumptions about women, their bodies, their sexuality and their choices" (Vincent, 2012, p. 126). However, before attempting to investigate pre-abortion counselling, it is important to explore how pre-abortion counselling, as a component of abortion care, has been conceptualized and researched within the growing literature. In this chapter, I synthesise important issues covered in the literature and critically unpack them. The literature I surveyed, and which largely informs this chapter, comes from published and unpublished research (e.g., PhD theses), abortion care guidelines (e.g., IPAS, 2013), online websites (for example, Family Reproductive Health and the Guttmacher Institute) and contributions from organisations and health professionals working in the field[10].

I begin this chapter by providing a brief overview of the literature covering abortion counselling, with an emphasis on the public health sector of South Africa. I then delineate what constitutes pre-abortion counselling by identifying what can be regarded as sub-types of pre-abortion counselling, which can be conducted independently or in combination. These are: (1) options/decision-making counselling, (2) procedural and pre-procedural counselling, and (3) contraception counselling. Following this, I identify some of the problematics identified in pre-abortion counselling, such as the management of third-party members, mandated/compulsory counselling and how counselling can become directive depending on what (mis-) information is shared during the interaction.

The next focus of the chapter is an overview of some counselling approaches that have been used in pre-abortion counselling. I present three types of approaches, two of which have documented use within the South African context. These two approaches are crisis intervention and a pastoral hermeneutic approach. The third approach is based on patient-centred

[10] This was mainly done through e-mailing medical professionals working in the area of abortion in South Africa.

philosophies, which I briefly outline; I provide an example of how these principles have been combined with feminist counselling philosophies (Ely, 2007). In discussing all these approaches, I show how they contribute to some of the controversial issues associated with pre-abortion counselling, both nationally and internationally.

In closing this chapter, and in consideration of the literature on pre-abortion counselling, I argue for the importance of focusing on the talk (both structure and content) that takes place in pre-abortion counselling. Such a focus necessitates collecting data on how such counselling is conducted in everyday practice.

2.2 An overview of abortion counselling literature

The literature on pre-abortion counselling is substantial and continues to grow. It can be divided into four types. The first are handbooks, which are used to train health service providers and which contain practical information (see Perrucci, 2012; Baker, 1995; Baker & Beresford, 2011; Ipas, 2014). These are generally written by practitioners and organisations that deal specifically with reproductive health concerns.

The second type is research that draws on empirical evidence. Globally, research on pre-abortion counselling has tended to focus on three main themes, namely abortion decision-making (Chiweshe et al., 2017; Brown, 2013; Mavuso, 2014; Purcell et al, 2014), the abortion counselling experience for patients/health care providers (Beja & Leal, 2008; Ely, 2007; Mavuso & Macleod, 2020), and patients expressed needs or statements concerning the importance of pre-abortion counselling (Brown, 2013; Strydom & Humpel, 2009). These studies have tended to collect data through questionnaires and retrospective interviews with patients and healthcare providers. Interestingly, very little research has focused specifically on the counselling interaction itself as a unit of analysis.

The third type of literature, also within the academic domain, includes discussions of counselling techniques and practical recommendations (Ely, 2007; Singer 2004; Strydom & Humpel, 2009; Upadahyay, et al, 2010), as well as critical and theoretical commentary on controversial issues associated with providing pre-abortion counselling. These issues include abortion counselling policies (Gold & Nash, 2007), the ethical dilemmas involved in providing informed consent and information sharing (Woodcock, 2011), and challenges in conducting pre-abortion counselling (Vincent, 2012).

2.2.1 Research on pre-abortion counselling in South Africa

Abortion counselling in South Africa has been identified as a feature of abortion care that requires more attention to increase its frequency and its quality (Vincent, 2012). Below I present some of the research that has investigated pre-abortion counselling in some way or another in South Africa. I unpack the importance of these studies and argue, based on this discussion, for the collection and analysis of the counselling interaction itself.

Abortion counselling is a component of abortion care which has some research attention in South Africa. Govender (2000) qualitatively explored women's psycho-social experiences of abortion under the CTOP Act at different healthcare facilities in KwaZulu-Natal. Although her sample only consisted of 13 women, her findings are some of the first empirical insights into pre-abortion counselling in South Africa. Findings show that only six out of the 13 participants received pre-abortion counselling. For the women who did not receive counselling, it is unclear whether this was because it was not offered or because they refused the offered counselling.

Women reported abortion counselling to be structured around a brief statement of the possible options which was generally followed by a series of questions to ascertain whether the women were certain of their decision to proceed with an abortion (Govender, 2000). Participants felt as though the counselling sessions were rushed as nurses had to see other patients. They felt the counselling session consisted of asking clinical questions (i.e., information gathering) and neglected to acknowledge the women's feelings and provide emotional support during the abortion procedure.

Some participants' narratives of the experience of pre-abortion counselling, as reported by Govender (2000), are alarming, but at the same time open a window to further critical exploration and investigation. Jane, a participant in the study, described the counselling session as unhelpful as can be seen below.

> Jane: I was nervous because this was something out of my morals. She (nurse) told me everything I already knew. She asked me, are you aware that you are deleting a baby. It was not really counselling.

What is interesting is that, through this retelling, Jane expresses how a question, perhaps designed to ascertain that Jane was certain about her decision, was designed and delivered:

“Are you aware that you are deleting a baby?” Such a combination of words is of interest to critical discourse analysts and conversation analysts who investigate what and how social actions are achieved in institutional interactions and what the possible implications might be. In this case, the rhetorical question may imply a moral judgement rather a request for a response, where the only allowable response may be “yes”.

Govender (2000) draws on her findings to argue that abortion is a traumatic experience for women and aligns herself with Forrest (1994), who advocates that counselling is crucial in providing the necessary support for women to better deal with the issues associated with abortion. Govender (2000) calls for the adoption of a counselling approach that utilises crisis intervention problem solving techniques (discussed later in this chapter) to help women make informed decisions so as to “help women reach stable levels of functioning” (Govender, 2002, p. 145).

Engelbrecht’s (2005) PhD research, which compared and evaluated TOP services at various facilities in the Free-State during 1998 and again in 2003, provides valuable descriptive findings regarding pre-abortion counselling in South Africa. The results show how many women received counselling, their overall satisfaction with the service, how long the sessions lasted for different reproductive ages, the content that was included, as well as the training of the health service providers who provided the counselling.

For both years the majority of participants had received counselling prior to TOP. However, in 1998 an overwhelming majority (94.7%) of participants received individual counselling in comparison to just over half (55.8%) of the participants in 2003. Such a finding is interesting because it indicates a remarkable decrease in the percentage of patients who received individual counselling over the course of five years. However, this does not necessarily mean that no counselling occurred, but rather that some women received pre-abortion counselling in a group context. This form of pre-abortion counselling may be more common than expected as Smit et al. (2009) report the same form of pre-abortion counselling taking place in the Western Cape. They reveal, further, that counselling conducted in this form tended to focus on abortion care (i.e., information provision) rather than decision-making (Smit et al., 2009). Counselling conducted in a group context can be deeply problematic as it provides no privacy and places women in an uncomfortable position where they have to share their personal situation with others, selectively disclose, or remain silent so as to avoid disclosing their circumstances and

experiencing possible embarrassment. Minors and adults may be counselled in the same group; patients could be strangers or members of the same community. In such cases the objectives of the CTOP Act and the reproductive rights of women are directly being undermined by the very practices that were created to ensure these rights.

Engelbrecht's (2005) findings also reveal that respondents' overall satisfaction with PTOP counselling only slightly decreased from 1998 (72%) to 2003 (64.2%). Data from the 2003 component of the study worryingly reveal that 26.7% of the minors and 15% of the adult respondents indicated that counselling services were not available at the facility they attended. Of those facilities that did provide counselling, an overwhelming majority of patients (>80%) indicated that they were satisfied with the service. Respondents who were unhappy with the service attributed their dissatisfaction to: counsellors asking questions in groups, as counselling was not conducted individually; and the counsellor appearing to be in a hurry.

In 2003, the duration of counselling sessions varied. For adults, nearly half (48.8%) of the counselling sessions lasted between 30-39 minutes, whereas for minors most (41.0%) of the sessions lasted between 20-29 minutes. These would be considered lengthy for an individual/one-on-one counselling session; however, the author fails to state the nature of these counselling sessions, which could quite possibly include both individual and group counselling sessions. It is also worth mentioning that a substantially higher percentage of minors (20.5%) compared to adults (4.4%) reported having sessions lasting less than 10 minutes. It is possible that the minors attending these PTOP counselling had already made their decision regarding their pregnancy and thus only required information regarding the relevant procedure(s). The shorter time spent counselling minors may also be associated with the under-resourcing of clinics with insufficient staff being present to provide the necessary services and/or with counsellors' attitudes, beliefs and values regarding young people and pregnancy (which are generally quite negative) (Geary, 2014; Ngomane & Muladuzi, 2012)

In terms of actual counselling content, seven out of ten respondents in 2003 indicated that the counsellor had explained various options other than abortion. Although this is a high percentage, it also provides evidence that in 30% of cases options were not discussed. It is also reveals that health care providers (HCPs) who offer counselling are not abiding by the CTOP Amendment Act which states under section (4) "that counselling in every case [shall] include the available alternatives to abortion, and in particular the ways in which the State and other

agencies will support the mother and child, particularly in the event of the child being born disabled".

Smit et al. (2009), in their study conducted in the Western Cape, found that counselling and information sessions were not always carried out by midwives certified to conduct abortions. A large percentage (44%) of counselling and information sessions were conducted by midwives who had not completed abortion care training but had qualifications in some related discipline (e.g., community health, primary health care) or by social workers (36%).

The authors evaluated how abortion services were executed in practice, through questionnaires and semi-structured interviews, versus how they were intended to be carried out according to the protocol set out by the Western Cape Department of Health (Western Cape Department of Health, 2000). According to this approach of evaluation, the information and advice component of the counselling pre-abortion care was appraised as "adequate" whereas the resolution/options counselling was "inadequate" (Smit et al., 2009). It is a positive sign that information was being disseminated during PTOP counselling sessions. However, it depends from what perspective one may consider the resolution/options counselling as 'inadequate'. From the perspective of the Western Cape Department of Health's protocol, instances where possible options are not considered may be viewed as incomplete and inadequate counselling. However, some women may not be interested in receiving information about their options (having already made the decision) and may only require procedural information. This is an example of how certain information may be relevant for specific patients and as such is concentrated on in counselling at the expense of other information. It also highlights the nuances of pre-abortion counselling and the various topics which are discussed in relation to the patients' situations.

Since 2017 there has been a growing surge in research outputs focusing on pre-abortion counselling in the South African context. This is partly due to the Critical Studies in Sexualities and Reproduction (CSSR) at Rhodes University establishing a broad research project to explore how pre-abortion counselling is conducted in South Africa. Several researchers have been involved in the wider project, including myself, and below I present some of the key research outputs.

One of the first outputs came from our early data collection of the pre-abortion interaction but also the experiences of nurses, counsellors and patients at various hospitals in the Eastern Cape. From this data, the CSSR produced a policy brief highlighting the key findings from our data

collection (Mavuso et al., 2017) and a step-by-step guide to a patient-centred approach to abortion counselling (Mavuso et al., 2018). These two research outputs were well received being presented at a national conference and being used in workshops. Our research findings and recommendations have been incorporated into a comprehensive national clinical guideline published in 2021 by the Department of Health (Department of Health, 2021). Notably, these guidelines emphasize the importance of making counselling sessions non-directive, non-mandatory, and more person-centered, particularly in the manner in which critical topics like choice and associated risks are addressed during these interactions.

Mavuso et al., (2020a) published their PhD work exploring patients' experiences in pre-abortion counselling. The findings revealed that patients produced narratives around (1) appreciating non-directive and empathic counselling, (2) being provided with information, (3) that counselling was upsetting and hurtful, especially where abortion was awfulised, and (4) the foetal personhood discourse (discussed in chapter 7). Other published research looks at how stigma is resisted in per-abortion counselling (Mavuso et al., 2020b) and how nurses and counsellors conduct counselling based on their motivations and understandings of counselling (Mavuso et al., 2021). More recently, the findings from this thesis have contributed to a book chapter which presents and critically discusses how directive counselling undermines “safe” abortion (Mavuso et al., 2022). At the time of writing this, the CSSR has developed and is providing in-service training to nurses in the Eastern Cape (discussed in more detail in chapter 8).

Having provided an overview of the pre-abortion counselling research in South Africa, the next section discusses the various abortion-related topics that constitute the pre-abortion interaction as well as the different types of abortion counselling.

2.3 What constitutes pre-abortion counselling

Providing a comprehensive account of what constitutes pre-abortion counselling is difficult as there is considerable variation in abortion counselling styles globally (Baker, 2009; Perrucci, 2012). However, within the reproductive health literature abortion counselling is consistently described as a useful, necessary and an integral component to providing abortion services (Beja & Leal, 2008). At a general level, it is useful to think of abortion counselling as existing along a spectrum, which includes obtaining informed consent, health education, and unbiased emotional and psychological support (Perrucci, 2012; Upadhyay et al., 2010; Gould et al., 2012).

Most of the literature available recommends a counselling approach that is patient-centred (Ely, 2007; Hyman & Castleman, 2005; Holden et al., 1997; Ipas, 2014; Turner & Huber, 2014). A patient-centred approach, sometimes also referred to as a client- or woman-centred approach, recognises the importance of foregrounding the needs and individuality of the patient. In addition, the social context in which the individual is embedded is acknowledged as playing a critical role in shaping their experiences, before, during and after the abortion procedure (Fisher et al., 1998). It is a counselling approach that is explicitly shaped around the patients' concerns. As an approach it broadly seeks to: (a) help the patient explore and choose the available option that is most suitable for her; (b) demonstrate respect and empathy for the emotional responses the patient might express; (c) help the patient to cope both psychologically and physically with the entire process; and (d) support and potentially increase the patient's ability to take and assert control over reproductive health issues that affect her (Fisher et al., 1998). I discuss this approach in more detail later in this chapter.

What I present below is a discussion of the different types, or rather sub-types, which might make-up pre-abortion counselling in everyday practice. These types of counselling may occur distinctly (e.g., procedural counselling only) or they might be combined with other types of counselling (e.g., options counselling and procedural counselling).

2.3.1 Options and decision-making counselling

Abortion can be a highly emotional event in a woman's life (Upadahay et al., 2010) and some women arrive at clinics confused, uncertain or ambivalent. Often the news of an unintended pregnancy can evoke various and sometimes conflicting emotions, which can make decision-making particularly difficult, especially if the patient is unsure of her available options (Harvey- Knowles, 2012; Singer, 2004). To deal with this issue of decision-making, options counselling is often deemed appropriate and deployed.

Options counselling is a short-term and specific component of abortion counselling (Baker, 1995). It generally involves sharing comprehensive and contextually relevant information about the options that are available for pregnant women (Baker, 1995; Hoggart, 2015 Holt et al., 2017; Singer, 2004). One way of sharing information is using decision aids which can include booklets, videos, pictures, models and so on. Research has shown that decision aids lead to greater patient knowledge which lowers decisional conflict from being uninformed

(Donnell et al., 2011; Upadahay et al., 2010). However, it is critical to mention that although this might be a useful technique in sharing knowledge, the decision aids themselves must be interrogated and checked factually to ensure they are not reproducing false information and/or serving an agenda.

Options available to patients are, of course, always dependent on the legal context in which they are located. Options counselling is ultimately conducted to ensure that the patient is sufficiently informed about available options (within the legal context) and resources so as to make an informed decision regarding their pregnancy (Simmon & Likis, 2005; Singer 2004; Upadahay et al., 2010).

After the necessary information has been shared, the patient is left with the very important task of deciding about their pregnancy. Even with all the information provided, it is, according to Perrucci (2013), completely normal for a patient to experience emotional, spiritual, moral conflict and/or ambivalence. Perrucci (2013), in her influential book, provides a framework for dealing with each of these issues. Her approach is highly patient-centred (discussed later in this chapter); she maintains that the answer lies within the patient and thus she emphasises autonomy in the decision-making. The framework is based on a three-level approach which is generally used sequentially; the approach focusses on (1) validating and normalizing the patient's feelings and experiences, (2) doing this through understanding the patient's circumstances, and (3) (re)framing the patient's situation and decision more positively (Perrucci, 2012). It also requires that counsellors listen (i.e., practice active listening), resist making assumptions about the patient and the pregnancy, and be self-reflective of their own role in the interaction (Perrucci, 2013). By applying this approach, it is hoped that the patient will feel comfortable in the decision they eventually make.

It is not uncommon for women to change their decision at a later stage (Brauer et al., 2019; Foster et al., 2012; Söderberget al., 1997), sometimes even at the last possible moment before the procedure commences. This is correlated with the degree of ambivalence patients experience (Rowlands, 2008). In such instances, women may wish to engage in further counselling to clarify their decision further and to receive emotional support.

Decisions, no matter when (i.e., before attending the clinic or after receiving counselling) and how they were made, require some exploration. This forms a part of decision-making

counselling, which Perrucci (2013) describes as a "joint conversational adventure" (p. 19) between the patient and counsellor. The focus is to explore the important factors that underpin the patient's decision and to establish whether the patient is comfortable or at the very least understands the reasoning behind their decision.

2.3.1.1 The context of decision making.

There are various reasons why women decide to have an abortion. These include, *inter alia*, the continued pregnancy is unsupportable either personally and/or economically (Wiebe et al, 2005), the pregnancy was unplanned, lack of support from one's partner and/or family, perceived completion of family (Oye-Aderniran et al, 2004), contraceptive failure, social stigma in relation to the pregnancy (Orner et al, 2010; Shah & Alman, 2009), pregnancy due to rape, incest or with an abusive partner (Orner et al, 2010, Ashnafi, 2004; Harries, 2010), the need to complete education, abandonment by partner, age (too young or too old) (Halldén et al., 2005), and concern for other children (Korenromp et al., 2007).

Decisions regarding abortion are inherently underscored by a myriad of interrelated "factors" (Orner et al, 2011) operating at various intersecting levels. Decisions are shaped and influenced by, but not limited to, the socio-cultural climate, legislation, gender relations, the economy, government funding and service delivery, the media and so on. All these "factors" intersect on multiple levels (i.e., the intrapersonal, personal, institutional and communal) and create a unique reproductive healthcare context which can influence the decision a woman takes regarding her pregnancy.

In South Africa, studies have revealed that decision making regarding a pregnancy is particularly challenging for women living with HIV. Women living with HIV are caught in a difficult position – they must balance their own needs with that of societal childbearing expectations, and all whilst experiencing judgmental attitudes for reproducing as an HIV positive person (Orner et al., 2010). There are also reasons for having an abortion which are specific to women living HIV. These include: patients fearing that the pregnancy would progress their illness, the fear of giving birth to an infected baby, and being unable to care for the baby due to illness. The reasons often coincide with personal socio-economic hardship and within the context of problematic partner relations (Orner et al, 2010).

Although making a decision is a key outcome of pre-abortion counselling, research suggests that many women have already settled upon a decision prior to consultation with a healthcare

provider (Allen, 1985; Baker & Beresford, 2009: Brown, 2013; Kumar, Baraitser, Morton & Massil, 2009; Perrucci, 2013) – a notion which is echoed by healthcare providers themselves in Portugal (Beja & Leals, 2008). In these kinds of circumstances, offering options counselling may be experienced negatively by women (Mavuso & Macleod, 2019).

2.3.2 Procedural and pre-procedural counselling

Procedural and pre-procedural counselling are two sub-types of counselling that overlap in the sense that they are both concerned with the actual abortion procedures that are available to the patient. Procedural counselling, as the name suggests, is counselling that specifically deals with providing information about the relevant abortion procedure the patient is going to have (e.g., medical or surgical abortion, dependent on gestation period). Here the concern is to provide additional information about the procedure and inform the patient about what to expect in terms of the procedure, risks (including possible complications), side-effects, indications and contraindications (Beja & Leal, 2010). This type of counselling is inherently focused on providing health education to the patient and thus requires the counsellor (whether a clinical nurse or independent counsellor) to be adequately informed about the medical facts related to the procedures that are offered to women.

In contrast, pre-procedural counselling can be thought of as the counselling one may have prior to the actual procedure (Singer, 2004). In this case, the patient has already made the decision to have an abortion and may request or require emotional support before the procedure (Singer, 2004; Mavuso et al., 2018). This type of counselling may not be clearly demarcated as pre-procedure counselling but could occur *in situ* (even during the procedure) as the patient may request or need information and/or emotional support.

2.3.3 Pre-abortion contraception counselling

Discussing contraception may occur as a part of pre and post-abortion counselling. Here, the goal is to ensure effective planning (Beja & Leal, 2010; Tornbom, 1999) in preventing unplanned pregnancies in the future. This might require the counsellor to ask questions about the patient and their partner's current contraceptive strategy, including what methods are used and how. Research by Beja and Leal (2010) found that when health care providers discuss contraception in counselling, they tend to focus on "promoting awareness, providing information, negotiating, selecting and prescribing/delivering a contraceptive, promoting the uptake of contraceptive methods that fits the woman's characteristics" (p. 330).

Contraception counselling is often based on the assumption that the pregnancy could have been prevented if proper contraception was used — this frequently implies dual-contraception and responsibilising women to manage contraception within the context of a sexual relationship (Kimport et al., 2011). Contraception counselling may imply some sort of failure on the part of the patient (i.e., woman) and as such the objective is to correct the failure through identifying it, providing health education, and supplying contraceptives post-abortion. Although this makes sense from a public health standpoint, it ignores the gendered power relations in which sex occurs and that in many cases women are unable to negotiate contraception; this is particularly evident in transactional sex work where limited sexual power is associated with inconsistent condom use (Pettifor et al., 2004). In addition to this, participants from a study in South Africa reported the difficulties in accessing contraceptive services in the public health sector (Harries et al., 2009).

Although some studies have documented how including discussions of contraception may help to improve contraception uptake (Ceylan et al., 2009; Schumann, 2006) and reduce future unplanned pregnancies (Johnson et al., 2002), other studies from "developing countries" have reported that the uptake and the use of reliable methods can remain low if the contextual and personal issues around contraception are not explored during counselling (Kumar et al., 2004). Other studies have found contraceptive counselling is not effective in increasing contraceptive use after an abortion (Bender & Geirsson, 2004; Ferreira et al., 2009). More recently, a systematic review by Cavallaro (et al., 2020) investigating the effectiveness of various counselling strategies for modern contraceptives found there to be limited research, and concluded that future research is needed to conclusively determine the effectives counselling may have on contraceptive behaviour.

2.4 Controversial issues in (pre -) abortion counselling

Many of the controversial issues in abortion counselling stem from the moral and ethical divide between anti-choice and pro-choice advocates[11]. Anti-choice organisations seek the criminalisation of abortion arguing that to legalise abortion is to legalise murder. They use rhetoric that personifies the foetus and refer to studies suggesting that induced abortion leads to poor physical (e.g., breast cancer) and mental health outcomes[12]. Seen in this way, a

[11] In referring to pro-choice and anti-choice advocates, I acknowledge that these descriptors are often used as a brush-stroke description and that abortion politics is far more nuanced than this bifurcation suggests. Nevertheless, the veracity within which abortion politics are played out often results in this stark contrast (Crawley et al., 2005; Smith, 2005).

[12] These findings are disputed in the scientific and research community.

women's body is not rendered hers to govern, but instead is controlled by the state. Pro-choice advocates take into consideration the reproductive realities of women and approach the debate from a framework based on reproductive health, rights and justice. At the core of this framework is the imperative that women should have the right to make un-coerced decisions regarding their reproductive lives and live in a reproductive context that is non-oppressive. Such an approach seeks to actualize women's freedom and autonomy rather than seeking to restrict and control it.

Even though abortion is legal in many countries, the reproductive struggle for abortion access continues due to various social and structural barriers. The battle is played out in courtrooms, parliament, the internet, outside abortion clinics (e.g., protests) and even within healthcare services themselves (e.g., between health-service providers providing abortion and those not). The practices surrounding abortion counselling are no exception. Abortion counselling is one of the most important components of abortion care, especially if it involves information sharing and decision-making. Counselling, in most cases, is a private interaction, mainly consisting of talk and perhaps the only place where one-on-one persuasion and manipulation can take place. In the literature on abortion counselling, attention has been given to the *directiveness* of the counselling, *information sharing* (e.g., sharing factual vs. methodologically flawed research) and the *language* which is used to convey this information. These three issues are not easily separable, but one thing is for certain – the way in which they work together can threaten or promote informed consent and autonomous decision-making. These issues are discussed below.

2.4.1 The issue of (non-)directivity

Non-directivity is a notion that flowed from Carl Rogers' work on "patient-centered" therapy during the 1940s/1950s and since then has underpinned counselling practices around the world and in various settings. In a broad sense, the aim of non-directive counselling "is to enable clients to make informed and independent decisions with minimal risk of manipulation or coercion" (White, 1999, p. 5). Some may even consider the counsellor's (non)agreement with the decision as irrelevant. Non-directiveness is considered necessary in respecting the patient's right to make an autonomous decision without being coerced, manipulated or restricted in any way and is believed to be upheld through providing counselling that is also value-neutral.

'Non-directive', as a concept, is often used in legislation to describe the form abortion counselling should take (see, for example, CTOP Act, section 4). Although the issue of non-

directive counselling is often mentioned in the abortion counselling literature (see; O'Rielly, 2009; Rowland, 2008; Singer, 2004: Woodcock, 2011), it remains a largely enigmatic concept that has not received the critical discussion it requires. Much of the work on non-directive counselling concerning reproductive matters has come from researchers in the field of genetic counselling, who have for a long time grappled with the concept of non-directive counselling, questioning the confusion around its definition and whether such counselling is in fact possible or even desirable (Wachbroit & Wasserman, 1995) considering some of the ethical and practical limitations (Kirkin, 2007; White, 1999).

Respect for patient autonomy and value-neutrality are referred to as the key features of non-directive counselling. These have received considerable attention in the literature, particularly the ideal of value-neutrality. Wachbroit and Wasserman (1995) argue that there is an unwarranted assumption that non-directive counselling requires value-neutrality. Rather, non-directive counselling should not necessitate value neutrality wholeheartedly; instead, it requires the counsellor to adapt their method/approach/techniques in whatever way to ensure that the patient's decision is fully informed and voluntary (Kirkin, 2007; Wachbroit & Wasserman, 1995).

An obsession with impartiality and value-neutrality can actually constrain the counselling interaction, particularly for patients who do not know which questions to ask, do not fully understand the information given, and do not have the capacity to make a decision for some reason (Caplan, 2020; White, 1999). In such circumstances, counsellors may sense these issues in the interaction and may wish to explore the patient's feelings and thoughts but may feel reluctant to do so for fear of being accused of interfering, being persuasive and providing directive counselling.

There is also a tension between the theoretical ideals of non-directiveness and the patient's unique situation. Studies in genetic counselling have revealed that some counsellors shape the information they give to patients based on their assessment of the patient – a common practice by physicians in everyday consultations – and thereby digress from the non-directiveness ideals (Chieng et al., 2011; Veach et al., 2007; White, 1999). Counsellors in such instances are caught in an ethical dilemma: on the one hand, if they do not cover all the information they are failing to counsel appropriately (according to non-directive counselling guidelines), but on the other hand, if they fail to address and focus on patient specificities, they are doing a disserve to the patient. Likewise, questions could be posed about whether counsellors should be expected to

support patients' decisions which are unethical (e.g., sex-selective abortion, see Abrejo et al., 2009; Kasstan & Unnithan, 2020) or to explore these issues further.

One way to deal with the ethical and practical issues of non-directedness is to focus on the dialogue that occurs and how the interaction unfolds as a joint endeavour. White (1999) argues that instead of being fixated on providing non-directive counselling, counsellors should aim to enhance the quality of the deliberative process through mutual dialogue, as interactive dialogue more closely corresponds to the natural way people make decisions than structured sessions. The goal is not to be unnecessarily exhaustive in providing information but rather to tailor the information specifically for the patient, and to what they deem significant for consideration (White, 1995; Brunger & Lippman, 1995). What is considered significant may, of course, be a contentious issue (as indicated above), but one which is perhaps better understood in the real-life interaction.

From a feminist model of counselling, the opinions of the counsellor are not considered to be necessarily coercive as "not giving one's point of view may be no less directive than giving it, and because exposing one's own personally-, culturally-, and historically-embedded self does not dictate another's decision" (Brunger & Lippman, 1995, p. 165). Counselling conducted in this way moves away from the preoccupation of non-directive counselling and adopts an approach that recognises both patient and counsellor as social beings and provides a naturalistic manner of engaging in institutional talk.

In the context of feminist counselling, the act of obscuring one's stance by concealing personal biases and subjectivity is regarded as unethical due to its detrimental effects on trust, reinforcement of power disparities, and absence of authenticity (Edwards & Chen, 1999; McLeod, 2010). A feminist counselling approach places a strong emphasis on the principle of transparency and recognizes the inherent presence of biases within therapists/counsellors, as well as clients (Brown, 1994; Enns, 2004). The act of openly acknowledging subjectivity is widely seen as a morally and practically advantageous method, as it cultivates confidence, enables those seeking assistance to take control of their own growth, and establishes an environment conducive to open and honest communication (Corey & Callanan, 2011; Enns, 2004; McLeod, 2010). Therapists/counsellors can effectively engage in meaningful dialogues with clients by openly identifying their biases. This practice empowers clients to make informed choices and allows for the exploration of the many nuances present in their lived experiences (Brown, 1994; Corey & Callanan, 2011; Enns, 2004).

Just because a form of counselling deviates from the prescribed guidelines of non-directive counselling does not render it immediately directive. The distinction between non-directiveness and directiveness is not always clear and especially when dealing with complex situations which can make decision-making difficult (Clarke, 2017). Instead of dedicating resources in defending and/or contesting non-directive counselling, focus should be placed on what constitutes directive counselling and how it is performed in interaction. By deepening understandings of directive counselling (in practice) and the implicaitions thereof, new approaches to counselling on sensitive issues such as reproduction can be devised. A starting point is to investigate what is said during the interaction, what information is shared, in what format, and the language which is used to discuss the situation. This study contributes to these understandings.

2.4.2 Providing information; how much, what and how?

Counsellors have the challenging task of providing information to the patient. As was mentioned previously, women should have all the necessary information to make an informed decision about their pregnancy. This raises the question of the exact information that should be disseminated in a counselling session and gives raise what Woodcock (2011) terms the "informed consent dilemma". On the one hand, providing full disclosure (e.g., providing specific details of foetal development) to patients has the potential to evoke strong emotions such as guilt, shame and angst. On the other hand, selective disclosure may result in uncertainty, confusion and simply not enough or the necessary information for the patient to make a decision; it may also be perceived as keeping the patient ignorant. Both of these types of disclosure can threaten the autonomous decision-making process and ultimately the patient's ability to make an informed decision.

Full disclosure or exhaustive information can be overwhelming for women who are considering the termination of their pregnancy (Woodcock, 2011). There is an assumption that a patient can only be fully informed if they have all the information, and that as long as all the information provided is accurate, women can then proceed to distil the information in a way that would help them to make a decision. However, information, even if considered accurate and truthful, can stir up feelings of guilt, anxiety, confusion and other "normal" emotions. Full disclosure may also lead to women being exposed to graphic iconography which depicts morphological features of the "foetus", such as the heartbeat and fingernails. Women may be subjected to explicit explanations of the abortion procedure and the dangers associated with having an abortion (often without the accompanying information about the risks of taking a

pregnancy to term). Information of these sorts subsequently produces feelings that exert a powerful influence and disrupt the patient's ability to make a decision (Woodcock, 2011). In addition, it may also be very distressing if the woman feels she has no other option, for whatever reason. As such, information sharing can alter the way a woman comes to view and understand her pregnancy, abortion and the foetus.

Selective disclosure refers to the sharing of specific information. Disseminating selective information is a challenging task as the counsellor cannot always be sure what information the patient might find useful without the patient being informed first. For a counsellor to decide what information should be shared can be considered as paternalistic (Woodcock, 2011) and a minimalist approach that can be interpreted as providing directive counselling.

Information that is disseminated during counselling is firmly embedded in powerful medical discourses that construct abortion and its consequences in particular, but mostly negative, ways. Drawing on Michel Foucault's work, Vincent (2012) argues that the discourses deployed in abortion counselling are used as disciplinary technologies in an attempt to control and persuade the female body. Reproducing problematic and disputed information (e.g., abortion causes breast cancer and future infertility, abortion can lead to post-abortion-syndrome) constructs the object (i.e., the abortion) and the subject (e.g., woman/patient) in particular political and agenda serving ways. By utilising such discourses, the counsellor, due to her role as medical professional, is able to make "truth claims" concerning the patient's body and psyche (Vincent, 2012). All of this is done through the communicative practice of talk and the use of language, which are the focus of my research.

2.4.3 The power of language

Literature on providing non-directive counselling encourages counsellors to use language that is neutral during the interaction; this refers both to lexical choice and sentence construction. Language used by the counsellor may appear neutral, for example asking the questions, "Do you know the baby's gender?", or "Do you know who the father is?" (Pro-voice counselling guide, 2013; Upadhyay et al., 2010, Woodcock, 2011). However, closer inspection is required.

The entity growing inside the women's womb can be described in several ways (e.g., embryo, foetus, baby, child) with each signifier closely tied to an ideological stance underpinned by particular assumptions of the subject. The social meanings associated with each word construct the pregnancy, and in turn the woman, in a particular way. For example, the simple use of the word "baby" in counselling frames the pregnancy in a unique way. The word "baby",

innocently inserted, immediately personifies and confers a status of babyhood to the "foetus" and similarly positions the woman and her partner as parents (Macleod, 2011). These subject positions are problematic as they are inextricably tied to certain societal expectations of parenthood which assume that women should be responsible for childbearing and nurturing of children (Woodcock, 2011). So dominant is this cultural script that to abdicate this nurturing role is to go against the "societal norm" (Woodcock, 2011). In addition, now that the "foetus" has been ascribed human status, abortion is no longer perceived as a termination of pregnancy but rather tantamount to the "murder" or "killing" of an individual. Comparatively, the signifier "embryo" and "foetus" are considered to be more medically accurate than "baby", is a medical term that is used to describe a certain point in human development. Its meaning is not intertwined with social expectations in the same way "baby" and "parents" are, and for this reason is considered a more neutral word.

The second question, of "do you know who the father is", suggests that the person co-responsible for the pregnancy is already in a relationship with the foetus as an independent being through the use of the word father. It also implies that the woman ought to have a relationship of some kind with that person, and if they do not, this is could be attributed to "promiscuity".

2.4.4 Managing third- party members

Women who seek TOP services may be accompanied by a third-party member (e.g., relative, guardian, partner, friend or parent) who may offer emotional support, guidance and can also play a role in the decision-making process. Although the assistance of a third party is not required in South African legislation (e.g., parents in the case of minors), third parties are not prevented from attending the consultation. The inclusion of a third-party into the counselling session inherently changes the way in which the counsellor conducts the session (Vandamme et al., 2013) and how counsellors are tasked with managing situations where "pressure/coercion and/or disagreement" may be evident between parties (Beja & Leal, 2010, p. 330).

The research on the involvement of third parties in pre-abortion counselling is limited. Altshuler (2016) conducted a mixed-methods review into male involvement in the abortion care and found that there were four main types of involvement:

> (1) Presence in the medical facility, (2) participation in preabortion counselling, (3) presence in the room during surgical abortion procedure or while the woman is experiencing the effects of abortifacient medications and (4) participation in postabortion care (p.209).

Concerning participation in pre-abortion counselling, only one study was found conducted by Becker et al. (2008) who reported that out of the United States sample of 774, 27% of patients came with their partner, 28 % came with someone else (e.g., a friend or relative) and 45% alone. Other literature addresses the importance of effectively managing third-party participation during counselling (Beja & Leal, 2010), such as ensuring they do not dominate the conversation but are given a space to talk, provided the patient agrees.

Third parties do not only refer to family members, friends and partners who may accompany a patient during abortion. In some cases, third parties can consist of other patients. In certain contexts, like South Africa where the public health facilities are chronically underfunded and under resourced (Maphumulo & Bhengu, 2019; Manyisa & van Aswegen, 2017), it is has been reported that abortion counselling occurs in a group setting with multiple women of different ages all receiving counselling at the same time (Engelbrecht, 2005). In such cases, there are many third parties/patients which changes the counselling dynamic patients may experience. This means that women must share their circumstances with others, perhaps complete strangers or fellow community members, directly infringing on their privacy and confidentiality. Some women may feel uncomfortable in disclosing sensitive information under such circumstances, rendering their voices silenced by the very space where it is meant to be centred.

2.4.5 Mandatory/compulsory counselling

In the United States of America (USA) abortion counselling is mandatory in 35 out of 50 states (Buchbinder, 2016; Guttmacher Institue, 2020). Mandatory counselling is also found in Central and Eastern Europe countries[13] (Hoctor & Lamacakova, 2017) with many countries also enforcing a mandatory waiting period. Contrary to this, some countries have made abortion counselling legally non-mandatory, such as New Zealand, Australia, the UK, and South Africa.

Mandatory counselling has been described as counselling that provides information to women so that they are "adequately" informed to make a decision regarding their pregnancy (Gold & Nash, 2007). However, opponents of mandatory abortion counselling have argued that for many women it might be unnecessary (as many have already decided), that it diverts resources from those that might need it (Brown, 2013; Rowlands, 2008), and that (mis)information may be shared in attempt to dissuade women from having an abortion (Bain, 2020; Gold & Nash, 2007). Others have argued that abortion is a "safe medical procedure that does not need

[13] "Biased counselling and information requirements […] have been adopted in countries such as Georgia, Latva, Lithuania, Macedonia, Romania, Russia and Slovokia" (Hoctor & Lamackova, 2017 p. 253)

expanded counselling" (Guttmacher Institute, 2020, p. 1). Furthermore, there is little evidence that suggests abortion counselling should be made mandatory (Hoggart, 2015) as it does not necessarily benefit those who have already decided and may delay the abortion seeking process (Brown, 2013)

In relation to South Africa, although the CTOP Act states that abortion counselling should be "non-mandatory" (p. 5), in some facilities counselling forms part of the everyday procedure of providing abortion services. It is built into the abortion service and many women may be unaware of what their rights are under the CTOP Act (Jewkes et al., 2005; Macleod et al., 2014) (i.e., that they can refuse to receive counselling) or simply might be so desperate (Barnett, 2000; Haddad & Nour, 2009) that they simply follow and accept the services as provided to ensure a timely abortion. In addition to the above, there is still a major interest in trying to mandate abortion counselling in South Africa. In early 2018 the African Christian Democratic Party (ACDP) put forward a parliamentary bill which, if passed, would subject women to mandatory ultrasound examination to see the developing foetus and mandatory counselling. However, later that year the parliamentary Portfolio committee on Health deemed the bill prohibitive, undesirable and as creating additional barriers for women wanting to access termination of pregnancy services (TimesLive, 2018).

2.5 Documented approaches to counselling

In this section, I present three approaches adopted and used to provide abortion counselling. Crisis intervention is the first model discussed and frames unintended pregnancy as a crisis that needs to be resolved. The second is the pastoral/hermeneutical approach, which draws on religion and allows clients to share their experiences as narratives. The final approach presented in this section looks broadly at the person/patient-centred approaches. Here, the patient is centred, and everything else is considered concerning their circumstances. The feminist approach is also based on patient-centredness, which I also unpack below.

2.5.1 Crisis intervention as a model for pre-abortion counselling

Unintended pregnancies and deciding whether to have an abortion are often described as a time of significant hardship and crisis for a woman and their family (Singer; 2004; Strydom & Humpel, 2009). There is an array of discourses which, when used, construct abortion purely in negative terms and can reframe the way in which the patient thinks of her situation. These narratives are medical (e.g., abortion causes breast-cancer), psychological (e.g., abortion causes

post-abortion syndrome), cultural (e.g., it goes against our African culture), moral (e.g., it is not right to kill an unborn baby), and religious (e.g., abortion goes against the religion).

If unintended pregnancy and having an abortion are synonymized with being in a state of crisis, it then becomes understandable why so many facilities offer counselling regarding outcomes decision-making for unintended and unwanted pregnancies. These centres tend to employ a crisis intervention counselling approach which consists of six stages/phases. The first stage is known as the *report phase,* which involves the woman disclosing that she is pregnant to the counsellor. In this initial phase it is imperative, according to the proponents of this approach, that the counsellor listens to the woman's experience with concern and empathy and does not judge the patient (Evanglesti, 2000; Van der Berg, 1997). In the second phase, the objective is focused on *decreasing anxiety*. Here the counsellor must identify the source of anxiety, which may or may not be clear (Botha, 1995). Authors suggest discussing coping skills that can used to reduce her anxiety (McCulloch, 1996).

The third phase deals with the *actual crisis*, which according to this approach, is the unwanted pregnancy. Here, the woman must openly express her emotions regarding pregnancy (Strydom & Humpel, 2009). In addition, Botha (1995) suggests establishing long term goals which are referred to throughout the therapeutic intervention. Phase four is an *evaluation phase* where the woman is presented with a number of alternatives/options to resolve the crisis (i.e., unintended pregnancy) to her satisfaction (ni Riain et al., 2013) and "view the [whole] experience as one episode in her growth towards adulthood" (Cain, 1979, p. 52 as cited in Strydom & Humpel, 2009).

Encouraging and supportive action is the fifth stage and, as the name suggests, is concerned with supporting the woman's decision/action. Authors suggest that, irrespective of the woman's decision, the counsellor should be supportive and continue to provide emotional support (Le Roux & Botha, 1997; ni Riain et al., 2013). It is expected at this stage that the woman will be more open with her emotions and show signs of positivity such as hope and trust (Van der Berg, 1997). *Follow-up/Closure* is the final phase. This stage involves a series of follow-up counselling sessions after the decision has been made and action taken. According to Botha (1995), the patient has reached closure when the "persons (sic) equilibrium is restored and she sees her situation in perspective, can make decisions independently and is capable of continuing daily life" (p. 182). It is at this point that counselling can be concluded.

There are some strengths to the crisis intervention model proposed by Strydom and Humpel (2009), if evaluated uncritically. Firstly, it is a relatively straight forward and structured approach to conducting pre-abortion counselling. There are six phases each with objectives that need to be met before proceeding to the next phase. Pedagogically, a structured approach such as this breaks down each component of the counselling process and can be easily taught to nurses, social workers, and other professionals wanting to conduct pre-abortion counselling, without prior in-depth theoretical knowledge. Secondly, the approach is highly fluid; patients may return to earlier phases if the need arises.

There are a number of weaknesses to this approach as well. Firstly, it is presented as an overly individualistic approach where the "crisis" is located within women. By foregrounding the individual, the model fails to take into consideration the micro-level interactions (e.g., partner, friends and family, medical professionals) and macro-level issues (e.g., legislation, governmental funding, cultural patterns, childcare support, economic factors) (Feltham-King & Macleod, 2015) which underpin the experience of the pregnancy (i.e., a "crisis" situation).

In addition, it may be the case that for many women who have an unintended pregnancy, the experience can be emotionally difficult and considered as a period of crisis (e.g., in cases of rape, unwanted teenage pregnancy, lack of resources to look after the child). If a woman is clearly in a state of crisis, then it is important for the trained counsellor to explore with the patient what elements are underpinning the crisis. However, it must be equally stressed that some women in the same situation are still able to make a decision regarding their situation without entering into a state of "crisis" (see Kownaklai et al., 2022; Remennick & Segal, 2001). It is also worth stating the crisis pregnancy centres that espouse this approach have been associated with anti-abortion activity (Kissling et al., 2022; Mavuso & Macleod, 2021).

2.5.2 Pastoral/ Narrative hermeneutical approach

Baloyi (2012) champions the use of a narrative hermeneutical approach. The author acknowledges that within the South African context, abortion counselling does not always occur in practice. This is to the woman's detriment, as counselling is vital in ensuring that women can deal with the "problem" they may be experiencing (Baloyi, 2012). In response to this lack of counselling provision, the author suggests involving pastors in providing abortion counselling utilizing a narrative hermeneutical approach.

The strength of this approach, when used for abortion counselling, is that it encourages women to tell their stories using their own language (Gerkin, 1997). Such an approach positions

patients as the experts of their own experiences – much like a patient-centred approach – and calls for the counsellor to actively listen and interpret the woman's situation, which is unravelled through her story. It is through actively listening to the story that a counsellor can identify key social and personal issues that could be further elaborated upon and discussed (e.g., fear of telling parents about the pregnancy, fear that the pregnancy may interfere with life plans and so on) to help reduce any negative feelings the patient might be experiencing.

An essential factor to consider in this type of counselling is the sensitivity of having a pastor, a person who holds Christian beliefs, providing the counselling. On the one hand, if the patient is Christian, perhaps receiving counselling from someone with the same belief system may be ideal for her. This might be directly related to the content of the interaction when carried out by a religious counsellor. They might draw strongly on a religious discourse due to their pastoral counselling training. Of concern is how the religious discourse is deployed (whether intentionally or unintentionally) and how it constructs abortion (e.g., as immoral), the foetus (e.g., as a child already) and the patient herself (e.g., as a mother already). The deployment of such a discourse may work to alter how a woman comes to view and experience her pregnancy. However, on the other hand, a person who is part of another belief system may find the counsellor's interpretations and assessments of her situation somewhat unnecessary. For example, a woman may walk into the counselling room with the preconception that the counsellor is strongly associated with the teachings of the bible and thus may construct a narrative that omits what she perceives to be "unchristian".

Worryingly, Baloyi (2012) uses specific terms and draws on other pastoral counselling literature work which consistently describes the woman in problematic terms such as "victims" (p. 1), "abortion sufferers" (p. 3) and "committers of abortion" (p.3). Referring to women as individuals who "commit" abortion, although unintentional, may associate women with negative connotations such as the "committing a felony". Such suggestions appear to serve a specific agenda deployed by anti-abortionist lobbyists, which views abortion as tantamount to murder – a common phrase used amongst anti-abortionist advocates (Marquis, 1989). Using words like "victim" and "committer", women are positioned both as the perpetrator (i.e., committer of abortion) and "sufferer/victim" (i.e., victim of the abortion). At the very least, a woman presenting for abortion counselling should be referred to in a neutral way (e.g., pregnant woman).

2.5.3. Patient/client/woman-centred approach

A patient/client- or, within the abortion literature, woman-centred approach, is an approach to service provision in various medical fields. In relation to abortion services, IPAS[14] has produced two key training manuals (IPAS, 2004; IPAS, 2013) for service providers that are defined as woman-centred. These manuals seek to provide guidelines for comprehensive abortion care. Within the manuals, a woman-centred approach to abortion provision, including pre-abortion counselling, is described as an approach that requires providers to:

- Identify their personal beliefs and values about abortion
- Separate their beliefs and values from those of their clients and focus on their clients' needs
- Show respect to all women, regardless of their age, marital status, sexual reproductive behaviours and decision
- Treat woman with empathy – understanding their feelings and perspectives and communicating this understanding (IPAS, 2013, p.vii).

In addition to the above, three elements are highlighted. These are: (1) Choice, (2) Access, and (3) Quality. Within the manuals produced by IPAS, considerable emphasis is placed on ensuring women's choices (i.e., reproductive rights), access to safe abortion, and ensuring that all aspects of abortion provision are of high quality.

Central to the element of quality is ensuring that counselling is tailored to the unique social circumstances of the individual. This element of quality within woman-centred care is about prioritising the patient's needs so that she receives information pertinent to her situation and that she may have requested. In this way, unnecessary information is not shared (Moore et al., 2011), and time can be spent ensuring that patient concerns are identified and addressed. A common theme in patient-centred counselling in all contexts is that it is non-judgmental to ensure that patients feel comfortable enough to share their personal circumstances and receive relevant information. To do otherwise is to adopt a counselling approach which is not centred on the woman/patient but rather on correcting 'problematic' behaviour.

A major difference between patient-centred approaches and others is the strong emphasis on active client participation (Upadhyay et al., 2010). In contrast to this, some approaches to counselling adopt a didactic format, where the counsellor shares information and the patient

[14] "Ipas is a non-profit organization that works around the world to increase women's ability to exercise their sexual and reproductive rights, especially the right to safe abortion" (IPAS, 2013, p. 1).

acts as a passive recipient absorbing the information with little input. However, research (Kim et al., 2003) has shown that when clients are encouraged to actively participate in counselling, they seek information more effectively than when they are simply told information. Similarly, research has also found that many women prefer an individualized approach to counselling (Moore et al., 2011), citing that it is within those sorts of spaces that women can pursue issues that are of importance to them.

2.5.3.1. A Feminist approach. In a study that explored abortion patients' narratives of their counselling experience in the United States of America, Ely (2007) puts forward practice recommendations based on a feminist counselling framework, which is intended to meet the needs of women. Feminist counselling models locate the patient's unique situation/difficulties within the social context (Land, 1995; Perrucci, 2013) and are inherently regarded as patient-centred, as there is an emphasis on allowing the patient to guide the session (Ely, 2007). The practitioner seeks to normalise the patient's experiences as well as challenge and provide a supportive two-way conversational environment "that acknowledges the political climate that often intrudes on the personal experience of women's reproductive health care" (Ely, 2007, p. 65).

Feminist counselling models are highly flexible in practice. Feminist counselling philosophies respect a women's right to refuse counselling. They also consider it both problematic and counterproductive to mandate what topics must be covered in the session[15] (Ely, 2007). Mandating counselling itself is also problematic for several reasons. Mandatory counselling, which is potentially agenda serving as noted previously, can erode a women's sense of confidence and self-esteem. It has the possibility to create or exacerbate emotional distress particularly when information is used to manipulate a women's decision (e.g., showing morphological images of the foetus).

In her recommendations, Ely (2007) explains how counsellors should create a friendly and supportive environment. The counsellor should express openness, warmth and acceptance towards the woman's decision regarding her situation, all of which are vital in combatting the negative social and political understandings of abortion. A feminist counselling approach is useful for exploring and clarifying the woman's feelings as well as for dealing with the contextualised realities of the pregnancy. For example, many women live in contexts where

[15] This does not apply to important medical information that is required for the woman to make an informed decision.

the public domain has been dominated by anti-abortion discourse and come to think of abortion as inherently deviant. A counsellor drawing on a feminist counselling model can work in conjunction with the client to critically understand such discourses, deconstruct the stigma attached to abortion, and reframe the situation in a way that reasserts the patient's decision-making rights. In this way, the focus is on understanding the patient's situation within the broader social context. It also works towards normalising abortion as a routine and common gynaecological procedure.

2.6 Investigating pre-abortion counselling by focusing on talk

Through surveying the literature, I found that much of the research on pre-abortion counselling consists of personal practitioner narratives, retrospective questionnaires and qualitative interviews conducted with patients and those medical professionals providing counselling. Although these contributions are valuable, few substantive claims and problematisations of abortion counselling are grounded in real-life pre-abortion consultations. In other words, there is a mismatch between the knowledge that has been produced (mainly exploratory and descriptive data collected from questionnaires and retrospective interviews) and the critical questions that should be posed within the critical health community (e.g., Is pre-abortion counselling directive? Are patients' autonomy under threat in the interaction, and if so, how? What information is shared and requested, and how?). There are no studies, to the author's knowledge, that have analysed real-life everyday recordings of pre-abortion counselling sessions; and without such data, researchers cannot empirically outline with certainty what pre-abortion counselling entails in practice.

More importantly, one cannot answer some of the critical issues that so desperately require attention. Pre-abortion counselling is an activity centred on communicating, and thus an exploration of this activity should focus on the talk that takes place. It is through *talk* that counsellors and patients go about engaging in the activity of counselling. As such the analytical lens needs to focus on the *talk* that unfolds during the consultation by recording the interaction in everyday practice. Conversation analysis (CA) and Discourse analysis (DA) are two approaches that are particularly useful in analysing talk.

CA and DA take talk to be action orientated, that is, people do things with talk such as greet, inform, persuade, negotiate, and so on. CA provides the tools to map out the structure of talk whilst at the same time calling for a turn-by-turn examination of the practices (e.g., questions) and activities (e.g., options discussion) of interaction which play a role in creating the

institutional context (Walton & Fanlay, 2015). Similarly, DP attends to *talk* but generally tends to focus on identifying discourses and exploring how discourses constrain and/or enable particular possibilities within talk — in other words asking the question, "What is this passage of talk doing here?". Together these two approaches provide the necessary analytical tools for understanding how activities (e.g., pre-abortion counselling) are constructed in social interaction (i.e., the CA component) and simultaneously embedded in institutional discourse (i.e., the DP component).

CA, specifically applied CA, and DP has been utilized as approaches to studying the broad activity of counselling in institutional contexts. The counselling interaction that takes place in healthcare settings has been for a long time, and continues to be, a significant area of focus for conversation analysts. Much of the research that has been conducted specifically investigated: HIV/AIDS counselling (Silverman, 1997; Silverman, et al., 1992; Perakyla, 1995), genetic counselling (Pilnick, 2002; Wessels et al., 2014), patient counselling by pharmacists (Pilnick, 2002) and diabetes counselling (Karhila et al., 2003). The research has generated a wealth of knowledge regarding the intricacies of how certain activities are interactively achieved such as: information/advice giving and receiving (Silverman et al., 1992, Pilnick, 1999), choice and decision making (Hindmarsh & Pilnick, 2007; Pilnick & Zayts, 2012; Wessels et al., 2015), negotiation (Kahrhila et al, 2003; Pyorala, 2000) and interactional difficulties/trouble talk (Pilnick, 2002). Some studies have drawn on the strengths of CA and DP when investigating counselling as an interactional practice (Miller & Silverman, 1995; Watermeyer & Penn, 2009).

CA is a valuable analytical approach to working with talk in the health setting where often making changes and improving practice is based on what evidence is available (Rycroft-Malone et ., 2004). CA collects and analyses the ideal data to use as evidence to inform change. Data is collected from naturally occurring healthcare interactions and often involves multiple parties of interest (e.g., patients, nurses, doctors and healthcare workers). This enables an explication of how counselling interaction operates in everyday practice (Madill et al., 2001). Through doing so, counsellors can reflect on what is working well and how/if changes might be beneficial (Streeck, 2010). Some insights into counselling practice have been identified through CA in the health care set-up.

For example, Hutchby's (2005) work that focuses on child counselling using CA showed how "active listening" can be performed in talk through the practice of "formulation"[16]. To demonstrate active listening counsellors can engage in an extended question-answer whereby they: "(1) refer issues back to the child, especially in terms of their subjective experiences; (2) refer issues to feelings the child may have or concerns they may harbour; and (3) refer issues to their consequences in terms of child-parent relationships" (Hutchby, 2005, p. 30). This provides some empirical insights into how counsellors can ensure active listening, which is important for a counsellor to engage in because it shows empathy and responsivity towards patients, thus facilitating rapport.

Another example of CA's contribution to exploring counselling and consultation insights is through the work of Boluwaduro (2020), who examined the practice of offering medical advice in HIV consultations conducted in Nigeria. They found that doctors can establish their medical authority through exploring turn design and sequential distribution and that patients are mostly neglected in shared decision-making. They argue that within HIV counselling, doctors may exercise medical paternalism for the patient's best interest. As such Balowaduro (2020) calls for a reconceptualisation of how "medical authority" and "adherence" feature within contextually different medical institutional settings.

Despite the vast amount of research concerning counselling, pre-abortion counselling is one type that has not enjoyed the same level of popularity – perhaps due to its sensitive nature, the ethical considerations/difficulties, and the moral aspects associated with having an abortion in many contexts. This is discussed in more detail in the next chapter.

2.7 Conclusion

In this chapter I unpacked the literature concerning pre-abortion counselling. I started by providing an overview of the abortion counselling literature and what types of information have been produced (e.g., policy guides, training workbooks, etc). My focus then shifted to discussing how pre-abortion counselling within the South African context has been investigated. Through accessing and reading the available literature, it is evident that pre-abortion counselling, as an aspect of abortion provision, has not received much research attention within the South African context. The research that has been conducted has largely

[16] A formuation can be defined as a conversational practice described as "summarizing, glossing, or developing the gist of informants earlier statements" (Heritage, 1985, p. 100).

collected data through interviews and/or questionnaires with patients and health service providers. Although the data do reveal interesting findings regarding how the practice is experienced and conducted in South Africa, it cannot reveal what takes place, at the level of talk, during counselling sessions.

I then proceeded to discuss what constitutes pre-abortion counselling and outlined the various elements it can focus on, such as: (1) options, (2) decision-making, (3) pre- and post-procedural information, and (4) contraceptive counselling. I discussed all these elements in relation to the literature and how they have operated in various degrees within the South African context.

Pre-abortion counselling as a controversial issue is then discussed. The first controversial issue I unpacked is that of directiveness and non-directiveness in the counselling interaction, and arguments for both were presented with a focus on foregrounding the patient's autonomy and agency to make a decision. Central to directiveness is sharing information and language, as the way in which information is described and delivered in interaction (choice of words, for example foetus or baby) can shape how the pregnancy is perceived by the patient. In addition, how much information to share, to whom and why, are all important considerations in pre-abortion counselling. Another controversial issue I addressed is that of managing third-party members in pre-abortion counselling in such a way as to ensure that the patients' autonomy and reproductive rights are respected and upheld. The final issue I considered is that of mandated/compulsory abortion counselling. This is discussed in relation to its usefulness and how it may only serve to benefit women who want to receive counselling.

The final section of the literature review identified and discussed three documented approaches to pre-abortion counselling. The first approach is that of Crisis intervention pre-abortion counselling which frames the patient's unintended pregnancy as a crisis that needs to be resolved. The second approach is a pastoral/narrative hermeneutical approach to counselling which provides the space for women to talk through what they are experiencing and can include some religious elements as well. The third approach is that of patient-centred counselling which has been adopted in various contexts and seeks to ensure that women are treated as the central in the counselling interaction. Their needs, experiences and narratives are foregrounded with emphasis on ensuring that their reproductive rights are upheld. A brief account of a feminist approach was also presented. I highlighted the importance of recognizing the power of discourse in deconstructing stigma and how discourses can be used to reframe the patient's

decision making and perception of their pregnancy, whilst simultaneously acknowledging the social context.

In the next chapter, I lay out the theoretical lens that I use to conceptualize the pre-abortion counselling event as an institutional everyday practice. In doing so, I discuss my theoretical stance - a social constructionist paradigm – which informs understandings of discursive psychology and conversation analysis.

Chapter 3: Pre-abortion counselling as interaction: A critical interactional approach

3.1 Introduction

In this chapter, I describe the theoretical lens that I use to conceptualise and investigate pre-abortion counselling in this study. Firstly, I state my ontological stance, which is (social) constructionism. I discuss (social) constructionism as a theory of knowledge. Following this, I describe my orientation as one that shares the same political and research agendas as critical social psychology and feminism. The combination of (social) constructionism infused with a critical research agenda creates the possibilities for exploring (reproductive) health issues and institutional interactions in new ways. It steps beyond the biomedical approach and into the realm of discourse and social interaction at the level of talk.

With this lens as a backdrop, I view pre-abortion counselling as:

1) Institutional talk-in-interaction
2) A discursive event (this enables using an approach that steps beyond the biomedical approach's obsession with patient satisfaction and addressing the social problem of "unintended/unplanned" pregnancies)
3) A site where power, gender and oppression operate at the level of talk
4) Being goal orientated and conversationally organized in some way
5) A critical component of reproductive health-care services in South Africa
6) Comprising of certain discourses which position patients and make certain assumptions about their reproductivity

With my one foot firmly entrenched in feminist (critical) social constructionism I then go on to my epistemological stance which flows from, and is, as I argue, compatible with social constructionism and feminist research goals. My epistemological approach is explained through a discussion of Discursive Psychology and Conversation Analysis. For each approach, I discuss their specific objectives, theoretical underpinnings as well as the analytical concepts that I draw in relation to their usefulness in providing insight into pre-abortion counselling as an institutional and reproductive health encounter. I discuss some of the contestations between each approach and argue that they can in fact exist in harmonious tension within the same analytical project, whilst at the same time both contributing to a feminist research endeavour. I outline how all the above come together to form a way of doing critical health psychology,

an approach which is committed to addressing the issues of inequality, power and oppression at various levels (e.g., interpersonal, community, organisational, cultural)

Power dynamics, inequality, and oppression aren't limited to just broad societal structures; they persist and are perpetuated through everyday social actions, both in ordinary interactions and within institutions. To gain a deeper understanding of the challenges – and potentially the successes – faced by women, including both patients and healthcare providers, we must delve into these interactions at the level of speech and discourse.

3.2 Social constructionism

It is difficult to provide a comprehensive and universally accepted specific definition of Social Constructionism. It has been called a movement, a theoretical orientation, a paradigm and an approach (Andrews & Cork, 2012; Galbin, 2014; Stam, 2001), and over the years has been utilized in great variety of academic endeavours, including in as ethnomethodology, feminism, post-structuralism, psychology and linguistics studies (Elder-Vass, 2012; Stam, 1990). For this reason, no unified position of social constructionism exists but rather variations of thereof (see, Burr 2015; Galbin, 2014; Wooglar, 1988). Below I present a version of social constructionism as understood in this research project and how I utilized it in this thesis.

In many social science studies, researchers adopt a positivist approach where 'truth', events and experiences are conceptualized as being directly observable, measurable, relatively fixed and existing 'out-there' in the social world independent of human interference (Hammersley, 2003) and our understanding of it. Alternatively, social constructionism takes "reality" to be socially constructed and a product of various social processes (Gablin, 2014; Parker, 1999) and it is through these "*processes* … [that] people come to describe, explain or otherwise account for the world (including themselves) in which they live" (Gergen, 1985, p. 266, emphasis added). The focus on social processes leads to a natural interest in language. For the social constructionist, language is understood not only as the primary means of social interaction but also as the "dominant carrier of categories and meanings" (Parker, 1999, p. 23). Social constructionists resist a realist understanding of language. Language is not understood as a "relatively straight forward path to 'real' beliefs or events, or a reflection of the way things really are" (Gill, 1996, p. 142). Instead, social constructionists view language as having constructive potential. It is a resource people use to make sense of their world, and their subjective lives, and to construct multiple and competing 'truth' claims/realities. Our

experiences are mediated through linguistic descriptions (Burr, 1995) that we, as social agents, have created and have at our disposable.

The constructive use of language enables multiple versions of an account. To present something as 'factual' is to, in effect, provide one construction or version of that thing. Social constructionists propose that there are multiple ways of describing real-life experiences with each description no more 'truthful' or legitimate than another. Linked to this idea is that our constructions are always located. In other words, to describe anything is to provide a construction that is historically and culturally situated (Burr & Dick, 2017; Cromby & Nightingale, 1999). Our use of language and broader systems of meaning-making (i.e., discourses – discussed later) are produced in certain historical and cultural contexts and enable certain ways of understanding the world and our role in it within that historical moment.

Social constructionism, as a paradigm, provides an alternative way of thinking about knowledge and how it is produced. As mentioned above, it acknowledges the multiplicity of truth and as such social constructionists

> […] actively seek to explore aspects of our world, in particular ways for particular purposes, and in so doing create knowledge which we then take as the 'truth' about our world. But other activities carried out for other purposes might have produced alternative 'truths' (Cromby & Nightingale, 1999, p. 5)

Knowledge production, from a social constructionist orientation, is not 'incorrect' or 'false' but seen rather as one way of explaining something, or one way of making sense, as the researchers have drawn on discourses and knowledge to do so.

The ideas from social constructionism have provided critical and feminist researchers (in various discipline) with new ways of theorising about social issues at both the micro and macro levels. Social constructionists ask different questions of issues and seek to investigate them using alternative methods and theories – mainly those that recognize there are multiple truths which are constructed through language, interaction and power relations. Social constructionists also recognize the subjectivity/experience of the participant within the research process (Andrews, 2012).

Since social constructionism foregrounds the importance of language and the process in which people produce versions of 'reality', it is naturally interested in the ways people talk, or rather

discoursesand narratives that people use to construct their reality and as such underpins much work in Discourse analysis (DA). DA can be broadly described as an approach that explores "human speech/writing, actions and products (texts) to identify and analyse these of ways of understanding" (White, 2004, p. 9). In other words, DA examines how people go about constructing their lived experiences through discourse. However, since it is based on the premise that meanings are constructed, it also makes it possible for those meanings to be deconstructed.

DA, underpinned by social constructionism allows for an exploration of how knowledge is produced and how it shapes people's understandings of the world. For example, critical and feminist scholars have challenged the ways in which the academic community (which has historically been populated by white, middle-class men) has produced, and continues to produce, certain knowledge. This knowledge is often described as being neutral, objective, based on empirical findings and thus factual. Such knowledge very often penetrates into the everyday interactions of the layperson and broader society and is used to make sense of the world. In many cases, knowledge is simply incorporated into our way of being and understanding the world. We take this knowledge for granted which enables it to exist unchallenged and unquestioned in our lives.

Social constructionism has no disciplinary allegiance and has been used in work that intersects across a variety of disciplines such as psychology, sociology, political science and so on (Potter, 1996). Furthermore, as a theoretical framework, it has underpinned work in conversation analysis (Atkinson & Heritage, 1984; Geils & Knoetze, 2008), discourse analysis (O'Reilly & Lester, 2017; Potter & Wetherell, 1987), ethnomethodology (Button, 1991; Holstein & Miller, 2017), and rhetoric analysis (Billig, 1987; Troyer, 2017). Projects that adopt this paradigm seek to explore the process by which meanings are produced, resisted, accepted, sustained and modified (Schwandt, 2003)

3.3 Critical, Feminist and Discursive psychology

Critical psychology is a broad term used to describe a perspective of psychology that draws heavily on critical theory. Critical psychology is "critical" in at least two senses. In one way, it is critical of the taken-for-granted ways of "being" in everyday life – from the level of talk to broader structural and institutional practices. It is also critical of psychology as a discipline and

profession which is based on particular assumptions (e.g., what it means to be a 'good mother') and practices (e.g., research, therapy) that have the social power to influence society and people in various ways (e.g., being the authoritative discipline on mental health); this can involve oppressing and marginalizing certain groupings of people (Hepburn, 2003; Murray, 2015). The objective of this dual critique is to identify aspects of current society and psychological practices that are (1) problematic and to (2) interrogate and acknowledge their oppressive functioning, with the end goal being to (3) dismantle them in ways that are emancipatory and disrupt the status-quo. The 'critical' characteristic in critical psychology has attracted considerable attention in the last 20 years and has permeated through other areas of psychology, such as: social psychology, health psychology, African psychology and Liberation psychology.

Feminism, with a focus on gender (Gough et al., 2013) and social structures (Farganis, 2015), has contributed significantly to the continual development of critical social psychology. It is also an approach that is particularly useful in this research because it understands that people's experiences (e.g., of pre-abortion counselling) are embedded within discursive and social power relations (Mavuso et al., 2019, p. 12). I now turn to a brief discussion of feminism and feminist psychology.

As with many definitions in the social sciences, feminism has multiple definitions, viewpoints and objectives, but there appears to be two common themes that different versions share (Unger & Crawford, 1992). Firstly, feminism places a high value on women (Anderson et al., 2013;Wilkinson, 1996). It doesn't view women as more important than men and other genders but calls for the focused consideration of women and minority genders as worth studying in their own right. Secondly, "feminism recognizes the need for social change on behalf of women" – it is for this reason that feminism and feminist psychologies are unashamedly and "avowedly political" (Wilkinson, 1996, p. 3) and seek ultimately to end the oppression of women at all levels (i.e., structural and the personal level) (Kelly et al., 2013)

Feminist research has been critical of the ontologies, epistemologies and methodologies that have been utilized within the traditional positivist research paradigm; it is critical of mainstream research practices (e.g., the relationship with participants) and the way in which knowledge is produced, understood and disseminated. As such, its overarching agenda is to critique dominant (masculinist) conceptions of knowledge (Banister et al., 1994; Weatherall, 2012) which have shaped the realities of women's lives in inequitable and oppressive ways. Feminist scholars have responded by developing alternative ways of conducting research.

These can be classified into feminist empiricism, feminist standpoint theories, and discursive (e.g., postmodernism or post-structuralism) feminism (Boonzaier & Shefer, 2006; Wilkinson, 2000). In this thesis I align myself closely with feminist work that has focused on reproductive health matters and adopts a critical discursive approach.

A constructionist understanding of the world underpins discursive feminist research, which is interested in how people construct their social experiences through language (Burr & Dick, 2017; Galbin, 2014; Wetherell, 1986). It conceptualises social life as being textual and discursive and thus privileges qualitative methods that focus on talk (e.g., DA, Grounded Theory, Conversation Analysis, and Thematic Analysis). In the below sections, I introduce and discuss the key concepts used in critical, feminist and discursive psychology research. These are also the concepts that will be utilised in this study to explore the pre-abortion counselling interaction. The first key concept is that of discourse, where discourses are understood as being constructed, action-orientated and situated. The second concept concerns subject positions, specifically interactive and reflexive positioning, and draws on the work of Bronwyn Davies and Rom Harré. The third key concept I draw on is framing the pre-abortion counselling interaction as a discursive event. Here, I primarily draw on the work of Norman Fairclough and conceptualise the interaction as comprising spoken/written language, a discursive practice, and a social practice

3.3.1 Discourse.

When people speak, they are inevitably engaging in discourse and it is through discourse that people make sense of their world and locate themselves within it (Durrheim, Mtose & Brown, 2011). The concept of discourse within the research literature has been conceptualized differently by various authors as:

- "Systems of statements which cohere around common meanings and values [that] are a product of social factors of powers and practices, rather than an individual set of ideas" (Hollway, 1983, p.231).
- "A system of statements which construct an object" (Parker, 2002, p. 145)
- "Language used as social practice" (Fairclough, 1993, p. 138).
- "Practices that systematically form the objects of which they speak" (Foucault, 1972, p. 49
- "Recurrently used systems of terms for characterising and evaluating actions, events and other phenomena" (Potter & Wetherell, 1987 p. 149).

- "Discernible clusters of terms, descriptions, common-places, and figures of speech often clustered around metaphors or vivid images and often using distinct grammatical constructions and styles" (Potter, Wetherell, Gill & Edwards[17], 1999, p. 212)

Within this study, my understanding of discourse is informed by Wetherell's, Fairclough's and Parker's writings on the topic. I am aware that their conceptualizations and methodological recommendations are not identical. However, as will be discussed and demonstrated throughout this thesis, I draw on elements from each approach to frame and investigate the pre-abortion counselling interaction. Below I identify and discuss the theoretical understandings of discourse. There are three core theoretical principles of discursive psychology which provide the foundation for how analysts using this approach view the nature of discourse as being (1) constructed, (2) action orientated and (3) situated. There are discussed below.

3.3.1.1 Discourse is constructed. Discourses do not exist as pre-packaged universal ways of speaking about events, topics and the world. Instead, discourses are made-up or constructed using a variety of linguistic building blocks (Wiggins & Potter, 2007) such as: words, categories, metaphors, idioms, rhetorical devices (Edwards & Potter, 2001) and so on. Accumulated together, these become the discursive resources that are available to speakers (Taylor, 2007) and are used and combined in various ways to construct versions of the world and our experiences in it that are historically and institutionally located (Harper, 2006).

Discourses are deployed through discursive practices, such as talk, conversations, writing etc. Constructing an account is an interdiscursive practice that people do in everyday interaction. For example, the utterance 'I need to go to the doctor because I am feeling ill' is constructed by drawing on specific categories (the doctor, and the speaker as someone who is sickly), actions (going to the doctor) and explanations (being ill). These all come together to produce a medical discourse, which has associated meanings and assumptions for the actors within the discourse (i.e., a sick person becomes a patient who requires the assistance of a medical professional/ doctor; the doctor is an expert in diagnosing the person's illness and may prescribe treatment, which the patient should follow).

[17] These authors prefer to use the concept 'interpretative repertoire' instead of discourse to emphasize that discourses are drawn on in social interaction as flexible and interactional resources.

Discourses are also considered to be constructive. This means that utterances and discourses are constructed in certain ways to serve or do particular interactional work (Edwards & Potter, 2001) – that is whatever is being constructed has conversational or interactional value and use. Deploying a discourse in talk is to offer a particular version of something out of the indefinite potential versions that could be utilized. However, people's constructions of events and experiences are not random but serve an interactional purpose. In this way, people use discourses in talk much the same way a person uses legs in a marathon to perform the necessary actions to complete the objective. Thus, discourses can also be considered as action-oriented.

3.3.1.2 Discourse is action-oriented. Discursive psychology focuses on the action orientation of talk in social interaction and practices (Ussher & Perz, 2000). Talk is not taken merely as communication for communication's sake, but is seen as a behaviour (i.e., using language) which is used to carry out social actions. That is, when people deploy discourses, they are engaging in certain actions such as: questioning, blaming, explaining, justifying, flirting, and so on. Seen in this way, much of our social interaction is guided by or directly involves discourse. For Edwards and Potter (2001) discourse is considered to be the "primary currency of interaction" (p. 1). This makes discourse a particularly important aspect of my study which seeks to explore the interaction of pre-abortion counselling.

It is worth mentioning that discursive psychologists do not necessarily treat people's talk as corresponding to their action (Edwards & Potter, 2001). This has often been referred to as a non-cognitivist approach to talk which asserts that one's talk need not necessarily reflect 'true' internal states or drive certain behaviour. For example, a person may construct themselves as displaying a racist attitude through their talk but such talk might not necessarily drive their personal behaviour. As such a racist attitude is not seen as an inherent and fixed construct within the individual, but rather racism, or rather *doing* racism, is considered as a discursive practice that is constructed through talk (Potter, 1996). This is a particularly important theoretical concept to highlight in this study as I am interested in exploring how discourses are used to carry out the institutional goals of pre-abortion counselling. And as much as discourses are action-orientated, they are also situated within local conversational contexts.

3.3.1.3 Discourse is situated. In the section I discuss how discourse is situated at both the mice and macro level of talk.

People use discourse in everyday interaction, but they do not use it in the same way in different settings, practices and with different people. Discourse usage is uniquely influenced by the *where-ness* or the *situated-ness* of talk. Discursive psychology understands discourse to be situated at two inter-constitutive levels (Edwards & Potter, 2001). The first level of situated-ness takes place at the conversational level. At this level, discourse is used and located within the interactional production of on-going talk, which is shaped by sequences of turns. At a conversational level, words, turns and discourses (which are all action oriented) are understood to be relevant depending on what has been said previously in the conversation and are thus situated in relation to the previous turn within the overall conversational interaction. This micro level of conversation has traditionally been the focus for conversation analysts.

The second level takes discourses to be dually situated within a particular setting (e.g., abortion clinic) and the practices (e.g., abortion counselling) which make-up that setting. For example, a nurse who conducts abortion counselling (practice) at an abortion clinic (institutional setting) would generally draw on legal and medical discourses during the consultation. Caution must be exercised, however, to not view discourse use as being simply contextually determined. It is overly simplistic to assume that talk is determined by the physical context alone. The fact that there is talk in an abortion clinic does not necessarily mean that it must be medical or legal. Institutional activities and identities are made relevant by the speakers themselves by examining how their talk is oriented to in the pursuit of institutional activities and goals. It is not the context itself that determines the talk but rather how speakers orient to differing turns and the setting (Edwards & Potter, 2002).

Discourse is also situated at the macro level. A macro level of understanding involves recognizing and acknowledging that discourses are culturally available and are embedded within historical and accompanying societal conditions (Gavey, 2005; Harper, 2006). That is, although we deploy discourses in our talk, there are certain societal meanings that are associated with these discourses on a broader level. In other words, to draw on a discourse is also to refer to societal understandings of that discourse and how it is appraised and assessed by people within that given society at that given time.

3.3.2 Positioning theory

When engaging in everyday talk people draw on discourses that construct the human subject (Burr, 2003) and position them in some way or another (e.g., as nurse, professional, responsible). Within discursive work, this is commonly referred to as subject positioning, a theoretical idea developed by Davies and Harré (1990) as well as Hollway (1984). For Davies and Harré (1990, p. 49) subject positioning is "both a conceptual repertoire and a location for persons within the structure of rights for those that (sic) use that repertoire" (Davies & Harré, 1990, p. 49). Thus, once a person has been positioned, they begin to experience the world from that vantage point. For example, in the pre-abortion setting a patient may be positioned as already a mother and that may change the way they come to consider their pregnancy, the foetus and their options.

There are various ways in which a person can be positioned (see Harré & Van Langenhove, 1991; Harré & Moghaddam, 2003; Mcvee et al., 2018); here, I present three. The first is *reflexive positioning* which involves a person positioning themselves, and the second is *interactive positioning,* whereby a person is positioned by another (Davies & Harré, 1990). Individuals are not always passive recipients who accept being interactively positioned. In cases where a person has been positioned in a negatively valued subject position (e.g., irresponsible parent), the person can resist such a position through various rhetorical strategies. For example, an individual may trouble the proposed subject position and explicate or negotiate why it may not be suitable or desirable in that particular communicative context (e.g., positioning a pregnant woman as a mother before she has made a decision regarding her pregnancy). Alternatively, an individual could resist the subject position by providing an alternative subject position, effectively changing from interactive positioning to reflexive positioning (e.g., as a responsible reproductive decision-maker). The third positioning is that of *imperative positioning,* which is based on one's own biographic detail (Taylor, 2006). These can include age, race, gender, marital status and so on. By simply being a single pregnant woman, a participant may already be positioned within a particular discourse and have to negotiate the prior positioning within their talk.

Importantly, Davies and Harré (1990) consider positioning to be a discursive practice that takes place in conversation with others. When people talk, whether in institutions or everyday interaction, they position themselves and others in that instance. Thus, a speaker's positioning is not only worked up through interaction with another, but it is also locally situated, or rather

made relevant in that interaction (Harré et al., 2009). This idea is echoed by Wetherell (1998), who calls for an emphasis on "the highly occasioned and situated nature of subject positions and the importance of accountability" (p. 394). For Wetherell, the interest is on how subject positions are worked up in talk and how speakers come to manage those positions in interaction. As such, more emphasis is placed on the interactional construction of positions and less so on the discourses that make them available.

Wetherell (1998) argues that what a subject position comes to be is only partly the consequence of the discourse in which it is deployed – subject positions are also fuelled and shaped by the accountability or participants' orientations to the unfolding conversational settings. In other words, subject positions do not only do descriptive work within a discourse, but it is within the unfolding talk and the process of 'doing' things in talk (e.g., explaining, blaming) that a subject position's significance and connotations are worked up. From this view, subject positions are seen to have descriptive (through discourse) and interactional (through interactive talk) significance – and these levels of positioning should not be seen as distinct but rather as constitutive.

Analytically through focusing on positionings I seek to explore how speakers come to view themselves, ideas (about certain events, e.g., carrying a foetus) and make sense/assign meaning to their experiences (e.g., abortion, pregnancy) (Davies & Harré, 1990; McVee et al., 2018). It is through positionings that people view the world and their place in it. They become emotionally invested in particular subject positions and use these as a consideration in everyday life. In other words, a person's understanding of their position (i.e., whom they are presented as) may be intricately interwoven with their behaviours.

In this study I used positioning theory to identify the subject positions that are worked up for nurses/counsellors, patients and third-party members within the abortion counselling space. This provided insight into how parties within the interaction are positioned, and how these subject positions are made relevant. This exploration assists in understanding the pre-abortion counselling as a discursive event.

3.3.3 Pre-abortion counselling as a discursive event

Within the critical discursive literature, Norman Fairclough, puts forward the concept of a 'discursive event'. For Fairclough (1992), a discursive event is simultaneously an instance of language (analysed as text), an instance of discursive practice, and an instance of social practice. For definitional clarity, a discursive practice is taken as the process whereby text is built up using various resources (e.g., discourses, subject positions); this includes both the event's production and its interpretation (Fairclough, 2013). A social practice refers to the "institutional and organisational circumstances of the discursive event and how that shapes the discursive practice" (Macleod, 2002, p. 18). For this study, I use Fairclough's (1992) conceptualization of a discursive event to frame my understanding of pre-abortion counselling. Pre-abortion counselling is an event produced through (1) spoken or written language (including documents) which cohere as a (2) *discursive practice* where social actors continually interpret and respond to previous text (i.e., discourses), and in which (3) both *text* and *discursive practice* are mutually constitutive and are delivered in ways that set the interaction along a trajectory within a particular institutional (clinic) space (*social practice*). I take the talk in pre-abortion counselling as a discursive practice as much as an institutional practice. Therefore, I understand discourse as shaping the institution and in turn, the institution also shaping the discourse(s) used.

This framing of pre-abortion counselling takes not only discourse but also the social processes and setting in which it is produced as central to the construction of the event itself. Thus, in order to explore the discursive event of pre-abortion counselling, one needs to consider how text, discursive practice and social practices work together. In this way, discourses (and other discursive resources) are treated as constitutive of the event itself and an abstract notion of discourse avoided (Potter et al., 1999).

There are two additional concepts Fairclough developed that are useful in understanding pre-abortion counselling as a discursive event. The first is of *genre*. According to Fairclough (1993), genre is "the use of language associated with a particular social activity" (p. 138). Here the focus is not on the discourse *per se* but rather on the semiotics used to construct the discourse and social practice (i.e., the signs and symbols that are used to make meaning when communicating). For example, in the pre-abortion counselling interaction, a nurse may draw on a medical discourse which, in terms of genre, may mean that she uses medical terminology such as risks, consequences, or demonstrate how manual vacuum aspiration (MVA) works.

The second concept is that of *interdiscursivity,* which refers to how multiple discourses and genres are combined and locally produced in social practice (Fairclough, 1993). It ties into Parker's (2002) idea that a discourses "embed, entail and presuppose other discourses to the extent that the contradiction within a discourse open up questions about what other discourses are at work" (p.150).

3.4 Conversation analysis

Conversation analysis is a qualitative, micro-level, systematic approach to examining social interaction at the level of talk. CA was developed by, most notably, Harvey Sacks, an American Sociologist, and introduced through his pioneering lectures on his work at the Los Angeles Suicide Prevent Centre. Sacks' work was heavily influenced by ethnomethodology (Garfinkel, 1967), theory of the interaction order (Goffman, 1983) and linguistic philosophy (Wittgenstein, 1953). Harvey Sacks together with his colleagues Emmanual Schegloff and Gail Jefferson are considered among the first to synthesise these ideas into an empirically grounded, data-driven, and highly structured research agenda.

Heritage and Atkinson (1984) describe the central goal of CA as "one of describing the procedures by which conversationalists produce their own behaviour and understand and deal with the behaviour of others" (p. 1). Its interest is the *in-situ* turn-by-turn organization and local production of conduct. It thus theorises participants as social agents who produce and orient to social order as they go about doing meaning-making work (Speer, 2005). A 'turn' refers to a unit of speech or segment of talk produced by one speaker in a conversational exchange (Sacks et al., 1974).

As the name suggests, Conversation analysis is interested in the interactional level of talk and how people use language to perform certain actions in organised and meaningful ways (Speer, 2005). It studies various aspects of talk-in-interaction from individual utterances (i.e., turn constructional units), organization of turns in sequence, and even the overall structural organization of an interaction. At a more critical level, it seeks to explicate how broader forms of social organization at the 'institutional' or 'social structural level' are implicated and feature in talk (Speer,2005).

Language is regarded as a resource that people use in conversation to perform certain actions, such as requesting, greeting, disagreeing and so on. It is not interested in talk *about* a particular topic; instead, it seeks to analyse "talk as an object in its own right" (Drew, 1992, p. 304).

One of the key theoretical points of CA is that it understands language to be a form of social action, that is, people *do* things with their words and talk, such as: request, greet, explain and so on. Further to this, these actions are not considered to be random, but are designed in socially organized ways such that they are intelligible to recipients. For conversation analysts the intelligibility of any turn at talk is provided for by its sequential position – "its location in an ongoing series of actions" (Pomerantz & Fehr, 1997, p. 67). It is through analysing turns and sequences of turn that researchers are able to discern how participants have heard the utterance, what action they have performed in response within that specific context, and how such an utterance is consequential for proceeding talk.

Gail Jefferson, as one of the key founders of CA, also developed a detailed transcription system for analysing talk (see Atkinson & Heritage, 1984) – it is often called the *Jefferson system*. The transcription notation enables talk to be transcribed in fine-grain detail, capturing interactional happenings such as pauses, silences, laughs, in- and out-breathes, overlapping talk, emphases, pitch. CA is not only concerned with verbal aspects of interaction but has sparked considerable analytical and theoretical interest in non-verbal features of interaction such gaze, posture, gesture and body (see for example Goodwin, 1980; Heath, 1986; Rossano, 2010) which conversation analysts would argue contribute to performing actions in talk. The interest in non-verbal features has led to the development of notations that mark their appearance in interaction.

In order to investigate the socially organized nature of talk CA has developed analytical tools and concepts through empirical observation of real-life talk. By utilizing these tools, CA provides "a distinctive way of doing sociology" (ten Have, 1999, p. 7) and uncovering the patterns and means of identifying and explicating the structures, practices and actions in talk (Toerien, 2014) that people make use of to go about living their lives and co-constructing their experiences. It is argued that so systematic and established are these tools that conversation analysts working on the same topic would end up with similar findings.

In the below section, I unpack key ideas that informed my conceptual approach to understanding the pre-abortion counselling interaction from a conversation analysis perspective. The first involves conceptualising the exchange as one where institutional talk takes place. I do this by focusing on how identities (of the patient and doctor) are interactionally established through dialogue in pursuing institutional objectives. After that, I present the

critical concept of overall structure organisation, which provides the explanatory framework to identify the structure of institutional talk by focusing on what activities are co-accomplished.

3.4.1 Pre-abortion counselling as institutional talk

Institutional interaction is an inevitable feature of social life and from a very young age, before even being able to talk, humans are socialised to participate in institutional interactions. Institutions have been studied extensively in multiple disciplines as both a physical domain and a form of patterned socio-cultural behaviour. Conversation analysts have been pivotal in producing invaluable insights regarding institutional talk. Using CA, analysts have contributed greatly in explicating the conduct of institutional talk (Heritage & Atkinson, 1984).

Conversation analysts adopt an ethnomethodological approach to understanding institutional talk. They are interested in explicating how specific institutional tasks, identities and inferences are achieved in that setting (Arminen, 2005), or, in other words, how institutions are "talked into being" (Heritage, 1978, p. 29) and "brought to life" (Heritage & Clayman, 2010, p. 32). From this perspective, it would be inadequate to assume that because participants are in a clinic this will predetermine how they will interact (Schegloff, 1992). Instead, these institutional identities are performed through various conversational devices and strategies which it is the job of the analyst to show

All institutional interactions have one thing in common; they all "involve at least one participant who represents a formal organization of some kind" (Drew & Heritage, 1992, p. 2). Further to this, Drew and Heritage (1992) identify three basic elements of institutional talk:

1) Institutional interaction involves the pursuit of goals which are in some way or another tied to institution-relevant identities (e.g., doctor and patient, police officer and citizen reporting a crime).
2) The talk in institutional settings is constrained by the institutional identities of each speaker and, as such, only certain utterances are considered as relevant to the pursuit of the pre-determined goal of the interaction. And finally,
3) Institutional talk is associated with procedures and inferential frameworks that are particular to specific institutional contexts.

Conversation analysis research on institutional talk has investigated conversation as a unique form of communication and has examined the structural features of talk such as: turn-taking, overall structural organization, sequence organization, turn-design and lexical choice

(Heritage, 2002). Based on the above characterizations, research has also sought to investigate how interactional practices, institutional identities and tasks are co-produced in interaction and what relevancy they have for the specific interaction (Heritage & Stivers, 2014). One way of investigating institutional identities is to look at how tasks or activities are carried out and how each participant is positioned in relation to that task.

Membership Category analysis (MCA) provides a unique means of illuminating how institutionally situated identities are worked up in interaction. MCA analyses "how members of society categorise themselves, others and locations" in various interactions (King, 2010, p.3). Categories, which Baker (2000) views as deployed in discourses, contain strands of different cultural and ideological understandings (e.g., regarding gender, race, class, ability and so on) and thus to categorize is to be positioned in relation those understandings.

Drew and Heritage's (1992) basic elements of institutional talk can be applied to that of pre-abortion counselling. Pre-abortion counselling is an institutional interaction that is goal orientated. Each interaction progresses towards a specific outcome (i.e., goal). For the patient this would include important activities that deal with information sharing and decision-making, whilst the counsellor is concerned with helping the patient to obtain their desired outcome through reasonable means. It is through this interactive process that speakers perform their institutional identities. In other words, the talk that is necessary in the pursuit of institutional goals creates the relevant institutional identities and is achieved by speakers 'doing' patient and 'doing' counsellor.

There is, as John Heritage (1984) emphasises, substantial evidence from CA studies of 'institutional' talk-in-interaction that such talk involves both a reduction – compared with 'ordinary' conversation – and a specialisation of the "range of conversational practices available for use" (p. 239). That is, speakers selectively reduce the scope of some conversational practices while concentrating on others. By doing this, participants are performing and creating a certain institutional context.

Institutional talk is seen as being produced in an institutional context "where the interacting parties orient to the goal-rational, institutionalized nature of their action" (Arminen, 2005, p. xiii), such as in schools, courts of law, hospitals, clinics, universities, parliament and so on. However, institutional talk should not be considered institutional because it is simply located and produced in a physical or symbolic setting. Institutional talk can occur outside of an institutional setting (Drew & Heritage, 1992), They also go on to specify that institutional

interaction is characterised by "role structured, institutionalised, and omnirelevant asymmetries between participants in terms of such matters as differential distribution of knowledge, rights to knowledge, access to conversational resources, and to participant in the interaction" (Drew & Heritage, 1992, p. 49).

Schegloff (1991, 1992d) was one conversation analyst who sought to address what else about institutional talk made it institutional. He acknowledged that statistical methods provide evidence to believe that certain social characteristics (i.e., variables) such as race, class, gender and ethnicity can influence talk-interaction, but these variables cannot show how a specific identity is made relevant and consequential within a passage of talk. In order for one to consider something as institutional talk, the analyst must be able to "identify and describe the range of practices through which identities – and whatever forms of power and inequality may be associated with them — are linked to specific actions in interactions" (Raymond & Heritage, 2006, p. 679). Schegloff (1992) referred to this as the interaction/social structure nexus and was calling for a detailed specification of (institutional) talk to identify the range of ways in which identities are made relevant. The notion of the interaction/social structure nexus posed two analytical challenges, namely that of (i) relevancy and (ii) procedural consequentiality.

Relevancy is an aspect of talk that requires conversational effort from all speakers involved. When people talk, no matter in what setting, they draw on pre-established social categories to talk about the world, their experiences and other people. The problematic here is that people can be described or identified in many ways. For example, a pregnant woman who is receiving abortion counselling can be categorized in terms of her race, gender, employment status, level of education, financial status, language spoken, age, and so on. Thus, if people can be described in various ways and effectively occupy multiple identities during talk, how can (conversation) analysts show when a certain identity is made relevant in that moment of talk? Schegloff (1987; 1991) hints that the answer may lie in paying close attention to the aspects of interaction to which participants orient within that moment and to "show how the parties are embodying for one another the relevancies of the interaction, and thereby producing social structure" (Schegloff, 1991, p. 50). In other words, before claiming a specific identity is being invoked, such as gender, the analyst must show how that identity is being made observably relevant to the participants' conduct within the interaction.

The second challenge of procedural consequentiality builds on from the issue of relevancy. Once a particular identity has been established as relevant in some way, the next challenge lies in showing how that identity matters in the institutional talk. For example, in an abortion counselling session the patient may occupy the teenager (social category) identity which could be consequential (Schegloff, 1992) for the trajectory of information shared, options provided, as well as turn design and lexical choice and so on. The social category of teenager leads to discussions of potentially informing their parents or around managing the pregnancy at school — discussions that would not be had with an older woman. Here, the analytical objective is to explicate the devices that speakers use in the interaction and how this has consequences for the preceding talk (Heritage, 2002).

Heritage (2002) asserts that institutional talk is realized and becomes distinct by looking carefully at the unfolding of the interactional organization and the choice of words. In regards to interactional organization, overall conversation structure and turn-taking in institutional settings are organized in very specific ways (e.g., medical consultation). In addition, lexical choice (e.g., "baby" or "foetus) and broader discourses (e.g., medical and cultural) shape the way in which participants orient to and do institutional activity. These are unpacked below.

3.4.2 Overall structure organization and activities

Conversation analysts regard talk to be organized in some way. Talk-in-interaction, whether ordinary or institutional, follows some sort of internal structure which keeps the interaction going forward. For example, opening (e.g., hellos/ *Molo*, how are you) and closings (e.g. cheerio, *Uhambe/Usale kakuhle*) are pre-specified phases of action that serve a particular goal or sub-goal in the interaction (Button & Casey, 1985; Schegloff & Sacks 1973) – a person greets another person to gain their attention which makes any proceeding talk understandable as entering into a conversation and thus appropriate. It would be out of the ordinary for someone to walk up to another person and to start speaking on a topic without greeting. In everyday conversation, other than openings and closings, it is extremely difficult to identify a recognizable structure as people co-construct their talk in highly fluid and unpredictable ways in the pursuit of performing specific activities, practices and interactional objectives (Heritage & Claymann, 2011).

Overall structure organization was one of the first analytical interests in conversation analysis, with early contributions by Schegloff (1967) and Sacks (1992; 1970). Despite the earlier works

in overall structural organization, it has not attracted much analytical interest and thus is largely still unexplored in different interactions (Robinson, 2012). However, matters are different when it comes to institutional talk. Institutional talk is not as fluid and unpredictable as everyday talk. More often than not, there is a mutually shared understanding of what the goal of the interaction is (e.g. to get medication for an illness) and it is this goal or objective that participants seek to work towards. Participants work towards the ultimate goal by completing smaller interactional sub-goals through activities and actions. Comparatively, institutional talk is generally structured, predictable and follows a "specific internal shape or structural organization" (Heritage, 1997, p. 120) also referred to as overall structure organization.

Central to conversation analysis is the concept of activities. Although no universal definition is agreed upon by analysts, activities are generally regarded as "the work that is achieved across a sequence or series of sequences as a unit or course of action" (Heritage & Sorjonen, 1994, p. 4). It is sustained talk that is topically coherent and/or goal-coherent in performing an action. Actions are seen as the multiple sequences of relatively distinct actions which "hang together" or cohere (Robinson, 2013, p. 257) and make up an activity. In other words, it is through 'doing' actions that an activity is accomplished. For example, to engage in the activity of an opening would include a greeting action (e.g., "Good day [patient name]") followed by the other speaker replying with their greeting action (e.g., "Hello doctor"). *Activity* is a unit of interaction, that is made-up of multiple *actions*, and gets its coherence from the *overall structure organization*, which can vary (Robinson, 2013).

One way of understanding overall structure organization is to see the interaction moving through particular stages or phases, where each phase deals with a sub-goal that is considered relevant for achieving the main objective of the interaction. For example, the main objective of visiting a physician would be for the patient to receive treatment/medication so that they can return to a healthy state. Treatment/medication is not immediately given to patients; instead, physicians seek to find out as much about the patient's condition (i.e., sub-goal) before providing possible treatment solutions (i.e., main goal). They can do this by asking the patients questions about their illness (e.g., so what seems to be the problem?) or through a physical examination if applicable. It is only through engaging in these sub-goals that the physician is able to acquire adequate information concerning the patient's condition so that they can accurately diagnose the illness and thus prescribe an appropriate form of treatment.

One of the most notable contributions to overall structure organization is the work by Byrne and Long (1976). Byrne and Long (1976) analysed 2500 recordings of primary care consultations with the aim of discovering discernible patterns of physician communicative behaviours. Through their analyses they proposed a six-phase model that mapped out the physician-patient visit, as can be seen below.

1) Relating to the patient (i.e., opening visit)
2) Discovering patient's reasons for attendance
3) Conducting verbal and/or physical examination
4) Considering patient's conditions (i.e., diagnosis)
5) Detailing treatment or further investigation
6) Terminating (i.e., closing the visit)

Each of the above phases involves a specific activity that is relevant towards accomplishing the institutional goal of the interaction — to provide relevant medical assistance to those seeking it. The goal is ultimately dependent on the quality and success of necessary activities accomplished through conversation, where the physician guides the encounter, accomplishing certain activities to achieve the goal. For example, in the third phase, the primary activity is gaining information about the patient's condition. This activity can be done in numerous ways (e.g., questions and answer sequences, physical examination). Each activity has its own sub-goal that enables the interaction to progress to the next activity and ultimately towards the main objective. It is important to note that in some cases not all activities may successfully be accomplished.

The phase model proposed by Byrne and Long (1976) appears systematic and logical in presentation; however, even though model is based on a great number of empirical interactions, such a model running so smoothly may not always occur in real-life interactions. As Bryne and Long (1976) cautiously stated:

> One of our greatest problems was to pin down a sequence which could be seen to occur frequently. The real difficulty was not defining the event but sequencing them in a logical form. The theoretical form finally agreed rarely appears in practice and should be seen as an ideal (Bryne & Long, 1976, p. 21).

Thus, one should not be lured into thinking that the phase model is a prescriptive tool that can be harnessed as map to explain real-life medical interactions. Instead, Byrne and Long's (1976)

research should be considered as a theoretical contribution to understanding how institutional medical talk is conducted in everyday interaction and what activities it involves. Mapping the overall structure organization serves as an 'analytical tin opener' that not only provides analysts with a structural overview of the interaction but also enables analytical claims to be located at the local level of phases/activities whilst at the same time embedded within and constituting the larger conversational structure. In other words, it maps and it contextualizes institutional talk-in-interaction at the local level (i.e., activities that are made up of sequences) and at the broader level (i.e. the overall coherence of the interaction).

As has been mentioned previously, not all talk fits comfortably within a phase model and it is not the objective of the analyst to see how an utterance can fit into a specific phase. Rather, the overall conversation structure should be used as an analytical resource that can show how "parties are oriented to such organizations in the talk and the conduct of the interaction" (Heritage, 1997, p. 122).

Robinson (2003) is another conversation analyst who has contributed significantly to work on understanding overall structure organization within institutional settings. Through his research and analysis, he proposes an alternative way of thinking about the organization of interaction, which is based on the idea that the establishment of a new medical problem makes relevant a particular interactional *project*. In Robinson's (2003) work a new medical problem makes relevant the project to work towards a treatment where the progression in the interaction is contingent on adequately accomplishing the objectives for each activity. Robinson's (2003) model consists of four central activities:

Activity 1: Establishing a new medical problem as the reason for the encounter
Activity 2: Gathering additional information (history taking and/or physical examination)
Activity 3: Diagnosis
Activity 4: Treatment recommendation

From this model it would be guess work for a physician to make a diagnosis (activity 3) without gathering information (activity 2) on the patient's situation. To successfully complete the project, participants orient to activities that will progress towards accomplishing the overall project. The unfolding of activities may occur smoothly, progressing from one activity to another, which would follow the structure proposed by Bryne and Long (1976), or it may take

on a more iterative format. If certain activities have not been completed to the satisfaction of either party, they may return to 'doing' that activity until it is accomplished successfully. Thus, to complete the project of the interaction is to ensure that all activities have been addressed.

Robinson (2003) argues that the mere existence of routinely occurring activities and actions alone is not sufficient to support the existence of a large-scale conversational structure. Additional evidence is required to substantiate talk as structured. Firstly, it must be demonstrated that participants *orient* to the current activities as being progressively relevant for the next activity. For the second type of evidence, which extends the first type of evidence, it must also be shown that each "activity is produced with reference to the project as a whole" (Robison, 2003, p. 33). This resonates with Schegloff's notion of procedural consequentiality as each speaker engages in talk to establish their identify in pursuit of the institutional goal.

3.5 Analysing the content and process of talk through positioning

The thesis offers a comprehensive examination of the pre-abortion encounter by integrating the ontological and epistemological perspectives of Conversation Analysis (CA) and Discursive Psychology (DP). In order to understand how language is used to navigate external reality, CA adopts a realist ontology at the ontological level (Sacks, 1992). In contrast, DP emphasizes that meaning is created through discourse and acknowledges the subjectivity and contextuality of knowledge (Potter & Wetherell, 2012), viewing reality as socially constructed (Potter & Wetherell, 2012).

From an epistemological perspective, CA prioritizes observable and objective phenomena in its analysis with the goal of revealing patterns and structures in communication and interaction (Heritage, 1984). In contrast, DP adopts an interpretive position and focuses on how people use language to make sense of their surroundings (Edwards & Potter, 2005). The thesis combines DP's social constructionist ontology and interpretive epistemology with a realist ontology and empirical epistemology from CA to overcome these ontological and epistemological gaps. The examination of how people engage with an external world through talk (CA) and construct their own realities through discourse (DP) is made possible by this integration. This method emphasizes that people interact with an external, common reality as well as construct various aspects of their own realities through conversation.

The above discussions regarding discursive psychology and conversation analysis have highlighted that each approach analyses different aspects of talk, namely, discursive psychology allows for an analysis of the *content* and macro level of talk whereas conversation analysis provides the theoretical insight into exploring the *process* and micro level of talk. Pre-abortion counselling is shaped not only by the content that is shared but also by the way in which it is delivered and processed in interaction. To gain a deeper understanding of how the pre-abortion counselling interaction unfolds requires a commitment to analysing both content (macro) and the process (micro) of talk. The analysis of the content and process together provides a fuller picture of the counselling interaction that could be achieved by only using one analytical method.

Discursive psychology and conversation analysis are both interested in how identities and context[18] are constructed. Yet they differ in how each is methodologically conceptualized (see previous sections) which leads to pursuing insights differently based on different understandings of social action through talk (Korobov, 2001). Discursive psychologists have been critiqued for not sufficiently grounding their analytical claims in linguistic detail (Schegloff, 1999). This includes invoking terms like 'power differences or 'hegemony' when it is not always linguistically clear how participants are orientating these themselves, or even how they understand them. Schegloff (1999) goes further to discuss that evidence of meaning should come from those speaking. In other words, it is how participants orient themselves through talk that determines what counts as observable or standing evidence (Billig, 1987). This allows the analyst to bind the analytical claim to the data and avoid producing interpretations that are merely ideological. Conversation analysts have been critiqued for their focus on the interactional moment (Wetherell, 1998) and explicating the fine detail of talk without broader ideological consideration. Such a focus not does not consider the larger argumentative threads and discourses that are displayed in participants orientations (Korobov, 2001, para 8). It is here where Wetherell (1998) calls for more analytical labour to be done, where talk (i.e., discourses) should be interrogated for taken for granted assumptions and what orientations they make available for participants.

[18] Conversation analysts are interested in context at an interactional level (i.e. how each turn creates the conversational landscape of the interaction) whereas discursive psychologists take context to be invoked and made relevant through the discourses that are drawn on in talk and the meanings, symbols and subject positions associated with each specific discourse.

The debate and distinction I make above is not to assert that CA is not ignorant of the larger socio-political context or that DP is completely myopic to the finer detail and micro constructions of talk (Korobov, 2001). What I am attempting to do in this research is to draw on the key insights from each analytical approach to assist in investigating pre-abortion counselling. The hope is that this will assist in conducting a type of conversation analysis which is more ideologically grounded and a discursive analysis that draws on interactional insights to analytically ground claims. It is hoped that by doing so will produce a fuller and insightful understanding into the talk that takes place during pre-abortion counselling and move beyond the dichotomy of CA versus DP (Wetherell, 1997). I seek to do this by drawing on the concept of 'subject positions' (discussed earlier in this section).

I see subject positions as the common analytical concept which can be used to bridge the different analytical understanding of context and identity between CA and DP. A combined analytical approach would find it important to determine who or what a participant does in particular interaction through their orientation to discourses and the emergent conversational activity. Focusing on subject positions enables this type of analysis to be conducted (Edley & Wetherell, 1997) because discourses make available subject positions and in conjunction with turn-taking people work to locate themselves within the context (micro) of the interaction but also the broader societal context (macro). Seen in this way subject positions are produced in discourse and interaction and understanding this, it is hoped, will enable an investigation of pre-abortion counselling which provides insights practical and ideological insights.

3.5 Conclusion

The objective of this chapter was to provide the theoretical framework which I used to work guide my thinking around the pre-abortion counselling interaction as an event. The chapter started with a brief discussion of the social constructionist paradigm and how it forms part of the philosophical foundation of discursive psychology. I then went on to discuss discursive psychology and introduce key concepts used in this study. Firstly, I unpacked the three features of discourse which are; (1) Discourses are constructive, (2) discourses are action orientated, and (3) discourses are situated. Following the discussion of discourse, I proceeded to introduce positioning theory by drawing on the work of Davies and Harré (1990) and Harré´et al (2009) and cover how discourses make available certain *reflexive* and *interaction* subject positions for

speakers. I also discussed how subject positions have implications for talk that takes place within institutional settings.

A key conceptualisation covered in this chapter is how I understand pre-abortion counselling as a discursive event. Here, I draw on Norman Fairclough's work on discursive wherein her takes discursive events to consist of three central features. These are that they consist of (1) spoken or written language, (2) are a discursive practice due to the way in which speakers interact with each other through talk and in some cases written text, and that by engaging in written and discursive practice the interaction is inherently one of (3) social practice.

Focus is then placed on conversation analysis. In this section, I provided a brief discussion introducing conversation analysis and then proceeded to address how I conceptualised the pre-abortion counselling interaction as one that is institutional in nature. In covering the literature of institutional talk, I introduced the key CA concept of overall structure organization. I then drew on the early work of Byrne and Long (1976) citing their six-phase model before moving to discuss Robinson's (2003) four activity model and how each activity is useful in achieving the overall project of the institutional interaction.

In closing this chapter, I make a case for using both CA and DP (and their respective key analytical concepts) to study institutional talk, and in this study pre-abortion counselling. I argue that although CA and DP approach talk in differently, they are ultimately both interested in identity construction and context. I put forward the idea informed by Margaret Wetherell's work that subject positions are the key concepts which can be used to bridge the two approaches, and enable an analytical engagement with the data that takes into consideration both the content (micro-level) and the process (macro-level) elements of talk. It is hoped that such an approach can aid in investigating pre-abortion counselling so that rich and full insights into the practical and ideological workings of the encounter can be explicated and theorised further.

In the next chapter I discuss the methodology the study followed with specific focus being placed on how data were collected and the procedures adopted in analysing the data.

Chapter 4: Data Collection and Analytical procedures

4.1 Introduction

Pre-abortion counselling is an institutional activity that many women seeking an abortion experience. In this study, my focus was on unpacking the interaction of pre-abortion counselling in terms of structure, interactional activities and content. At a structural level, I was interested in the conversational landscape that was created and followed, including the projects and activities that constituted the interaction. At a micro-level, I was interested in how certain activities such as information sharing, presenting options and providing/obtaining consent were achieved *in situ*. I was also interested to see what discourses were drawn up in the interaction and the subject positions they made available, particularly for patients as well as the foetus. I employed a multi-method analytical approach that drew on conversation analysis and discursive psychology to analyse pre-abortion counselling as a discursive event (discussed in the previous chapter). My analysis sought to critically examine the interactional details of talk in pre-abortion counselling.

As a point of departure for this chapter, I restate my research questions. This is followed by an explication of the overall study design, where I discuss the participants and recruitment procedures and provide descriptive statistics that summarise the data. Thereafter, the data collection process is described. I provide an in-depth account of the analytical processes I followed by describing how I employed conversation analysis and discursive psychology to illuminate conversational features of the pre-abortion interaction. In doing so, I demonstrate how a conversation analytical and discursive reading of data can be used to complement the findings produced using each approach. Lastly, I discuss key ethical considerations of the study and critically reflect on how my role (including all my different positionalities) shaped the research process.

4.2 Aim of the study and research questions

The overarching aim of this thesis was to explore, using a mixed methodology analytical approach, how first-trimester pre-termination of pregnancy (PTOP) counselling is conducted in the public health sector in the Eastern Cape, South Africa. In line with the overall aim, the overarching research question was conceptualised as follows:

How are pre-termination of pregnancy consultations conducted in the public health sector in the Eastern Cape, South Africa?

The overarching research question was investigated using the following sub-questions:

1) What is the overall conversational structure of a pre-abortion counselling consultation?
    1.1 What are the key phases/projects that take place?
    1.2 How do these key phases/projects unfold during the pre-abortion interaction?

2) What information is requested and provided by women (and/or third party if present) and the health care provider during the consultation?
    2.1 How is the information that is requested and provided by the woman (and/or third party if present) and health care provider delivered in conversation?

3) What reflexive and interactive subject positions are located/made available within the counselling conversation?

4) What discourses are drawn on when women, healthcare providers and third parties take up or offer particular subject positions?

4.3 An exploratory qualitative research design

In this section, I discuss the overall research design of the thesis, which was an exploratory qualitative design. Exploratory research is undertaken when there is very little research on a particular topic (Marshall & Rossman, 2014) and/or when a particular topic has not been investigated from a particular theoretical, methodological or analytical perspective. Further to this, exploratory qualitative research seeks to "build rich descriptions" of the topic under investigation to deepen our understanding and to stimulate further research (Marshall & Rossman, 2014, p. 34). In relation to this study, an exploratory research design was considered appropriate as the primary objective was to explore how pre-abortion counselling in South Africa is conducted in everyday practice, and although there has been some research on pre-abortion counselling, none, to the researcher's knowledge, has looked at how it is conducted as an interactional activity at the level talk.

Pre-abortion counselling, for this study, is conceptualized as a "discursive event [which is] an instance of language, text and social practice" all at the same time (Fairclough, 1993, p. 138). Central to this notion is that discursive events are co-produced through talk with different social actors (i.e., nurses/counsellors, patients and third-party members). As such, and for the purposes of this study, I was interested in exploring how people co-construct reality through interactional talk in an institutional setting, such as the abortion clinic. Based on this theoretical orientation, it was deemed appropriate to work from a social constructionist paradigm in which people's lived realities are seen as co-constructed, or rather co-produced, through a dynamic interaction of history, language, culture (Willig, 2013) and institutions. An exploratory research design located within a social constructionist paradigm resonates with the theoretical underpinnings of both conversation analysis (CA) and discursive psychology (DP).

4.4 Sampling strategy and description of the sample

Since the study was primarily concerned with investigating how pre-abortion counselling is conducted, the sampling strategy employed was purposive. Purposive sampling is a non-random approach often used in exploratory research when the phenomena, events or peoples under investigation are unique and/or specific in some way or another (Neuman, 2014). It is a strategy of sampling that draws on the judgement of the researcher(s) and the wider objectives of the study to inform how the sample is selected (Neuman, 2014). In the context of this study, where the primary aim was to explore how pre-abortion counselling (i.e. the event) is conducted, the key speakers were conceptualized as being (1) women/patients, (2) nurses/counsellors and (3) third-party members (e.g., parent, partner, friend and so on). Each of these are briefly discussed below in relation to inclusion criteria.

For women/patients to be included in they needed to meet the following requirements:

- Be a pregnant woman or girl
- Wanting to access pre-abortion counselling
- Consenting party

In terms of the actual sampling procedure, participants were sampled in consecutive counselling sessions. This provided the opportunity for all parties involved to provide their consent prior to the counselling session. In cases where group counselling occurred – this involved one counsellor and more than one patient – all speakers, other than the nurse or counsellor, were treated as patients unless otherwise stipulated or made discernible through the recording of the interaction.

As stated earlier in this thesis, counselling sessions were conducted by either nurses or counsellors, both of whom are regarded as health service providers within the South African context. Although nurses and counsellors have varying roles in providing abortion services, for this thesis, I use the generic term 'counsellor' to refer to any institutional representative who conducts the actual counselling. The inclusion criteria for counsellors were:

> An individual associated with the hospital, either through employment (i.e., nurse /midwife) or through an institutional agreement, who conducted some form of pre-abortion counselling with women/patients (e.g., independent counsellors).

As indicated by the literature (Beja & Leal, 2010; Vandamme et al., 2013), the presence and involvement of third-parties in pre-abortion counselling does occur and introduces its own interactional complexities. In this study, third-party members were regarded as any persons who accompanied the patient/women during the pre-abortion counselling session (e.g., mother, partner, sister). Third party-members were also required to sign the informed consent form. It must be noted that although party-members did accompany many of the patients to the hospital, they were not present for the actual counselling session. There was only one recorded case where the nurse requested that the patient's mother also join for a small portion of the counselling session where contraceptives were being discussed (see chapter 5, extract 20, 15-year-old patient).

During the initial conceptualization of the study, the research team identified five public health facilities from which we hoped we could collect data. Out of the five facilities, three provided the project with permission to collect data. The two sites that opted not to participate in this study cited their concern for patients' privacy and the workload of nurses as reasons.

Understanding that abortion counselling, for many women, is a sensitive interaction, I decided not to set or restrict the sample size but rather adopted an approach of collecting as many counselling sessions as possible. This was, in retrospect, the most appropriate approach for the study as many women declined to participate in the study, and the number of patients at sites varied considerably. This is discussed in more detail in the data collection section.

As has been mentioned in chapter 1, data were collected from three public hospitals in the Eastern Cape of South Africa that offer free abortion services. Below I provide a break-down of the counselling sessions as well as the sample from each of the three sites.

Table 1

Descriptive summary of the data (sample and counselling sessions)

Total individual sessions	21
Total group counselling session	7
Total number of counselling sessions overall	28
Total number of women/patients	58
Total number of Health service providers (nurses/independent counsellors)	4
Third parties	2
Average duration of counselling sessions	16:08 minutes

Overall, 58 women and 4 Health service providers agreed to have their counselling session audio recorded. In total, 28 counselling sessions were recorded: 21 of them were individual sessions and the remaining 7 were group counselling. The average duration of sessions collected in this study was 16:08 minutes. The shortest sessions were roughly 7 minutes, and the longest recorded session was 36 minutes – both sessions were conducted by nurses and not independent counsellors. Below, the demographic information of various parties, the duration of the sessions, the language of the counselling session and nurse/counsellor information for each site are presented.

4.4.4 Summary of sample and data from Site 1

Site 1 is a large government-funded hospital located in the central business district of East London. It is a tertiary training hospital associated with Lilitha Nursing College and Walter Sisulu University. Tables 2, 3 and 4 below summarise the data from site 1.

Table 2

Individual sessions (site 1)

Data file ID[19]	Pseudonym	Age	Race	Occupation	Duration (minutes)	Language of Counselling session
C2	Cece	19	Black	Studying	11:34min	English
556	Khule	29	Black	Studying	13:43min	English
17	Akhona	unobtained	Black	Unemployed	14:46min	English
16	Sophia	28	Black	Unemployed	21:36min	English

Table 3

Group counselling sessions (site 1)

Data file ID	Number of women	Duration (minutes)	Language of Counselling session
C	5	15:41min	English
559	4	10:49min	English
561	5	13:23min	English

At site 1 we managed to collect a total of 7 counselling sessions (4 individual and 3 group sessions). The group counselling sessions at this site had between 4 and 5 participants. The individual and group sessions lasted roughly the same time, with a calculated range of 10:47 minutes. Interestingly, there appeared to be no substantial difference in counselling duration across the two formats – as I will discuss in the analytical chapters, this is likely due to the fact that most of the counsellors followed a formulaic script to guide the counselling session and tended to apply the script regardless of how many patients were present. All the sessions at this site were conducted in English by two independent counsellors who were associated with a

[19] The data file ID was generated automatically from the recording device.

Christian NGO. The counsellors indicated that they had 4 and 3.5 years of counselling experience, respectively, as can be seen in table 4 below.

Table 4

Health service provider details (Site 1)

Pseudonym	Occupation	Work experience in providing abortion care	Race
Tracey	Counsellor (NGO)	4 years	White
Sara	Counsellor (NGO)	3.5 years	White

4.4.5 Summary of sample and data from Site 2

Site 2 is a large government-funded hospital located in a township in East London. It is a tertiary teaching hospital associated with Lilitha Nursing College and Walter Sisulu University. Tables 5, 6 and 7 below summarise the data from site 2.

Table 5

Individual sessions (site 2)

Data file ID	Pseudonym	Age	Race	Occupation	Duration (minutes)	Language of Counselling session
16	Linda	19	Black	Unobtained	18:38min	English
14	Thembisa	Unobtained	Black	Unobtained	12:24min	English
17	Lerato	38	Black	Unobtained	9:13min	English
15	Anathi	25	Black	Unobtained	11:44min	English
28	Dora	28	Black	Employed	14:58min	English
004	Nwabisa	27	Black	Employed	19:28min	English
0027	Tumi	Unobtained	Black	Employed	17:17min	English
005	Nomsama	Unobtained	Black	Studying	15:09min	English

003	Khule	Unobtained	Black	Unobtained	17:42min	English
0019	Sanele	26	Black	Unobtained	21:05min	English
P1	Noxi	17	Black	studying	16:07min	English

Table 6

Group counselling sessions (Site 2)

Data file ID	Number of women	Duration (minutes)	Language of Counselling session
0018	3	18:22min	English
0013	6	31:46min	English
561	5	13:23min	English

Half (n= 3) of the combined counselling sessions collected in this study came from Site 2. In total, 14 counselling sessions (11 individual and 3 group sessions) were recorded. The number of patients in the group counselling sessions varied between 3 and 5. The oldest patient in this study came from this site and was aged 38 years old. The was some variation in the length of counselling sessions, with the shortest being 9:32 minutes (individual counselling) and the longest being 31:46 minutes (group counselling).

All the sessions from site 2 were conducted in English by a nurse who worked at the facility. She had been providing abortion care for four years, as can be seen in table 7 below.

Table 7

Health service provider details (site 2)

Pseudonym	Occupation	Work experience in providing abortion care	Race
Pat	Nurse	4 years	Coloured[20]

4.4.5 Summary of sample and data from site 3

Site 3 is a large government-funded hospital in Gqeberha (formerly Port Elizabeth). It is a tertiary teaching hospital associated with Walter Sisulu University and Nelson Mandela Metropolitan University. Tables 8, 9 and 10 below summarise the data from site 3.

Table 8

Individual sessions (site 3)

Data file ID	**Pseudonym**	**Age**	**Race**	**Occupation**	**Duration (minutes)**	**Language of Counselling session**
001	Thandi	15	Black	Studying	36:50min	isiXhosa
002_1	Tuli	28	Black	Unemployed	14:00min	isiXhosa
3004	Jenifer	21	Coloured	Studying	18:53min	isiXhosa
002	Lindy	Unobtained	Black	Not obtained	7:05mins	isiXhosa
23	Jane	Unobtained	Black	Not obtained	10:52min	isiXhosa

Table 9

Group session (site 3)

Data file ID	Number of women	Duration (minutes)	Language of Counselling session
27	4	10:52min	isiXhosa
28	6	14:37 min	isiXhosa

A total of 7 counselling sessions (5 individual and 2 groups) were collected from site 3. Amongst the data collected at site 3 were the shortest (7:05 minutes) and longest (36:50 minutes) counselling sessions, both of which came from the individual format. In addition to this, the youngest participant, aged 15, in the study also came from site 3. In contrast, to the other sites, the counselling sessions were almost exclusively conducted in isiXhosa with a few

instances of code-switching to English (usually one or two words that did not have a direct isiXhosa translation). The counselling was conducted by a nurse who had been providing abortion care for 4 months, as can be seen in table 9.

Table 10

Health service provider details (Site 3)

Pseudonym	Occupation	Work experience in providing abortion care	Race
Olwethu	Nurse	4 months	Black

4.5 Data collection procedure

Data collection consisted of recording pre-abortion counselling sessions as they were conducted in every-day practice involving women/patients, counsellors/nurses and any third-party persons. Initially, it was envisioned that data collection would consist of both audio and video[21] recordings, but when data collection commenced, it soon became apparent that participants preferred not to be video recorded. In fact, throughout this study, the researchers experienced low participation rates, particularly from patients at all three sites. This might be attributed to the fact that abortion, for many women, is a sensitive issue, and they would prefer to get the process completed as soon as possible. This is supported by research that found many women feel counselling is unnecessary, particularly in cases where they have already made their decision (Brown, 2013). The low response rate might also be attributed to the fact that each site varied in terms of the number of women who presented on the days that data were collected.

Before data collection commenced, ethics clearance was obtained from Rhodes University Ethics Review Committee (see Appendix 1) and the Eastern Cape Department of Health (see Appendix 2). Relevant gatekeeper permission was obtained from the hospital managers at each site (see Appendix 3 and later discussion regarding ethics).

[21] Video recording in conjunction with audio recording is often regarded as the 'golden standard' in conversation analytical work. Data which are video recorded allow researchers to explore non-verbal communication (e.g. facial expressions, hand gestures, eye contact/gaze, body orientation) which forms a major part in how people interact during communication (Seedhouse, 2005)

The data collection process was primarily coordinated by two co-researchers, Jabulile and Snethemba[22], who were involved in the wider project. Jabulile, who was a female doctoral student at the time of collecting data, had extensive experience collecting data in public facilities in South Africa on topics relating to abortion and was competent in isiXhosa. Snethemba, the other data collector, was a female master's student and is fluent in isiXhosa. Considering the sensitivities involved regarding the issue of abortion and my own positionality as a researcher (discussed further in the reflexivity section of this chapter), it was decided that data collection would be conducted by Jabulile and Snethemba. My role involved writing the ethics protocol for the larger project, seeking ethics approval from the Eastern Cape Department of Health and obtaining permission to collect data at the various hospitals – this involved e-mail and telephone correspondence, site visits and various meetings with hospital management and clinical medical staff.

Throughout the data collection process, Jabulile and Snethemba spent, depending on the site, anywhere from a few days to a full week collecting data at each site for the broader research project. Before data collection began, we, as a research team, visited each site to negotiate site entrance and introduce the project and data collectors to the clinic staff – so they knew what to expect when data collection commenced.

The data collection process involved Jabulile and Snethemba arriving before the abortion clinic began its daily operations, which was usually before 7:30 am. They wrote ethnographic field notes of their visits to each site, where they documented their daily experiences of collecting data at each site. They generously shared these notes with me. Data collection (i.e. recording pre-abortion sessions) was the same for each site; the only difference was how data collectors obtained participants' informed consent, which I describe below.

At Site 1, the counselling was conducted by a Christian organization that offered their services to the hospital free of charge. Upon arrival, the hospital nurses introduced Jabulile and Snethemba to the counsellors. Jabulile and Snethemba explained the nature of the study to the counsellors, answered any questions they had and obtained their informed consent. Receiving patient consent followed a different process. On the first day of data collection, Jabulile and Snethemba introduced themselves and the research to all the patients in the waiting room – this

[22] Jabulile and Sinethemba were co-researchers involved in the wider research project. Jabulile was working on her doctoral thesis at the time, which sought to explore the narratives of patients' and health service providers – data were collected through interviews. Sinethemba was working on her master's thesis at the time, which examined the linguistic and cultural aspects of communication between counsellors and clients.

was a suggestion made by the hospital staff. However, this approach was changed from the second day onwards as nurses felt uncomfortable having the data collectors address the patients in the waiting room. For the second day, potential participants were approached individually before they were to commence counselling. Jabulile or Snethemba would explain the study, provide the informed consent forms and answer any questions potential participants had regarding the recording of their sessions. In some instances, the counsellors assisted the data collectors by mentioning the study to the patients once they were in the room. If patients were willing to have their sessions recorded, then the counsellor would notify one of the data collectors to enter the room and explain the study and obtain informed consent – the counsellor was not present for this.

Data collection at site 2 used a similar approach to site 1. On the first day of data collection, Jabulile and Snethemba obtained informed consent from the nurse who provided the counselling. Patients were notified about the study at the beginning of each day in the waiting room. At this site, the nurse was, in some cases, obtained informed consent from the patients herself and provided the data collectors with the signed form after the counselling had finished. The nurse also started and concluded the audio recording. In some instances, Jabulile and Snethemba would also approach patients before the counselling started to ask them whether they were willing to have their session recorded.

Data collection at Site 3 was less complicated. On the first day of data collection, Jabulile and Snethemba were re-introduced to the hospital nurses in the ward and obtained informed consent from the nurses responsible for conducting the counselling. With regard to obtaining patient consent, a similar strategy to Site 1 was used. Initially, data collectors introduced themselves to women in the waiting room and notified them of the study being conducted – no consent was obtained at this point. Patients would enter the counselling room, where the nurse would remind them of the study and inquire whether they would be willing to have the session recorded. If they showed interest, one of the data collectors was notified and entered the room to explain the study.

The initial round of data collection from all three sites produced only 14 recorded pre-abortion sessions, which was less than half of the data expected for the overall study. The low number of recorded sessions prompted a second round of data collection at each site. All the sites were located more than 130 km away from Rhodes University, and in an effort to maximise data collection, it was decided to include two more data collectors who were situated in the city of

the one site. The two data collectors, Kuhle and Nosihle, were female Psychology honours students from the University of Fort Hare (UFH). They were recommended by one of my colleagues working at UFH. Jabulile and I travelled to provide Kuhle and Nosihle with training in terms of approaching potential participants, operating and positioning recording devices, and how to go about answering any questions potential participants may have regarding the study. We also took them to the site, showed them the abortion clinic and introduced them to the nurses.

It is also important to highlight the potential convenience to ask nurses or other healthcare providers to collect data on the researcher's behalf, since they are there on a daily basis. It's essential to recognise the presence of inherent power dynamics If healthcare providers are responsible for obtaining informed consent for the project. In the absence of direct researcher involvement, some patients may have experience pressure to participate in audio recordings, potentially leading to confusion between providing medical information, consenting to medical care, and consenting to research participation. To enhance the ethical conduct of future research on similar topics, it is advisable that data collection processes be conducted independently of the healthcare service provider to mitigate potential power imbalances and ensure clearer distinctions in consent (Beauchamp & Childress, 2019; Emanuel et al., 2000; O'Reilly, 2012).

4.6 Analytical procedures

All the English recordings were transcribed verbatim by myself. During transcription, I used the Jefferson notation to represent interactional detail (discussed later). The counselling sessions that were conducted in isiXhosa were transcribed and translated by a professional translator from the Rhodes University School of languages and were re-examined for accuracy in translation by Snethemba (a member of the research team who had previously studied isiXhosa)

I adopted a multi-method approach to data analysis that drew eclectically on conversation analysis and discursive psychology. My overall aim was to investigate pre-abortion counselling at the micro level, focusing on the overall structure organisation, and the activities that constitute the interaction whilst at the same time identifying and inspecting discourses deployed and how speakers were positioned in relation to these discourses. The analytical procedures I followed are summarised in Table 11 below.

It is important to note that whilst my analytical process is presented and described sequentially in this section, in practice, the process was iterative, and I re-visited many of the phases multiple times. A summary of the analytical phases is presented below, followed by an elaboration of each.

Table 11

Analytical phases and description

Phases	**Description**
1) Familiarisation with the data	Active reading and listening to data, transcribing data verbatim, noting initial ideas. Iterative process. Reading co-researchers ethnographic notes.
Generating initial codes	Coding interesting features of the interaction through repeated readings and listening to the data
Composing (tentative) themes	Codes were refined into themes. Searched for patterns within cases and across.
2) Conversation analysis	
Identifying activities	Actively reading and listening to the data. Identifying activities which makeup the interaction. Identifying actions (e.g., pauses, explanations, requests)
Investigating key activities	Setting the scene, Information provision, accounting/explanatory labour, history-taking; decision-making was investigated. Interactionally and elaborated
3) Discourse and positioning analysis	
Positioning analysis	Identifying subject positions and exploring them contextually. This involved exploring how speakers positioned themselves and others in talk.
Discourse analysis	Identifying discourses. This involved identifying not only what topic or central themes of talk were being focused on (e.g., medical, risk, responsibilities) but also an exploration of how that talk created constructions of events, subjects and objects

	and how this may be interpreted as meaningful within the interaction. This phase of analysis overlapped with positioning analysis
4) Data sessions	Playing segments of recorded data with transcription. Discussion with co-researchers and research supervisor(s) around the preliminary analysis
Presenting preliminary findings, work-in-progress sessions	Throughout the research process, I was given the opportunity to present initial findings both to my fellow research colleagues at the CSSR and peers at various doctoral student conferences held by the NIHSS. Feedback from these presentations was invaluable.

4.6.1 Familiarisation and coding

Familiarising oneself with the data is not a once-off achievement that is accomplished by simply reading the data. To familiarise is to start a relationship with the data, a relationship that continually deepens through various forms of engagement with the data throughout the analytical process (Whitley & Kite, 2012). The familiarisation process, for me at least, consisted of immersing myself in the data by listening to all the audio recordings that were collected, as recommended by Braun and Clarke (2014). The objective was to get a sense of how the pre-abortion counselling interactions proceeded and of what was said during these interactions. After the initial listening to audio recordings, data were imported into NVivo[23] 11.

Once the transcripts were available in English, I worked through all the data from site 3 and selected targeted instances of talk that appeared to be analytically interesting (i.e., patterns of talk that were similar to the other two sites or where certain discourses and subjective positions were apparent). I compiled a collection of extracts and held several analytical meetings with Snethemba. In these sessions, I presented the extracts to Snethemba, explaining why I found them particularly interesting and together, we listened to the audio of the extract. Snethemba, having had training in conversation analysis, was able to provide me with the detail of the talk as it occurred in the recorded isiXhosa and together, we discussed how this would fit into the English translation (see Appendix 7 for an example of how isiXhosa talk was transcribed at a

[23] NVivo is software package developed to store, process and analyse qualitative research (See: https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home)

verbatim and conceptual level – only the conceptual column is presented in this thesis as data). This involved many replaying of the audio data, applying conversation analysis to the English transcript as best we could, and then re-listening to the original audio data. In this way, we dealt with the complications of doing conversation analysis with translated data in a collaborative manner.

Once all the data had been transcribed, I then engaged in the process of active listening and reading. I would play each counselling session and follow the transcription, jotting down interesting features or ideas that came to mind during this process. The ethnographic field notes provided me with descriptive and contextual information that simply could not be captured by listening to the audio data alone. For example, at Site 2, during one visit, Jabulile writes

> She [the nurse] 'confessed' to having shouted at the women this morning because of her frustrations over her work. She hasn't had a chance to mourn for her brother because of her workload and because she feels unable to take leave due to being the only committed one [nurse].

The above note documented the emotional difficulty the nurse was going through at the time. Her brother had recently passed away, and because they were understaffed, she (the nurse) was unable to take time off work to spend with her family. Ethnographic accounts, like the one shared above, allowed me to understand, as much as possible, the social realities that were experienced daily at each site. This information helped me to engage with the data from a more sensitised/contextualised perspective, and no doubt played a major role in how I came to understand and analyse data from each site.

I worked through the data, engaging with all the audio and transcriptions from each site before proceeding to the next site. At the end of this process, I had descriptive summaries of how counselling was conducted at each site and some tentative ideas I wanted to explore within and across the data at a later stage of analysis.

The next phase of data analysis involved coding the data. The coding process was done on NVivo 11, and I used two approaches in this regard which were conducted simultaneously.

My first approach was guided by my second research question, which was concerned with identifying what information was requested and/or shared by patients and the nurse in the interaction. Based on this, I immersed myself once more in the data but this time focusing on segments of interaction that dealt specifically with the activity of information sharing. I worked

through the data set coding and collecting all segments of talk where information was shared. At the end of this process, I built up a substantial collection of information codings.

My second approach to coding was less directed in the sense that it was not guided explicitly by any research question. I searched through the data and coding features of the talk that I found to be interesting such as phrases, positionings, potential discourses, terms/descriptors, and specific questions (some of which were coded as information sharing, hence illustrating the overlap between the two types of coding) (Morison, 2011). The coding process deepened my understanding of the data, and instead of viewing the interaction in its entirety, I slowly gained insight into the sum of its parts. To code is to dismantle the data into fractured units, and it is these fractured units in the early stages of analysis that potentially represented discursive resources (Maxwell & Miller, 2008).

4.6.2 Conversation analysis

The general approach to doing conversation analysis is to systematically work through the data using a broad list of the conversation analytical concepts (Ten have, 2007). Below I outline the approach I adopted when conducting conversation analysis.

4.6.2.1 Analysing overall structure organization. Analysing the overall structure organization involved actively listening and reading the transcripts in detail. Since an overall structure organization is built up through activities, which in themselves are built up from multiple sequences of actions (as discussed in chapter 3), the analysis began by working through the data turn-by-turn and asking the question, "What is this turn doing at this point in the interaction?". In other words, I began by looking at how sequences of actions were organised interactionally to accomplish a particular activity, which I would tentatively name. Having identified an activity, I sought to investigate why that activity was both *relevant* to, and *procedurally consequential* (see discussion in Chapter 3) for participants in that interaction (Schegloff, 1992). Such an approach enabled me, as the analyst, to piece together, or rather map together, a framework of coherence that consisted of understanding activities as being goal orientated but also consisting of sub-parts, which also required consideration of prior characterisations, such as topic, actions and interactional context of talk (early talk vs. later talk) (Robinson, 2013).

4.6.2.2 Analysing activities and projects. Analysing the overall structure organisation required me to identify activities that make up the interaction. In this study, I was specifically

interested in explicating how certain actions, such history-taking, presenting options, and negotiating consent, were accomplished. Initial coding, and analysis of the overall structure organization, proved useful in locating these activities within the interaction. The next step involved re-transcribing those segments of data where an activity featured using a simplified version of Jeffersonian notation (see Atkinson & Heritage, 1984, pp. ix-xvi), which allows the transcriber to represent the micro features of talk. The Jeffersonian notational system is comprehensive, but in this study, I utilised the following notations:

Figure 1

Jeffersonian notational system used

Symbol	Description
(.)	Noticeable pause
(3)	Pauses in talk which were timed in seconds
[	Aligned square brackets across lines to represent overlapping talk
.hh	in-breath
:	Colon used to show the speak has stretched the preceding sound
(word)	Guess of what the speaker said due to unclear audio
( )	Unclear talk, not discernible
=	Equal sign between speakers shows that there is no pause in talk
Word	Underlines used to indicate loud talk
WORD	Capital letters indicate louder talk
°word°	Degree signed used to indicate quiet talk
>fast<	Inward arrows show faster talk
<slow>	Outward arrows show slower talk

Once an activity was identified, it was investigated at a micro-level. The analysis of activities involved a turn-by-turn consideration of the actions that were being accomplished (Ten have, 2007; Schegloff, 1996; Pomerantz & Fehr, 1997). Actions were primarily analysed regarding their turn-design (including lexical choice) or rather how turns were packaged and delivered in interaction with the hearer (Pomerantz & Fehr, 1997) and how the receiver of that turn produced their response. In addition to this, actions and sequences of actions were then analysed in relation to the activity that was being performed and how that action, and its design, implicates the activity at hand as well as the "certain identities, roles and (or relationships) for

the interactants" (Pomerantz & Feher, 1997, p. 74). By following this analytical procedure, I was able to explicate and (interactionally) contextualise how participants co-construct, through a series of actions, the institutional activity of pre-abortion counselling.

4.6.3 Discourse analysis

The discourse analysis phase of analysis was informed by Potter and Wetherell's (1987) work on discursive psychology. Doing discursive psychology is a specific way of reading and engaging with text (Willig, 2015). Discourse analysis began with repeated readings of the coded data. Since I was particularly concerned with identifying the discourses participants deployed in the interaction, the analytical concept of discursive resources (discussed in chapter 3) was useful in making sense of the data (Potter & Wetherell, 1987). I read through the data and constructed themes based on the interpretative repertoires I had identified, which were the coherent ways in which objects and subjects were constructed in the talk.

Drawing on further insights from Potter and Wetherell's approach (1987) to discursive psychology, I then proceeded to investigate the action orientation of the interpretative repertoires I had identified in the data. This meant moving beyond the surface content of talk and exploring how interpretative repertoires were deployed, and in what way they were used interactionally (e.g., providing procedural information and the related consequences, discussing options). This was guided by the action orientated question of "what is this discourse doing here? in this specific interaction?" (Willig, 2015, p. 201). In order to answer such a question, I was also interested in identifying the discursive devices and rhetorical strategies (e.g., extreme case formulations, graphic descriptions, word selection) speakers used in the interaction and considered them in relation to the actions, activities and the overall structure organisation of the counselling session.

4.6.3.1 Positioning analysis. As is mentioned in chapter 3, discourses make available certain subject positions. Positioning is a useful analytical tool that can be applied at various levels (Korobov, 2001). My analysis was eclectic in the sense that it drew on Korobov's (2001) re-working of Bamberg's (1997) approach to analysing subject positioning (discussed in chapter 3) but also sought to explicate the interactional dimension of how subject positions are produced and become relevant in the interaction, referred to by Wilkinson and Kitzinger (2003) as "positioning in action" (p. 172). For Wilkinson and Kitzinger (2003), it is not merely enough to state that some sort of positioning is being done. They suggest that the analyst should also explore how the "positioning is effected and the action that is thereby accomplished" (p. 165).

I began this analysis by once again immersing myself in the data, which involved active listening to the audio and active reading of the transcription. I worked through the transcription, turn-by-turn, as well as the themes I had produced, identifying possible subject positionings. Once I had identified a potential subject position, I then proceeded to explore it at three conceptual levels, namely the level of (1) *turn (action),* (2) *activity* and (3) *discourse*.

4.6.3.2 Bridging Conversation analysis with discourse analysis. At the level of it *turn* it was important to consider how speakers formulated and delivered their turn. Special attention was focused on looking at the conversation circumstances (i.e., turns that had preceded the positioning) that invoked the subject position (Wetherell, 1998) by investigating the action (e.g., interrogative question) in which the subject position featured as well as the responses provided. For each turn, I was sure to note who the speaker was and the hearer as this had implications for explicating whether it was a reflexive or interactive positioning – I also specified who had invoked the subject position in the interaction.

At the level of *activity,* I considered how the subject positions were used by co-conversationalists in doing an activity. Further to this, once I had identified a subject position I traced it through the interaction, investigating other activities where it featured (e.g., providing procedural information, option-listing, etc.). By doing this, I was able to explicate the "highly occasioned and situated nature of subject positions" (Wetherell, 1998, p. 394)

Subject positions were then explored as part of the discourse they constituted. The question here was what it means, interactionally, to be positioned like X in this discourse, and what are the interactional implications in relation to pre-abortion counselling. To a large extent, this part of the positioning overlapped with the discursive analysis I conducted. Such an approach enabled an investigation of positioning, which acknowledges that subject positions are utilized in talk, in different turns, all the while in the interactional pursuit of some sort of (institutional) goal/agenda.

4.6.4 Data sessions

Throughout the analysis, I attended multiple data sessions with co-researchers working on the broader project. Data sessions, a common practice among conversation analysts (and other qualitative researchers), are informal get-togethers where researchers present and discuss data (Ten Have, 1999). More practically, the session begins with distributing transcripts and playing some audio segments of data. Before the recording is played, the presenting researcher provides some background and anything specific they would like to concentrate on (e.g., presenting

initial findings in the data). After presenting the data and giving some background, there is an initial period of listening and reading, and participants, or rather co-analysts, are invited to share any ideas they may have. This generally leads to an interactive discussion characterised by multiple re-listenings of the data. There is relative freedom in terms of what can be discussed: participants can bring in their own ideas regarding the data but they must be able to ground their ideas in the data at hand.

Data sessions were generally attended by myself, Jabulile, Snethemba and my supervisor, Professor Macleod. One session was conducted with colleagues from the University of York, in the United Kingdom who also formed part of the larger project. The sessions were useful in exploring alternative readings of the data and generating new analytical ideas (Heath & Hindmarsh, 2010) that were later explored by myself. The data sessions also provided a unique opportunity for quasi-investigator triangulation – whereby findings were presented, and fellow researchers assessed whether such a finding was demonstrably observable in the data. This activity adds to the quality and the rigour of the analytical process.

In addition to the data sessions, I also attended several works- in- progress sessions that were hosted by the Critical Studies in Sexualities and Reproductive (CSSR) research team and by the National Institute for the Humanities and Social Sciences (NIHSS). These sessions provide the opportunity for those conducting research to present on various aspects of their research in a collegial and supportive space. In some of the sessions I presented the textual and audio data along with my analysis. This generated much discussion and the feedback was invaluable in assisting me to view my data, and the overall research process, in new ways.

4.7 Ethical considerations

Ethics approval was obtained from Research Projects and Ethics Review Committee (RPERC) and the Rhodes University Ethics Standards Committee (RUESC). Once passed the research project was submitted to the Eastern Cape Department of Health (DoH) so that data could be collected from hospitals in the province. Permission to conduct the research was gained from each individual site where data were collected. In accordance with RUESC and ethical guidelines of the South Africa Department of Health, potential participants were identified and supplied with a comprehensive informed consent form. The informed consent form explained the nature of the study, what was expected of participants, and their right to decline participation in the study. The participants were assured that their decision to participate in the study would not have any effect on the abortion services they were receiving. The co-

researchers involved in data collection allowed participants time to read the informed consent form. The co-researchers were on stand-by to discuss anything related to the study and invited potential participants to ask questions or raise concerns before signing the consent form.

Understanding the sensitive nature of the study and ensuring respect to participants during the research process, participants were informed that they could opt-out of the study at any given time (up to write-up), without fear of any negative consequences. The researcher showed all participants (i.e., patients, counsellor/nurses and third-parties) how to turn off the recorder. As with the patients, counsellors were also informed that they could withdraw from the study up to write-up without any negative consequences. The co-researchers also made a point to reassure the counsellors that the collected data were for research purposes only and would not be used to evaluate their individual performance.

The informed consent forms for patients and counsellors were made available in isiXhosa and English to accommodate as many potential participants as possible (See appendices 4 and 5). In order to ensure the two versions were conceptually equivalent, we had the English version translated into isiXhosa by an independent translator. The newly produced isiXhosa version was then backwards translated into English to assess equivalence. This process was double checked by co-researchers who are competent in isiXhosa.

Considering the unique and sensitive nature of the study, a number of ethical considerations were addressed. These are discussed below.

4.7.1 Privacy, anonymity, and confidentiality of data

To ensure that there was no breach in anonymity and confidentiality all documentation (including consent forms and transcripts) and data (audio recordings and electronic versions of the transcripts) have been securely stored at the Critical Studies in Sexualities and Reproduction building at Rhodes University. All physical documentation and data have been stored in a locked cupboard and all electronic data has been backed up onto an encrypted USB. Only researchers involved in this project have access to the documentation and raw data for this study. The anonymity of participants is upheld through using pseudonyms. In signing the informed consent form, participants were not required to provide their name or surname.

Even though it was envisaged that some counselling sessions would be video recorded, no participants agreed to have their session video recorded. No video data were collected.

4.7.2 Potential consequences of participating in the research

This study sought to record the every-day institutional interaction of pre-abortion counselling as it happens in practice. In other words, the activity of pre-abortion counselling would have occurred regardless of this study and the resulting data collection. Recording talk of this sensitive nature does, however, have potential consequences.

From the patient's perspective, pre-abortion counselling might be the first opportunity for them to verbalise their situation, receive new information and to decide – all in one encounter. Such an encounter by itself can be overwhelming and difficult for the patient and could be further exacerbated with the realisation that what they have shared, perhaps for the first time, in that counselling session, has been recorded and will be listened to by strangers ('researchers'). Compounded by the fact that abortion in South Africa is still largely regarded as taboo and is still stigmatized (Favier et al., 2018; Varga, 2002) in many social circles, patient participants may monitor their talk in such a way as to produce socially desirable responses. The major issue here is that patients may provide socially desirable responses which do not accurately reflect their personal situation, and thus in effect could undermine one of the core objectives of pre-abortion counselling, which is to provide relevant information. Seen this way, the inclusion of the recorder could work in ways to indirectly disservice the patient. However, it must be mentioned that socially desirable responses may occur in reaction to the counsellor's attitude towards certain topics such as abortion or family planning. In such cases, it may be easier for the patient to align themselves with the counsellors than to disagree and cause potential trouble and conflict within the interaction.

To deal with these issues, the data collectors ensured that participants were completely comfortable with having their session recorded. Participants were also reminded that they could, at any time, opt out of the study without any consequences – they would still receive the counselling whether they participated in the study or not. Participants were shown where to turn off the recording device and were assured that, should they wish, the data would be deleted after the counselling was completed.

I was also aware that counsellors, having agreed to participate in the study, could very well monitor their talk and actively attempt to conduct the counselling in a manner that they consider to be socially desirable. A motivation for doing this might come from the idea that, as counsellors, they are being personally evaluated. To address this, the data collectors reassured counsellors that their performance was not being assessed and that the data collected from these interactions were strictly for research purposes that could possibly lead to the improvement of pre-abortion counselling provision in the public health sector in South Africa.

Further to this and taking to account that the literature reports that abortion facilities are grossly under-resourced (Brighton, et al., 2013; Jewkes et al., 2005), the researchers made a concerted effort to ensure that nurses'/counsellors' participation in this study did not disrupt their daily services, as this would affect both the counsellor's workload/duties and the services received by the patient. Initial site visits were useful in this regard. Other than introducing the research team to the clinic staff, they also provided an opportunity for the data collectors to ask nurses/counsellors how they go about conducting their services and what they would suggest as the best possible strategies for data collection that were practical and at the same time did not impinge on their clinic duties.

4.7.3 Inclusion of minors (under 18s)

From the earlier stages of conceptualization, all the researchers felt that it was an ethical responsibility for research on PTOP counselling to include all those who might access abortion. Within South Africa, this may very well include patients who are under the age of 18 and who are legally considered minors. The CTOP Act enables girls/women under the age of 18 – defined as a minor by the South African law — to undergo a termination of pregnancy without obtaining consent from a parent or guardian figure.

The Department of Health's (2015) Ethics in Health Research document, which provides guidelines for health-related research, states that "In particular circumstances, e.g. for reasons of sensitivity, like discussion about sexual activities, substance abuse etc., it may be desirable and ethically justifiable for minors […] to choose independently i.e. without parental assistance, whether to participate in research." (p. 33). It must be noted that researchers decided against any attempt at gaining parental consent.

In such cases where minors are to be identified as participants in a study, reasons for the desirability of independent consent need to be justified explicitly. A detailed justification was submitted to the Research Ethic Committee (REC) of both Rhodes University and the Eastern Cape Department of Health (ECDoH) (see appendix 6, summarised below). The justification of including minors in this study draws on relevant literature on the topic, contextualised understanding of reproduction in South Africa, and the legal frameworks within South Africa that guide health research.

Several researchers have endorsed these guidelines (Human-Vogel, 2007; Singh et al., 2006; Strode et al., 2010; Strode & Slack 2009). Singh et al. (2006), for example, argue that the guidelines make it possible to investigate valuable and necessary sexuality-related research on adolescents and that there is growing recognition in South Africa of the autonomous decision-making abilities of young individuals. They indicate that requiring additional parental or guardian consent may: (1) be logistically impossible; (2) serve as a breach of the confidentiality of research participants; and (3) place the participant at potential risk of harm, especially in relation to sensitive issues such as termination of pregnancy. Each of these applies in the case of this research. Firstly, when a minor arrives for a termination of pregnancy without a parent/guardian, obtaining consent for participation in the proposed research would be logistically difficult. Secondly, if a minor has chosen to not inform her parent/guardian about the termination of pregnancy, then speaking to the parents/guardian about the research would violate her right to confidentiality. Keeping the CTOP Act stipulation regarding minors in mind (i.e., that no parental consent is required), not being able to consent to participation in a research project stands in contradiction to this stipulation, and prevents them from sharing their experience of abortion services with a researcher. Thirdly, a minor may have chosen to not consult their parent/guardian for several reasons, including, for example, fear of violence or abandonment by the parent/guardian, or the pregnancy being the result of incest, or sexual abuse by a relative. Seeking parental consent for participation in research would put the minor at increased risk.

The researchers substantiated the inclusion of minors in this study to the Rhodes University Ethics Review Committee, the Department of Health and each site where data were collected. Each gave approval to proceed as described by the researchers.

4.8 Critical reflexivity in the research process

Ethical principles are often used as the only guide for the research process, particularly when thinking of participants. Although ethical guidelines are important, and it is imperative that participants' well-being is protected to the best of researchers' ability, it is only through reflexivity — understanding ourselves as part of the research process — that we, as researchers, can better understand our participants and ourselves and knowledge producers (Ellis & Berger, 2003).

Reflexivity is one way to deal and acknowledge subjectivity in research practice (Parker, 2005) and qualitative, particularly critical and feminist, researchers have been encouraged to apply it throughout the research process. There are many conceptualizations and a variety of ways in which reflexivity can be undertaken. For me, and for this part of the study, I focus on methodological reflexivity which involves "turning back on oneself so that the processes of knowledge production become the subject of investigation" (May & Perry, 2013, p. 1). I primarily do this by focusing on my positionality as a researcher and exploring the relation between myself as researcher, the research process and the people who agreed to have their counselling sessions recorded.

4.8.1 Positioning myself as a researcher

To look within oneself and to introspect is to do a form of personal/self-reflexivity (Berger, 2015; Finlay & Payman, 2013; Willig, 2013). Researchers are not empty vessels who engage with research purely on an intellectual level, and if we were, it would be naïve to assume that intellectual activity is the realm of objectivity, devoid of all those "factors"/"realities" that could contaminate the findings. Researchers, like all humans, are identity-saturated social agents that enter all activities with their "situated autobiography" (Usher, 1997, p. 36) that can influence the direction and shape of the research endeavour.

My biography, or what I prefer to call it, positionality (Khatri & Ozano, 2017), is shaped by me being: a professional (research psychologist), male, 'white', Christian, middle-class and English speaking. In contrast, the patient participants were generally persons of colour (PoC), female, many of whom were unemployed. Most of the participants conversed in English. However, all the sessions at site 3 were conducted in isiXhosa, a language I do not speak.

With the counsellors' things were a bit more diverse. At site 3 counsellors were women who were employed by the hospital as nurses/midwives and conducted counselling in isiXhosa and

thus were isiXhosa-speaking. At Site 2, the sole person responsible for counselling was a 'Coloured' woman who was employed by the hospital and conducted the counselling in English. At Site 1, the counselling sessions were conducted by self-reported qualified counsellors, who were White, spoke English and belonged to an independent Christian Organization that provided their services to the hospital free of charge.

The terms 'insider' and 'outsider' are often used to describe the relationship between those participating and those conducting the research. In this study, I share little with the patient participants and although some may regard this as a disadvantage, there are those who highlight some of the advantages being an outsider brings to the research process (Britton, 2020; Dwyer & Buckle, 2009)

Due to the sensitivities involved in researching this topic, it was decided that data collection would be conducted by two female identifying colleagues of mine who are competent in English and isiXhosa. One of my colleagues and co-researcher on the larger project has experience conducting abortion-related research in the Eastern Cape. Although I was not involved directly in collecting data, I did visit each site to get a sense of how abortion services were performed in the public health sector. It is worth stating, that before undertaking this PhD I was last in a public hospital in my teenage years, and only as a visitor. Before embarking on this PhD, my idea of a public hospital was based on the media's representation and people's personal narratives of using public health facilities – the overwhelmingly majority of which documented negative experiences. I had not been to a public hospital in so long that I thought it was pertinent not only for the analytical element of the project but also for myself to see the conditions women encounter when seeking an abortion in the public health sector.

My initial impression of the public hospitals came from a direct comparison based on my personal experiences in private hospitals. I acknowledge, that due to my class privilege, that I am part of the minority of South Africans who have access to private healthcare. What really stood out to me were the conditions of the physical hospital building: it felt unclean, unmaintained, outdated and under-resourced. It was clear that funds coming into the hospital were being used to ensure it kept functioning. I suspect very little was left to maintain the building. The hospitals were all full of people. Many wards were busy, with nurses doing their business and patients simply waiting. I remember walking down a passage, and patients were waiting patiently through each door. The lack of signage made it difficult – an inconvenience I hadn't encountered before in a hospital. Upon reflecting on that first visit, I remember feeling

many things, in particular ashamed and embarrassed that this was the state of our public health sector that is the only healthcare option for many South Africans. I felt emotional for the many patients both in the abortion clinic and the hospital in general – all there waiting patiently for medical assistance. I felt embarrassed because my class privilege allowed me to be completely oblivious and sheltered from the daily conditions many South Africans experience. Yes, I had engaged in the literature on the topic and was "aware" of the issues facing South Africa's public health sector, but never in all my life had the proverb "seeing is believing" rung so true for me. I also felt deep admiration for the medical staff who, I truly believe, do try their best under the circumstance. Visiting the hospitals and observing how they function daily, together with the field notes gathered from Jabu and Sne helped me approach my data with a sense of empathy and a deeper contextual understanding of the structural constraints under which pre-abortion counselling and other abortion services occur.

Throughout this research study, one of the most frequent questions I was asked by others, but also asked myself were "Why is a man studying a woman's issue [abortion]" or something similar such as "How does this reproductive issue affect you?". It is easy to slip into a bifurcation of reproductive issues (Feltham-King & Macleod, 2015). As part of the CSSR for many years, I was surrounded by many critical and (pro) feminist scholars. One of them is Dr Malvern Chiweshe, who, as part of his PhD journey, explored abortion decision-making in Zimbabwe. He also reflects on the same position and highlights that for men to do pro-feminist research, they should not support from the sideline, but rather actively support women's causes (Chiweshe, 2018). There is a caution to be taken in this sentiment because although a man can work and comment on abortion, there needs to be an "acknowledgement of the wider social power imbalance, alongside the recognition that women have traditionally been silenced through being spoken about by science experts" (Bellamy et al., 2011, p 699).

Through working with a research team where I was the only man and engaging with the sensitivity of this research topic, I have learnt and continue to learn how to be an ally and a man who fights for gender justice through my research topic and the methods I use to highlight injustices. As such, I like to view this research journey as one that has provided the opportunity for me to start re-working my masculinity into what Ratele (2013) defines as progressive masculinity, which is masculinity which seeks to be "non-patriarchal, non-sexist, egalitarian and a caring masculinity" (p. 268). I am still a work in progress, but I hope that other men seeing the type of research I engage in and talk about will go some way in highlighting the

gender injustices many women experience in South Africa but also normalising that men are welcomed allies in the fight for gender justice for women.

A concept that many feminist and critical researchers are concerned with involves thinking through how the experiences, stories and realities of others are presented and communicated to others on behalf of the research (Hoskins, 2015). The politics of representation requires me to be continually cognisant of my involvement and work with this research and acknowledge that the way I conduct and present this work can empower, oppress — and even potentially do both at different times. The group data sessions as well as the work in progress colloquiums were spaces where I could share and talk about my research to others. In these spaces not only did I share my data and initial ideas with colleagues but also reflected on how I was experiencing the research process as a man. Throughout the data analysis process, I would continually pose questions to myself about the data which got me to consider the contextual realities of the participants (both patients and nurses/counsellors) experiences within that interaction.

4.9 Conclusion

In this chapter, I discussed the research methodology used in this study. I began by restating the aims and research questions that provided a conceptual framing for this chapter. Following this, I outlined the exploratory research design I employed in this study and demonstrated its appropriateness considering the established research questions. Next, I described the sampling procedures followed. I discuss how participants were selected (i.e., inclusion criteria) using purposive sampling and how they were approached to participate in the study by co-researchers at the three sites.

In data collection, which involved audio recording pre-abortion counselling sessions, I describe the procedures the co-researchers followed at each site. The descriptive statistics of the data sources are reported, such as the total sample size (patients, nurses and third parties), total number of counselling sessions (individual and group), and average consultation length. From this, I proceeded to provide a summary of the data collected from each of the three sites.

The chapter then explained the dual-analytical approach I adopted in this study, which consisted of using analytical insights from discursive psychology and conversation analysis. I describe in detail the various phases of the analytical process, which primarily focused on an eclectic use of DP and CA analytical procedures. I outline how I identified and analysed the discourses, subject positions, activities/projects and the overall structural organization of pre-

abortion counselling. I also briefly describe the data sessions I had with colleagues and my research supervisor.

In closing the chapter, I addressed some of the unique ethical considerations, including minors, risks of participating in this study and issues around privacy, anonymity and confidentiality of the research data. This is proceeded to a reflexivity section where I reflected and acknowledged how my positionality as a privileged (man, white, psychologist, middle-classed) researcher affected my involvement in the research process and shaped the research output.

Having outlined my methodology, the following three chapters are concerned with presenting my analytical findings. Following the order of my research questions, Chapter 5 provides a detailed structural analysis of pre-abortion counselling where I identify and explicate the seven key projects that constitute the interaction. Chapter 6 looks at discourses related to abortion as a medical procedure and the associated risks and consequences. Finally, chapter 7 focuses on discourses used to construct choice, women as patients and mothers, and the foetus as having personhood.

Chapter 5: Mapping the conversational landscape of pre-abortion counselling

5.1 Introduction

The aim of this chapter is to present how nurses/counsellors and patients(s)/third parties do counselling, moment by moment, turn by turn, in everyday practice. In this chapter, I am particularly interested in how parties initiate and negotiate activities at a structural level, or rather, how activities are talked into the counselling sessions by all involved parties and how these activities shape the counselling at a conversational level. Throughout this chapter, I identify the goals of each phase and investigate how activities were co-produced. In order to investigate this talk-in-interaction, I draw on conversation analysis (CA).

One of the central objectives of this study was to map the overall structural organisation that pre-abortion counselling sessions tended to follow and to provide a detailed analysis of the talk that takes place. Through in-depth analysis of the data and continual engagement, I identified, within the counselling session, "distinct clusters of activity/[ies]" that Byron (1997, p. 167) refers to conceptually as "projects". Each phase, as I show, consists of several actions that are used conversationally to work towards achieving the overarching goal of the institutional practice of counselling (i.e., to share and provide information).

5.2 Overall structural organization of the pre-abortion counselling interaction

Analysis revealed that, structurally, pre-abortion counselling consisted of seven distinct projects. These projects were taken as characteristically unique segments of talk that focus on achieving a specific sub-goal through various actions. The seven projects identified were:

(1) Context setting
(2) History taking
(3) Establishing the reason for abortion
(4) Presenting options
(5) Providing procedural information
(6) Obtaining verbal informed consent
(7) Family planning

These seven projects represent the structural organisation of most of the data. However, it is important to note that not all the projects necessarily occurred in the order presented above, nor did they necessarily feature at all. Projects could be revisited, meaning that once a project had featured, it could then later be revisited again to discuss issues related to it. For example,

providing procedural information could be discussed, followed by family planning which could then initiate further discussion regarding procedural information – especially in cases where a family planning method, such as the intrauterine device (i.e., the Loop), would be given post-procedure.

The overall structural organization, which is made-up of the different projects, also differed across the three sites and is shown in table 1 below. The inclusion of the table is not to assess which site conducted the 'best' or most comprehensive counselling. Rather, the table illustrates what projects were the most common at each site.

Table 12

Overall structural organization of the pre-abortion interaction by site

Site 1 (Counsellor) 13 sessions	Site 2 (Nurse) 7 sessions	Site 3 (Nurse) 7 sevens sessions
Context setting (11)[24] History taking (3) Establishing reasons for abortion (6) Providing procedural information (13) Obtaining verbal informed consent (7) Family planning (11)	Context setting (6) History taking (7) Establishing reason for abortion (4) Presenting options (6) Providing procedural information (6) Family planning (6)	Context setting (2) History taking (3) Establishing reason for abortion (3) Providing procedural options (6) Family planning (7)

There was also much variation within and across the sites. In tables 13, 14 and 15, I provide examples of the overall structural organization at each site. For each site, I report the structure of two individual counselling sessions and two group counselling sessions. The information in these tables is to illustrate how pre-abortion counselling varied (1) across sites, (2) when conducted by nurses or counsellors and (3) when conducted in either an individual or group format.

[24] The numbers in brackets indicate the frequency count of a specific project featuring across all the counselling sessions at a site.

Table 13

Site 1: Examples of different structures (in conversational order)

Individual counselling 1	Individual counselling 7	Focus group 1	Focus group 2
Context setting Establishing reason for abortion Family planning Obtaining verbal informed consent Providing procedural information	Providing procedural information History taking Family planning Providing procedural information	Context setting Providing procedural information Family planning	Context setting Providing procedural information

Table 14

Site 2 : Examples of different structures (in conversational order)

Individual counselling 1	Individual counselling 3	Focus group 1	Focus group 2
Context setting History taking Family planning Establishing reason for abortion Providing procedural information Presenting options	Context setting History taking Family planning Establishing reason for abortion Presenting options	Context setting History taking Family planning Providing procedural information Presenting options	Family planning History taking Presenting options Providing procedural information

Table 15

Site 3: Examples of different structures (in conversational order)

Individual counselling 1	Individual counselling 4	Focus group 1	Focus group 2
Family planning History taking Establishing reason for abortion Providing procedural information	History taking Family planning Providing procedural information	Context setting Family planning	Context setting Family planning Providing procedural information

As can be seen above there were notable variations in how the projects featured across the different sites. Within the dataset, counselling interactions typically encompassed at least two

projects. Site 1 featured a range of 2-5 projects, Site 2 ranged from 4-6 projects, and Site 3 varied between 2-4 projects. In most instances, individual counselling sessions involved a greater number of projects. However, at Site 2, the number of projects remained relatively consistent between individual and group counselling sessions. Notably, the initial projects at Site 2 and 3 consistently included Context Setting, History Taking, and Family Planning. Conversely, Site 1 displayed more variability in its initial projects, with Context Setting being the common element across different counselling formats. The delivery of these projects are presented, compared and discussed below.

5.3 Detailed analysis of the projects

In this section, I provide a detailed analysis of each of the seven projects. For each project, I provide a contextual account of how it featured across the different sites. I do this by providing a brief explanation of what each project involves and then, by drawing on transcribed data, identify and explicate, using conversation analysis, how key actions were initiated and negotiated by the parties involved.

5.3.1 Project 1: Context setting

As a means of starting the pre-abortion interaction, counsellors and nurses would commonly begin by (1) introducing themselves and (2) the organization and/or clinic with which they were associated.

Before any counselling could commence, patients were called from the waiting room and ushered to a room with more privacy. Rooms varied in terms of space (by site) but were generally acknowledged as designated spaces where counselling was conducted. The rooms usually had a table with a few chairs for patients to sit on, and at site 2 there was a basin with running water. In addition to this, nurses had access to patient documents that had been filled out by patients or that were going to be filled out by the nurse during the counselling. The independent counsellors did not have access to these documents and so would spend some time gathering the particulars of patients – I suspect for their own organizational records.

5.3.1.1 Setting the interaction. The first few exchanges between the counsellor/nurse and patient were concerned with establishing the communicative genre of the talk to come (i.e. setting the interaction so that all parties are informed of what is to be discussed). By doing so, the parameters of relevant talk were set up and played a major role for the conversation to

come. Below are a few examples of how nurses and counsellors introduced themselves and/or the organization with which they were associated:

Extract 1
Site 2 [ID[25]: 0018; Focus group, N = nurse; English]

```
1  N:   Now ladies wha-h.-t we are going to do (.) first and
2     → foremost .hh (.) ((cough))do you all understand English
3       (.)
4       ((Collective yes at the same time))
```

Extract 2
Site 2 [ID:0019; N = nurse; P= patient, English]

```
1   N:   Good morning lady
2   P:   Good morning ma'am
3   N:   My name is Shannon Petrus [pseudonym] neh
4   P:   Mhm
5              (1.2)
6   N: → is it alright if I speak English?
7   P:   yes, its fine (.) not a problem
8   N:   .hh you can call me whatever you want
9   P:   Okay
10  N:   what can I call you?
11  P:   Sanele [pseudonym]
```

In both extract 1 (line 1 "Now ladies…") and extract 2 (line 1 "Good morning lady") the nurse starts the counselling through an initiating statement. The use of initiating statements, as seen above, enables the nurse to set the scene of the interaction, or rather how the conversation will proceed. This is evident in extract 1 where the nurse states, "What we are going to do?". In extract 2, the "good morning" works to initiate a conversational sequence that should follow a standard greeting exchange. In both extracts, the conversational scene is initiated by the nurse/counsellor.

Setting the language of communication, or what I refer to as "language-checking"— was an activity of the interaction that was not always addressed. The interactions would generally start by one person saying something in either English or isiXhosa and with the other replying without any issue. If this was the case, then the consultation would simply proceed in that

[25] "ID" represents the identification tag that was given to transcripts.

language. However, it was common, as part of setting up the interaction, for nurses to initiate a directive[26] sequence that involved a question (extract 1 line 2) or request (extract 2 line 6) that checked the language preference of patients.

In extract 2, line 5, the counsellor provides her name, and the patient replies with a minimum turn token 'mhm', after which there is a 1.2 seconds gap. This gap could potentially allow the patient to expand on her turn and reciprocate the introduction by providing her name to the nurse. However, no name is forthcoming; to deviate from the expected exchange – I tell you my name and you tell me yours – is to create trouble in the talk. As a means of correcting this, the nurse puts forward the request to speak English, which, by the patient replying positively, confirms that she does understand English but also suggests that the patient chose not to share her name. However, in line 10, the nurse asks directly what she can call the patient, to which she responds with her name.

The independent counsellors did not engage in language-checking during the 'setting the interaction' phase of the consultation. This is more than likely due to the fact that they may not speak isiXhosa or are not fluent enough in isiXhosa to conduct counselling. In the majority of cases, they would open the interaction up by introducing themselves and their organization, as can be seen in the below extracts:

Extract 3
Site 1 [ID:17, C = counsellor; P = patient, English]

```
1   C:   We've been around since two thousand and (.) nine >i'll
2        just give you a bit about us< and you then you'll know
3        that we can be your friend and you >can trust us a little
4        bi!t< and to date we've seen probably about fifteen
5        thousand girls of all cultures, all ages, our youngest
6        has been twelve .hh so there is nothing new (.) can say
7        that's going to shock me (.) um our support is
8        unconditional. We just really there to love yo!u (.) and
9        to tell you now you in a crisis, you've had  DOUBLE
10       shocking news today
11  P:   Ya(h)a
12  C:   and just to try and (.) tell you about your options
13       because >you're probably feeling a little overwhelmed<
14       .hh and the consequence of each option and just to offer
15       (.) our support and to say that we're there for you [...]
```

[26] Directives are initiated in order to get the recipient of talk to do or say something.

Independent counsellors provided a lot of upfront information regarding the organization for which they worked and what they considered to be the primary goals of the consultation. The independent counsellors essentially engaged in describing labour where they not only described the *nature* of their role with the patient but also the *content* of what was to be shared or discussed. This worked to reflexively position themselves as experts, trustworthy, competent, supportive and empathic: all particularly powerful positionings within the context of counselling.

Counsellors described their role as one of a supportive "friend" (extract 3 line 2) who offers "unconditional support" (extract 3 line 8). Interestingly, in extract 3 lines 4-5 the counsellor engages in 'convincing labour' that intended to persuade the patient that the consultation is being conducted by a professional and competent individual who is part of a reputable organization. The counsellor engages in 'convincing' labour by drawing on history ("We've been around since two thousand nine"), numbers ("fifteen thousand girls") and diversity in counselling ("girls of all cultures and, all ages…") and does so to build a compelling case, or rather to assure the patient, of her organization's legitimacy and her competency.

In addition to this, the opening passages of talk work to establish the identities that are relevant to the institutional interaction. By doing the relevant talk associated with that identity (i.e., counsellor doing counsellor talk "our support is unconditional", "you now in a crisis"), the nurses/counsellors establish their identity within the interaction but also the patients. Interestingly, in extract 3, the counsellor has established her expertise as a counsellor but also makes reference to certain pastoral qualities, such as "be your friend" (line3), "trust" (line 3), "love you" (line 7) and "offer our support" (line 13). It is also critical to note that through talk, the counsellor positions herself not only as competent but also interactively positions the patient as in crisis ("you now in a crisis") and, therefore, in need of help ("offer our support").

In terms of the content of the consultation, the counsellors would make particular reference to sharing information regarding options, procedures and consequences. In other words, they would provide a pre-telling of what was going to be discussed in the counselling session. Evidence of this can be seen in extract 4 below.

Extract 4
Site 1 [ID:16, English]

```
1  C:   My name is Sara and I am with the organization called
2       ((name omitted)) .hh and what we do is that we counsel
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3 the ladies before they go in before they go in for
4 termination (.) .hh so that they understand the (.)
5 various procedures they understand the consequences and
6 they understand (.) um (.) what the:: um the whole
7 options are (.) as far as um termination is concerned. I
8 am just going to take down your details and then we will
9 go from there
10 P: Okay

Pre-tellings within the counselling context work to delimit the topics of talk but also to forecast, for the patient, what is to come in the consultation; they can work, potentially, to get the patient to think what they want to ask or explore with regard to each project oriented to in the interaction. By covering the content of the consultation, the counsellor provides a framework for what might be considered task-orientated talk. In comparison, nurses would cover the topics to be discussed in the counselling session to a lesser extent and instead would get down to the business of the interaction, which usually involved focusing on history-taking, providing procedural information and discussing family planning. In extract 4 (lines 4-7), the patient is positioned as lacking information and understanding and therefore is in need of counselling.

Although the majority of consultations did have some opening or leading into the interaction, this phase was not required in order to open the interaction (Zimmerman, 1992) – there were cases where project 1 was completely skipped over, done partially or even rushed through in a few sentences, as can be seen in the below extract

Extract 5
Site 3 [ID:23, Translated from Isixhosa]

1 N: Hmm (.) sit properly and relax. We are still going to
2 chat here. sit properly, sister. Do not sit as if you
3 are passing through (.) How old are you?
4 P: I am 28=
5 N: =Which method of family planning were you using?
6 P: I was using pathogen
7 N: And then what happened?
8 P: ◦Hmmm◦ I became sick for a long time so I could not visit
9 the clinic on date I was supposed to because I was in
10 pain (1) so then I ended up not going
11 N: When was your last period, young lady?

In the above extract, the nurse sets the interaction in an authoritarian manner. The institutional position of the nurse enables her to take on this authoritarian position. The opening sentence of line 1 (“Hmm! Sit properly and relax”) sets up the interaction as one in which the nurse is

in charge – she is able to issue instructions such as "sit" and to reprimand the patient when she appears to be conducting herself contrary to the expectations of the nurse. Setting the interaction up in this way means that the nurse can move straight into asking personal (line 5) questions (i.e., history taking) without the niceties expected in introductory sequences and to ask the patient to account for her actions in line 7 ("and then what happened?"). Importantly, the accounting work in lines 6 – 10 works interactively for the patient to position themselves as not blameworthy, as she sought medical assistance as soon as she became sick.

5.3.2 Project 2: History taking

History-taking was the project that generally followed the context-setting aspect of the interaction. History-taking primarily involved gathering the particulars of the patient and is considered a vital component of many healthcare interactions (Boyd & Heritage, 2006). The personal information gathered about the patient was then used as a resource, or foundation, for focusing the interaction to cover certain issues – other than the topics that might have been covered during the initial introduction. For example, if a patient disclosed that they did not use contraception or used it incorrectly during history taking, then that could be identified by the counsellor or nurse as an "issue" that needed to be addressed. In addition, unlike a doctor-patient interaction, history-taking never led to any form of physical examination but could lead to an assessment of the patient's gestation period.

History taking as an activity was, in all cases where it featured, initiated either by nurses or counsellors and consisted of a few question-answer sequences, as can be seen below in the following extract:

Extract 6
Site 2 [ID:16, English]

```
1   N:   Okay (4) ((shuffling noise)) I'm saying again good
2        morning neh
3   P:   ◦Morning◦
4   N:   (s     )
5        ((writing something down))
6   N:   How old are you?
7   P:   ◦nineteen ma'am◦
8        (2) ((writing down information))
9   N:   when was your last period?
10       (1.25)
11  P:   January
12       (4) ((Writing down information))
```

13 N: any high blood sugar, any illness
14 (2)
15 P: any illness?
16 N: Ya
17 P: ◦No◦ (.) HIV positive
18 (2.5)
19 N: is that all?
20 P: Yes

As can be seen in extract 6 the nurse greets the patient and then in line 6 immediately initiates history taking by engaging in question-answer sequences. The nurse asks the patient a series of questions that are mostly answered succinctly and in type-conforming fashion (Raymond, 2003). In line 13, the nurse asks if the patient has any illness (first-pair part), to which there is a two second delay before the patient's response. According to Sacks et al. (1974), pauses might denote some difficulty or uncertainty on behalf of the patient concerning what constitutes an illness or what a relevant response is. This could be attributed to the fact that questions containing the word "any" have a negative polarity (Borkin, 1971; Horn, 1978); that is, they are tilted towards "no" as a grammatically preferred response (Schegloff, 2007). However, in line 15, the repetition of "any illness" by the patient is heard as an insert expansion as her turn works to clarify or obtain a better understanding of the nurse's question. The issue with questions that contain negative polarity words such as 'any' is that important information may actually be suppressed during the interaction. However, in this particular instance and despite the negative polarity, the patient responds "No" (second-pair part – SPP) to the question and then adds a post-expansion of her being "HIV positive". The inclusion of post-expansion ("Is that all?") on the SPP suggests that the patient does not consider her response of simply "No" to be adequate; she may also consider her HIV status to be important, considering that the interaction is a health-related one.

Some counsellors adopted a formulaic approach to history taking where they would ask a series of short questions within a few lines, as can be seen below in the following extract where the counsellor asks a total of eight questions within 22 lines of talk;

Extract 7
Site 1 [ID:16, C= counsellor, P = patient, English]

1 C: umm your name is Sophia (5) ((written information))
2 ◦okay◦ Sophia how old are you.
3 P: I am thirty one

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C:   You're thirty one years old (.) are you single or are you
     married
P:   I'm single
C:   You're single (.) are you working (or) are you studying
P:   No: I'm not working
C:   You're not working .hh Sophia before you found out that
     you were pregnant (.) were you using any prevention
P:   ◦No I wasn't using anything◦
C:   Okay (.) do you have any children?
P:   ◦Yes◦ I have one
C:   how old is your child=
P:   =seven
C:   seven years old .h and how far pregnant are you now
P:   I hav- I am seven weeks
     ((more history taking 9 lines))
C:   Okay Sophia what I h. um noticed to start off with is
     that (.) umm you are not using any prevention
P:   (      )
C:   Is there a reason for that?
```

In extract 7, the counsellor engages in history taking by engaging in a question-answer sequence. Interestingly, and unlike in extract 6, the counsellor supplies the question as well as the acceptable answers to her own questions, as can be seen in line 4 where she asks, “are you single or are you married”. By designing the questions in this way, the questions effectively contain the response category within them, and all that is required is for the patient to select one option. One reason for doing this in history taking might be to streamline the interaction by providing the most common answers to the question so that patients do not need to spend time thinking about what an appropriate response is. However, these questions may not always function as intended. In line 7, the counsellor asks a question regarding employment and offers “working” and “studying” as potential answers. These two options are not exhaustive, and no option is provided for unemployment; we see that in line 8, where the patient replies with an answer of her own: “No, I’m not working”.

Of interest here and as proof of history taking as an information gathering activity used to identify key issues, Sophia answered that she was not using prevention in line 11, which is then used as a springboard, by the counsellor, into a new activity. Information that was gathered during history-taking and which was used as a springboard were: (1) duration of pregnancy (e.g., first trimester or second trimester) which led to a discussion of the procedure the patient legally and medically qualified for, (2) the use, non-use or misuse of contraceptive (i.e., family planning) which led to a discussion on contraceptives, and (3) relationship status which led to a discussion of the implications this might have for continued pregnancy or abortion.

What often signals the closure of history taking and a shift to another activity is that the counsellor ceases the question-answer sequence by means of a change of activity token "Okay" and a declaration - "I um noticed to start off with" (line 19). By doing this, she (for now) orients to Sophia's non-use of prevention and is interested in obtaining an explanation for her non-use (line 22). Without history taking, that information would have perhaps remained undisclosed or only revealed later on in the interaction.

5.3.3 Project 3: Establishing the reason for the decision (i.e. abortion)

Establishing the reason for wanting an abortion can be considered as the "why-phase" or the "accounting phase" of the interaction. The goal of the phase, from the counsellors' or nurses' perspective, was to get the patient to provide an explanation for why they wanted to have an abortion, irrespective of whether the procedure was going to be medical or surgical. This was one of the more common phases and was either initiated through (1) *direct questioning* or (2) *initiated from history taking*. Each is discussed below.

5.3.3.1 Directive questioning. Counsellors and nurses sometimes began the counselling by directly asking patients why they wanted to have an abortion which in all cases resulted in patients providing some explanation, as can be seen in the extract below.

Extract 8
Site 2 [ID: 005, C= counsellor, P= patient, English]

```
1   C:   Okay (.) now list(en) can I ask why ◦perhaps◦ (then you)
2        want to do the abortion
3        (.)
4   P:   I because I (.) I don't have option now because (2) .hh I
5        I had already a baby
6   C:   you has already a baby=
7   P:   =yes [and still and
8   C:        [how old is
9   P:   and still she's young
10  C:   ◦i see◦ how old
11  P:   is five years
12  C:   five years=
13  P:   =Yes
14  C:   Okay .hh and you are still young neh
15  P:   Yes i'm still young (and) I'm still studying so
16  C:   okay (mh-mh) that's understandable (2) .hh you know that
17       abortion is not an easy thing
18  P:   Yes I know sister
```

The "now list(en)" in line 1 announces that the nurse is going to say something of importance and is requesting the attention of the patient. She then proceeds to ask why the patient wants the abortion in lines 1-2 initiating a directive sequence of question and answer. The patient is expected to account for her decision to have an abortion and begins this accounting labour by stating that she "had a baby already" (line 5). Her response creates trouble (i.e., interactional uncertainty) in the interaction as she used the past tense verb "had" – which could possibly mean that she was pregnant and aborted or the baby had passed away; her response does not indicate that she has a child in the present. The counsellor provides a repair in line 6 with "you has already a baby". The verb "has" makes the present relevant. In other words, the patient has a child currently. This repair is accepted by the patient and is expanded by her stating that she is still young (line 9). The "I see" in line 10 is heard as a condition changer; the nurse has now received the response and acknowledges this. At this point, two reasons for wanting an abortion have been provided.

In line 14, the nurse states the patient is "still young neh" which serves as a candidate answer[27] to introduce another potential reason why the abortion is required for the patient. One of the key features of offering a candidate response is that it provides a model, or rather expectations, of the type of answer that would satisfy the speaker (Pomerantz, 2012). Schegloff et al. (1977) describe offering a candidate answer as also a "correction invitation" (p. 379). In other words, once the candidate answer has been shared, it is then up to the recipient to either confirm, elaborate upon or correct it. The patient accepts this candidate answer and adds that she is "still studying" (line 15), suggesting that she may not have the time nor financial resources to take care of two children. This is heard as an additional reason to have an abortion.

The accounting labour by the patient and the nurse's input have co-produced multiple justifications to have an abortion (i.e., already has a child, still studying, and the young age of the patient). We see the eventual acknowledgement of the accounting work (i.e., providing reasons) in line 16, where the nurse provides her assessment of the reasons for abortion as "understandable". The use of the word 'understandable' is noteworthy. By using it, abortion as a procedure is not viewed either positively or negatively but rather as a necessary procedure under certain circumstances that need to be justified.

[27] A candidate answer is a proposed, and often tentative, answer which is produced by one speaker on the behalf of the recipient. It is then up to the recipient to confirm or correct the candidate answer.

Across the data set, it was common practice for multiple reasons to be identified and explicated by patients to the nurse/counsellor in order to justify an abortion. In cases where one reason was produced, as we can see above, the counsellor would engage in actions that elicited additional reasons – in this instance, providing a candidate response. Multiple reasons were required in order to allow the interaction to proceed.

In the below extract, the nurse starts the counselling session by asking the patient directly about their reason for an abortion. In this case, there was no project 1(Setting the interaction).

Extract 9
Site 3 [ID:23, Translated from IsiXhosa]

```
1   N:    WHY do you want to terminate your pregnancy, young lady?
2   P:    Because I want (.) I will not be able to (.)
3   N:    Raise your voice a    [little
4   P:                          [Because I am studying, because I cannot
5         sit down again((patient has a child currently)) and look after
6         the baby (.) and my mom said that she would not be able to
7         look after the baby=
8   N:    = Why did you not go for family planning?
9         (.)
10  N:    A person who is still studying and is not ready to have a baby
11        goes for family planning. Why did you not go for family
12        planning? (0.9) I do want the reason
13  P:    [The reason
14  N:    [What is the issue between you and family planning?
15        (2)
16  N:    Because I do not know it and for me to be able to help you I
17        need to know (.)
```

The interaction starts with the nurse shouting the word "why" (line 1) and requesting that the patient provide an explanation for wanting an abortion. This positions the nurse as an authoritarian figure whose questions must be answered. As such, a directive sequence has been initiated. The patient's response comes in line 4, where she states that she is "studying" and that she "cannot sit down again and look after the baby". This works to reflexively position the patient as not blameworthy for wanting an abortion owing to another circumstance ("I am studying"). What is notable is that she uses the adverb "again" to indirectly reveal that she has a child already. In this way, two reasons for having an abortion have now been communicated – the one being that the patient is studying [reason 1] and the other being that she already has a child/baby [reason 2]. In addition to this, in line 6, the patient adds that her mother "would not be able to look after the baby". This suggests that, at some point, the patient considered keeping the child if her mother could have helped to look after it. Once again, multiple reasons

have been provided for seeking an abortion, with the reason to abort based on the patient's specific circumstances.

Unlike in extract 8, there is little evidence to suggest that this explanation was accepted by the nurse. Instead, in line 8, the nurse initiates another directive sequence, asking the patient why they did "not go for family planning" (line 8) – she is calling out the patient for her behaviour (non-use of family planning) and requesting her to account. When no response is forthcoming, the nurse starts a new action; she performs a declarative[28] orienting to the relevance of the patient's occupation as a student. In line 10, she subtly acknowledges that being a student is a sufficient reason not to have a baby (i.e., "not ready to have a baby") but that this should result in the use of family planning. In this way, the nurse has produced a contrast structure wherein the first part of her statement —"a person who is not ready to have a baby goes for family planning"— offers what is interpretable as a socially desirable action and a second part "not go[ing] for family planning" as an undesirable action. According to Smith (1978), contrast structures are frequently used in talk to produce a context in which to view behaviour as deviating from a general rule or expectation. In this case, the nurse's contrast structure works to locate the patient's non-use of family planning as an undesirable deviation from responsible behaviour. It, therefore, produces trouble that requires accounting work on the part of the patient to defend her undesirable position.

The nurse demands an explanation, "I do want the reason", in line 12, which can be interpreted as a display of power, or rather the nurse using her authority (as a nurse) to get the patient to share information. The demand is met with attributable silence[29] (Scheglofff & Sacks, 1973) from the patient in line 15 – it is unclear whether the silence is contemplative (Friedland & Miller, 1998) or hesitance (Friedland & Miller, 1998) or resistance (Brown & Coupland, 2005), where the hesitance might come from the way in which the question was asked or rather demanded. Kultura (2016) suggests that silences work to indicate that a speaker is in an unfavourable position conversationally. In line 14, the nurse is requesting the patient to account for her non-use of family planning, and so to provide a response would mean admission of guilt. In other words, to reply would require the patient to interactionally acknowledge that it

[28] Declaratives encode the speaker's right to know and to assert what is being declared, rights commonly predicated on the assumption that the speaker knows something that the recipient does not (Heritage, 2009, p. 309)

[29] According to Schegloff and Sacks (1973), attributable silences are instances where it is one speaker's turn to talk but they remain silent.

was because of her inaction that she fell pregnant and consequentially is responsible for the position she is now in.

In order to prompt a response, the nurse justifies her demand by stating, “for me to be able to help you I need to know”. This serves then to convey to the patient what the information (i.e. her response) is going to be used for (i.e., to help her). This is actually a critical moment in the interaction because it is possible that the patient might have remained silent to avoid further questioning and reprimanding. It, thus, highlights the importance of what actions feature in the counselling interaction as well as the volume and tone that is used to produce them. Questioning and reprimanding potentially have a silencing effect and may discourage disclosure within the interaction, thereby effectively decreasing the overall quality of the counselling service – an environment identified as one which should help and support patients rather than silence them.

Establishing the reason for abortion was often initiated after history-taking. Below we see a smooth transition from history taking to establishing the reason for abortion.

Extract 10
Site 1 [ID:556, C= counsellor, P= patient]

((Marital status was asked during history-taking))

C: So tell me Sandile what um (.) made you come into the hospital now if you are married .h and um you are pregnant (.) what made you come into the hospital to have a termination
(.)
P: u:h (.) mt its simply because uh. I'm not ready emotionally (2) for having another baby because I hav:e a lot of stress at school (.) (meaning) books and all of ( ) I won't have time (1) for raising this child (.) and secondly my husband (he's) not a hands on person (.) I know if I (.) gave birth to this child I have to (.) take full responsibility for the child ◦mhm◦
C: .h and if you didn't want to have a baby is there any reason why you didn't use prevention then
(1.8)
P: it is because he does want a baby so (.) he's always on my case (.) make sure that I don't use any prevention because he wants the ◦baby◦
C: .h so he wants a baby
P: Mhm
C: and you've decided that you don't want a baby=
P: Mhm

23 C: so now you are pregnant and you want to abort the baby

In extract 10, the counsellor uses "So" in line 1 to indicate a change in topic. The counsellor has completed the history-taking activity and has collected personal information regarding the patient. In these few lines, the counsellor is asking two questions, which relate to the patient's decision to (1) come to the hospital when she is pregnant and married and (2) have an abortion. These two questions require the patient to provide an account of her decision. In lines 1- 4, the counsellor makes relevant the patient's marital status and her decision to terminate the pregnancy. By doing so, she positions herself as a social expert (i.e., in marriage, you do not need to terminate a pregnancy) and Sandile as irresponsible for breaking marriage norms. An assumption by the counsellor is that marriage provides a supportive environment for bearing children, yet the patient is seeking a termination of pregnancy. By orienting to the status of "pregnant and married", the counsellor demands that additional accounting labour takes place. In other words, the patient would not only need to account for wanting an abortion but why they want an abortion when they are married.

The patient engages in accounting labour in lines 6-12, and, much like extracts 8 and 9, multiple reasons are provided as a justification for the decision to terminate the pregnancy. The first of these reasons, provided by the patient, is that she is "not ready emotionally" for "another baby". As one reason, her description is enough, yet, Sandile provides further description to legitimise her reason for wanting to terminate the pregnancy. Then, in line 10, she numbers her "second" reason for wanting an abortion, stating that her husband is not hands-on and the responsibility of childrearing will fall to her. The patient has presented multiple viable reasons in the effort to convince the counsellor that her decision, based on her circumstances, requires the requested medical intervention. In this way, her talk works to construct her abortion as doctorable.

Doctorability, according to Heritage and Robinson (2006), are conversational efforts/actions that patients orient towards in order to legitimise their healthcare visit. It is through doing doctorability that patients present their situation as worthy of a doctors, or any medical professionals, time and effort. Getting patients to account for their decision provides the conversational opportunity for them to construct why an abortion is warranted in their particular situation. It is also worth noting that providing multiple reasons for the abortion may be interpreted as an effort to strengthen the patient's docotorability.

5.3.4 Project 4: Presenting options

Presenting options was a phase mainly featured in counselling sessions that independent counsellors conducted. Although nurses mentioned options, they were primarily focused on providing procedural and family planning information.

Presenting options was an activity that involved a disproportional amount of interactional talk between the counsellors and patients – in many respects, an activity that resembles the didactic talk between teachers and learners. The talk was mainly directive, where the counsellor would talk for a long period of time and share a lot of information regarding the options with the patient(s).

Counsellors, when speaking about the options, engaged in option-listing (Toerien et al., 2011), which involved them listing each available option and describing each option in varying detail. Option-listing entails a speaker constructing a list of possible legitimate options (for example, A, B, or C or some combination) from which the patient may choose. Below are extracts of how options were presented to patients.

Extract 11
Site 1 [ID: 561, Group counselling; 5 patients]

C: So your first choice is termination >that is why you're here in this hospital< (.) second choice might be to keep your baby (1) to become the mother that god has planned for your life (2) third option is to have your baby adopted do you know there are some women (.) who are unable (.) to have a baby (3) ◦there some people who cannot have babies◦ and so what happens is that your baby could be a joy a happiness and can be fulfilment for that family who would be desperately wanted a baby but ◦who can't have◦ (2.8) so think very carefully it is your choice (.) um in this hospital you have until about twenty weeks before you um are not in a position to have a termination (1.2) but once you have a termination (.) you cannot reverse it (.) you cannot look back in later years (1.20) and wished that you never had it (.) it stays and becomes a little label attached to your life forever (2.8) does your partner know that you're pregnant
P?: Yes ma'am
C: and how does he feel
(3)
P?: (we don't really talk ((noise in the background))
(unless)
C: and how do you feel about the abortion
(2)

25 P?: ◦I feel bad (obvious) I have to do it◦

In extract 11, the counsellor begins to formulate a list of three possible options for the patient, each labelled as:

1) "First choice" – "termination" (line1)
2) "Second choice" - "keep your baby" (lines 2-3), and
3) "Third option" – "have your baby adopted" (lines 4-5)

For each option/choice, except for the termination, the counsellor provides a brief description of what it entails and thus reflexively positions herself as an expert on the various options. The counsellor also makes use of various devices to convey the notion of choice in different ways to the patient. One such way is through the shifting between personalised and depersonalised formulations of choice/options. A personalised formulation can be seen in line 1 ("your first choice") and works to convey the decision to take up this choice as one that the patient, herself, has personally decided by coming to the clinic.

In contrast, depersonalised formulations can be seen for the second and third options: no pronoun is used to suggest where the choice lies. At first reading, the depersonalised formulations create a degree of neutrality around the option (Toerien et al., 2013) as they are presented initially as facts, and there is no ownership of the option linked to the patient. However, in the presentation of the second option (to continue the pregnancy), the option itself is depersonalised, but the description that follows is personalised. The counsellor uses the pronoun "your" to personalise the description of the option, which is to become a mother to the patient's baby ("your baby").

The third option of adoption is where the counsellor orients to the patient's pregnancy and contrasts it to "some women who are unable to have a baby" (lines 5 and 6) and positions the patient as selfish for wanting an abortion. What follows is three seconds of silence, which is interpretable as contemplative silence (Albert & Healey, 2012). Contemplative silence is a moment of consideration that is either given to or taken by the receiver of new information. It is a time when the receiver, or in this case, the patient, can reflect on what they have been told, what it might mean for them, and the option they choose. In this case, the patient remains silent and offers no response turn. In line 6, the counsellor repeats softly that "some people cannot have babies". This might be heard in a sympathetic tone in an attempt to get the patient to consider her situation as actually fortunate. Although this is presented as a neutral fact, later,

the counsellor states "that your baby could be a joy, a happiness and can be fulfilment" (lines 7 and 8) for another family. By doing so, the counsellor has made relevant two social categories: (1) the pregnant women (which the patient is categorised as) and (2) a childless woman/couple. Out of the two categories, a pregnant woman is constructed as the more fortunate as they can decide whether to become a mother or abort the pregnancy. Alternatively, the childless woman/couple do not have the same freedom and is bound to the category due to certain issues (e.g., fertility problems). In other words, they cannot opt-out of the category and are unable to experience the joy, happiness and fulfilment that a baby can bring, according to the counsellor, at least not without the help of women giving babies up for adoption.

In lines 9 and 10, the counsellor emphasises, for the third time, those who cannot have babies and once more, we see 2.8 seconds of contemplative silence. This time, however, the counsellor requests the patient to "think very carefully" about her decision before reiterating that it is her choice. This strengthens the evidence for the two instances of silence being heard as contemplative in an attempt to get the patient to process, cognitively, the information regarding each option. In addition, the counsellor does not request the patient to make an announcement of a decision in the interaction[30]. In fact, we see the counsellor mention that it is only after twenty weeks that the patient is "not in a position to have a termination" (line 12). This works to convey to the patient that no immediate decision is necessary and that she still has time to think about her options.

After presenting the options, the counsellor returns to abortion (lines 13-17), but this time she orients to the seriousness of the consequences of that option. She describes abortion as a procedure that cannot be reversed and becomes a "label attached to your life forever" (lines 16 and 17). Here the negative aspects of abortion have been identified, which serves as additional information for the patient to take into consideration. Although option-listing can be used as a means of presenting viable options, I argue, much like Toerien et al. (2011), that the machinery of the action can be biased towards a particular option or against a certain option. In the above extract, three options were presented, but I have shown how each option is described differently. Option 1 [abortion] was described as being an experience that stays with the patient for the rest of their life. Option 2 [continued pregnancy] was described with no discussion of

[30] There were several instances where counsellors suggested that a decision is not needed;
"you do not have to make a decision today. You can go for the scan. You can leave the hospital, if you still feel that you need to come back you can come back in a day or two" (Site 1, 16)

what being a mother might involve for the patient and in relation to her personal circumstances. Instead, the counsellor associated the pregnancy with "God's plan". The inclusion of this sort of religious rhetoric is particularly powerful in a situation where it may be assumed that many of the women presenting at the clinic will identify as Christian. In this way, the option to parent may appeal to patients at a personal level (i.e., to become a mother) but also a spiritual level (i.e., to fulfil god's plan), and finally, option 3 (adoption) was presented as an option that could bring joy, happiness and fulfilment to a couple/family who is unable to conceive. In summary, to choose against abortion is to choose positive outcomes for oneself and others – whereas choosing abortion is to live with the label for the rest of one's life.

5.3.5 Project 5: Providing procedural information

Providing procedural information was a common phase that featured in all of the counselling sessions recorded and primarily involved the nurses/counsellors sharing information regarding the procedure for which the patient(s) were viable. Procedurally, abortion was divided into two major types – medical and surgical abortion. Patients who were in the first trimester, up to nine weeks, of their pregnancy were given medical abortion, which involved the patients being given a series of tablets (i.e., Misoprostol and/or Mifepristone) which would trigger contractions and expel the foetus. This procedure could be carried out at home and only required medical intervention if complications occurred.

After nine weeks and up to 20 weeks of pregnancy, the only available option for patients in these sites is surgical abortion. Depending on the site and resources available, this is carried out using either the dilation and evacuation (D&E) or manual vacuum aspiration (MVA) method. The below extracts are selected accounts of talk that dealt with each procedure and show how information was shared during the interaction.

Cross-site comparison of the provision of procedural information phases revealed two different rhetorical strategies that counsellors and nurses would employ; a catastrophising and normalizing strategy. With a catastrophising approach, counsellors would describe the procedure in graphic detail and draw on descriptors that suggested that the procedure was violent for both the patient and, in their words, "unborn baby" (i.e., anxiety invoking). In contrast to this, a normalizing approach described both the procedure and associated physiological reactions of the patient's body as expected and a normal encounter (i.e., anxiety diffusing)

5.3.5.1 Catastrophising procedural information. In this section, I present extracts that illustrate how the surgical abortion procedure was catastrophised in the group counselling interaction, as can be seen in the below extract:

Extract 12
Site 1 [ID: 559; Group counselling; 4 patients] Counsellor = Sara

```
1  C:   They push the metal tube into the vagina, into the cervix,
2       into the uterus and they suck the baby out-the baby comes
3       out  in bits  and  pieces ((shuffling))  I  want  to show
4       you (.) a photograph um you're seven weeks six weeks (.)
5       a:nd: eights weeks nine weeks okay so your (.) your: um:
6       (3) your babies (1.1) are of similar (1) size to this
7       ((noise)) photograph I'm going to show you
8  P:   isn't it (.) scary (.) heh.
9  C:   this is your life this is a baby that's growing inside of
10      you
11           ((passing image around?))
12 P:   Yoh
13           ((shuffling - passing around image?))
14 P:  (    )
15 P:   Mhm
16 C:   Sorry ((shows other patients image))
17      (2)
18 P:  (are we just/)
19     (3)
20 C:  that is the nine-eleven week old foetus ((noise))
21 P:  nine weeks with me=
22 C:  =you eleven eleven ya
23         ((door closing/opening))
```

In the above extract, the counsellor describes surgical abortion in graphic detail, loudly (for emphasis) stating that the "baby comes out in bits and pieces" (line 3). This works to reflexively position the counsellor as a medical expert. Her use of language is of significance here. The procedural actions, as described by the counsellor, are quite brutal – in terms of word selection, she uses "push" (over insert) and "suck" (over remove). Describing the procedure in such a way is to suggest that surgical abortion is a violent procedure for the woman and the "unborn baby".

The counsellor is doing describing work here: she has described the procedure using task directed talk – the talk is deemed 'relevant' in the sense that it relates to the abortion procedure. Later the counsellor states that she is going to show a photograph to the patients (lines 4 and 7) of a foetus inside the womb. It is important to note that this is a statement, and the counsellor

does not ask permission to show the photograph. Instead, the inclusion of the photograph appears to easily fit into the action of providing procedural information.

Describing verbally what the procedure involves adds one layer of information, but this information might still remain abstract to patients. The inclusion of the photograph operates as an additional explanatory layer. The description moves from task-directed talk to physical action (showing the image – illustrating what a foetus looks like) and, as such, works in tandem to produce a particular understanding of the procedure. By doing so, the counsellor gets the patients to consider the procedure in relation to the object (i.e., the foetus) of interest – in other words, what will come out in "bits and pieces".

The response to the assessment of the image is seen in line 12, where a patient replies with a loud "Yoh". Yoh is a South African slang word that is often used to denote surprise or awe, depending on the context. In this interaction, the "yoh" can be interpreted as a response to viewing the image and an expression of shock from the patient. In addition to this, "yoh" might also function as a change of state token (Heritage, 1984), which serves to verbally convey the registration of new information on behalf of the receiver (i.e., that there has been an epistemic shift). Thus, what we see in the above passage is successful information sharing regarding the procedure. The patient has learnt new information that might change the way in which they understand their pregnancy and abortion. In the following chapter, I critically explore the implications of using photographs/imagery to do explanatory labour and argue that it is a rhetorical strategy that is used to personify the foetus.

Below is another example of how counsellors catastrophized the abortion procedure:

Extract 13
Site 1 [ID: C2; Group counselling, 5 patients] Counsellor = Sara

```
1   C:    [..] with the second procedure (.) which is the procedure they
2         call manual (.) extraction (1) and what they do with manual
3         extraction is that they go into the vagina with a metal tube
4         (.) and they suCK the baby out (.) your baby comes out in bits
5         and pieces (1.5) that is usually done between nine weeks and
6         twelve (.) weeks of pregnancy .h for you: um Cebisa you are
7         going to be (.) mostly um most probably be given the um manual
8         extraction method .h because you're already on nine weeks the
9         others .h who are below nine weeks .h so you will be given the
10        tablet (1.2) remember that a termination is the TERmination of
11        the life of your baby (2.8) that is what we are doing here
12        (3.8) and as a result (.) those consequences will be with you
13        for life
```

The above extract comes from a group counselling session. The counsellor has finished describing medical abortion and, in line 1, begins to explain the surgical abortion (i.e. "manual extraction"). Similarly, to extract 12, the counsellor explains that a "metal tube" is used, and the "baby" comes out in "bits and pieces" (lines 3 and 4). In line 4, the pronoun "your" is used to draw attention to the object of the procedure. In other words, it is the *patient's* baby is going to come out in bits and pieces

5.3.5.2 Normalising and starting medical abortion in counselling. The nurse at Site 2, when conducting pre-abortion counselling in a group setting, often got patients to start the medical abortion procedure in the interaction, as can be seen in the below extracts:

Extract 14
Site 2 [ID:18; Group counselling, 3 patients]

```
1   N:    okay (.) good .h now you're going to take this one now (.)
2         then tomorrow (.) at the same exactly the same time .h you
3         will be taking the other four tablets that I will be giving
4         you
5   P:    (Okay)
6   N:    do you understand that (way)
7   P:    Yes sister
8   N:    good .h now I want you to take (.) ((pill box noise)) take
9         (1.5) thatha ((patient laughter)) take the(m)
10  P:    Thank you
11  N:    with water please (1) there's there's a (women's) ((walking
12        sound with heels)) cup
13        ((patients taking the tablet))
```

In lines 1 to 4, the nurse still provides procedural information by giving instructions concerning when each tablet needs to be taken. Such an activity interactively positions the women in the counselling session as responsible for their own medical procedure. For patients who were having a medical abortion, nurses, after explaining, either asked patients to repeat the information back to them or if they understand what had been shared. We can see evidence of this in line 6, where the nurse asks, "do you understand that (way)". Interactionally, the conversation would not proceed if there was no positive response or acknowledgement of understanding. If patients did not understand, the nurse would re-explain until they demonstrated their understanding. In the above extract, the patient indicates that she understands, which results in the nurse in line 8 using "good" to indicate a change in topic is coming. The change is from providing procedural information to actually starting the

procedure. In line 8, the nurse requests that the patient take the pill and begins to open the tablet box. There is no opportunity for the patient to refuse. The nurse invites the patient to take the tablets by stating "take" and "*thatha*" in lines 8 and 9. Here, "*thatha*" works as a prompter token: to invite the patients to take the pill and thus is understood as an alternative to "take". It is a token commonly used by isiXhosa people that means to take. That is potentially why we see laughter from the patient, as she may recognize the use of "*thatha*" as an attempt from the nurses, based on her limited understanding isiXhosa, to communicate in the patient's home language.

The group counselling interaction worked as an ideal and efficient space to get multiple patients to start the medical abortion procedure, as is captured in the below extract:

Extract 15

Site 2 [ID: 13 ; Focus group; 6 patients]

```
1   N:    It (will have    ) will stop when the water sack water sack=
2   C:    = gets loosened
3   P:    loose ((collective))
4   P:    Loosen
5   N:    that is the one beautiful ((group laughter)) you are on the
6         right path neh.h okay please take this one now with water is
7         there something there (.)
8   P:    Yes ((collective))
9   N:    Take it with water ver:y important (.) check the time (.) all
10        of you quick quick quick quick (.) there's one (.) two (.)
11        three (.) each one take one (.) four five
12        ((slight mutter and shuffling sounds))
13  N:    and six
14        ((more mutter))
15  N:    thatha (.) ((laughter from patients)) thatha ladies
16        (4)
17  N:    With the namanzi (.) (heza) uh uh ((noise)) yes
```

The nurse requests the patients to take the pill in line 6 of the extract and provides the instruction that it should be taken with water. In line 9, the nurse emphasizes an additional instruction that involves the patient checking the time before she starts to hand out the tablets. Similarly, we see the use of "*thatha*" in line 15, which is once again met with laughter from patients. Interestingly, in line 17, the nurse uses the word "*namanzi*" which is the isiXhosa word for water. What is evident in both extracts 14 and 15 is that codeswitching has occurred whilst getting patients to start the medical abortion procedure. Code-switching, in its simplest form, is a practice whereby a speaker or speakers alternate between two or more languages.

There might be various reasons for this, but in the above extracts, the words that are said in isiXhosa are repetitions of certain key English words (i.e., take and water) which are relevant for the medical abortion procedure. Taking into consideration that the majority of patients are familiar with isiXhosa, the nurse is seen to be engaging in codeswitching to ensure that the patients understand what is being shared and that they take action then and there. In this way, the use of code-switching denotes the sharing of interactionally important information. We see this being the case as code-switching only ever featured when procedural information was being discussed.

5.3.6 Project 6: "Obtaining" (verbal) informed consent

Obtaining verbal informed consent was a phase that only featured at Site 2 and seemed to form part of the nurse's formula for conducting the counselling. It was a project that mostly featured in one-on-one counselling sessions with no group counselling sessions featuring this project at site 2 – perhaps because the issue of informed consent was discussed in the waiting room before starting the counselling, or those participating in group counselling were all previously identified as providing informed consent. This might be employed as a strategy to streamline the services at an under-resourced facility, such as Site 2, where only one nurse is responsible for conducting the counselling.

At site 2, the nurse would read out two different informed consent forms. The one form, according to the recorded data, came from the Psychology Department of the hospital and covered issues regarding support and psychological distress. The other form came from the abortion clinic and covered issues relating to procedural information and the risks and possible consequences of an abortion. In many sessions from Site 2, informed consent was covered before procedural information was provided. In other words, patients had to agree to have an abortion in order to receive the appropriate procedural information. Below is an example of talk involving informed consent.

Extract 16

Site 2 [ID: P1]

```
1   N:    So: let me just read to you-I received counselling prior to
2         the abortion procedure .hh >the session prepared me with
3         regards to the possible pre and post psychological
4         complications< I did tel:l you that you need some help further
5         .hh if you feel that you need some help (.) after this you go
6         to the one that you can go to neh
7   P:    Hmm
8   N:    right, that is the psychologist .hh the decision to undergo
9         this procedure was purely my own and did not involve the
10        counsellor in any way (.)  am I right?
```

```
11   P:    Ya
12   N:    although the involvement of the father, parents, guardian was
13         suggested by the counsellor .hh the final decision to do (.)
14         so was left with you (.) neh
15   P:    Mhm
16   N:    Okay ((smacks lips)) ((shuffling paper)) just to tel:l you
17         that hh. um (1) you are going to have the method (1.5) uh the
18         medical pill
19   P:    ya
20
```

In the above extract, consent is covered in 15 lines and consists of three directive sequences. The first of these directive sequences appears in lines 1 to 8. Within these lines, the nurse initiates her turn by stating that she is going to "read" to the patient, which involves the reading of the informed consent forms. In lines 2-4, we see faster speech by the nurse but this is due to the fact that information about psychological support has been discussed previously ("I did tell you"). Up until line 6, the nurse has been engaging in information sharing. At the end of line 6, we see the directive token, "Neh". This token prompts the patient to acknowledge what has been said and is achieved through providing a minimal response in line 7 ("hmm").

The second directive sequence runs from lines 8 to 11. In line 8, the word "right" indicates that a change in subject is to occur. In this case, the nurse has concluded with the psychological consent form and is moving on to the Abortion Clinic's consent form. The consent form is read out and the nurse makes relevant the individuality of decision-making by emphasizing that the decision is the patients ("my own") alone. This notion of individuality is further strengthened by checking that the decision-making did not involve the influence of the counsellor. This is interactionally important as counsellors are the primary health service providers patients deal with prior to making a decision. Once again, we see in line 10 that the nurse initiates a directive ("Am I right?") which requires the patient to confirm her understanding of what has been said. However, the design of the question is particularly significant here. The question is grammatically designed in a way that favours a polarity (e.g. yes/no response), and that initiates one answer as preferred over the other. In this case, the question "Am I right?" serves to prefer (Pomerantz, 1978) a yes-answer over a no-answer. As is seen in line 11, the patient provides a minimal response of "Ya" (i.e., a positive response). As such, the yes-answer, which is a preferred response in this instance, means that the patient acknowledges what has been said but also serves to (re-) confirm that the nurse was not involved in the patient's decision-making. Preferred responses allow a conversation to proceed smoothly to the next turn, as we can see above. In contrast to this, a no-answer (i.e., dispreferred

answer) would mean that the Nurse is wrong and was involved in the decision-making. This would create "trouble" within the interaction and would need to be resolved before the counselling could continue.

The third directive sequence lies between lines 12-15. Line 12 is a continuation of the informed consent form, which mentions the possibility of including other potentially important members (e.g., father, parents and guardians) in the decision-making process. Ultimately, the final decision is constructed as being the patient's and once more we see a directive sequence unfold. The nurse, in line 14, states, "the final decision … was left to you (.) neh". Similarly, to the first directive sequence, the "neh" works to prompt a response from the patient, which is what is seen in line 15 through a minimal response ("Mhm").

It is clear from the above extract that there was minimum input from the patient. There are potentially two interrelated reasons for this. The first has to deal with the nature of the turn-taking system, which Schegloff (1982) has argued is designed to "minimize turn size" (p. 73). In this way, there is an element of efficiency in spoken communication, where speakers utter no more than is required to enable the interaction to proceed as smoothly as possible. The brief responses from the patient in the above extract are indicative of this.

The second reason for minimal input from the patient might be due to their personal experience of their pregnancy. As has been reported in previous research (Jones, et al., 2010; Moore et al., 2008), a large majority of women have already decided regarding their pregnancy before even making contact with the clinic. From this perspective, mandated counselling can be viewed as a bureaucratic hurdle that one needs to go through in order to receive the abortion procedure. In addition to this, and within the South African context, research (Harries et al., 2007) has shown that some women do present relatively late in the second trimester for abortion, which can render their particular situation time sensitive, especially when some clinics have waiting lists and/or are under-resourced. As such, the strategy for many women might be to get through the counselling session as quickly and with as little hassle as possible. This may help to explain patients' minimal input during the pre-abortion counselling interaction.

The Clinic's informed consent form also had a section that covered the potential risks that women could experience as a result of undergoing the abortion procedure. An example of this is presented below.

Extract 17
Site 2 [ID:04]

```
1         ((Counselor reading informed consent form))
2   N:    [...] then the decision to undergo this procedure was purely
3         my own (.) was it your own
4   P:    yes
5   N:    .h and did not involve the Counsellor in any way (1.5)
6         although the involvement of father, parent, guardian was
7         suggested by the Counsellor
8   N:    .hh  I didn't suggest-any(.)thing neh because this is
9         absolutely (.) your own decision neh
10        (.)
11  N:    the final decision to do so (.) was left to you (.) okay (.)
12        ((shuffling paper))
13  N:    now the other consent .hh  I the undersigned hereby consent to
14        the >termination of pregnancy and to such further alternative
15        procedures as may be< .hh be found necessary during the course
16        of the above ◦mentioned◦ procedure (.) with you you are less
17        than nine weeks pregnant meaning that you are going to have a
18        medical (.) pill (.) right
19  P:    ◦okay◦
20                  ((nurses explains procedural information))
21
```

Similarly, to extract 17, the nurse reads out the informed consent forms. In line 3, the nurse asks the patient if the decision to undergo the procedure was her own, to which she replies with an affirmative "Yes" in line 4. This is significant as the response comes directly after the question with no discernible gap in talk. Such a response is often referred to as a "well timed" response. It is also at this moment that the patient has expressed informed consent to have an abortion.

From lines 5 to 18, the nurse proceeds to read through the informed consent form. What is notable is, once more, the emphasis is on individual decision-making. We can see in line 8 ("absolutely you own decision") and again in line 11 ("the final decision to do so was left to you") that the decision is constructed as solely belonging to the patient. In line 8, we see an instance of self-initiated repair, where she states that she "didn't suggest anything". This self-initiated repair is a breakaway from the reading of the informed consent form. Repairs are often used in conversation to deal with potential misunderstanding (Schegloff et al., 1977), and as seen here, it would be reasonable to assume that the nurse was engaging in repair in order to make it clear to the patient that she, the counsellor, was not involved in the decision-making process. By doing so, the nurse rhetorically works to construct herself as uninvolved in the decision-making process. There are also two instances of "neh" used in lines 8 and 9, which in extract 16, were used to prompt a response from the patient. However, in extract 16 the "neh" fails to elicit a response from the patient, as can be seen with the noticeable gap in line 10. This

might indicate that the patient has heard the nurse's repair as part of the activity of reading the informed consent form. With no response forthcoming, the nurse resumes reading the informed consent form, from line 11 onwards ("the final…").

In line 13, the nurse begins to read the Clinic's informed consent form, which primarily covers the medical risks involved in having an abortion. We see quickened speech in lines 13-14. The increased pace for that section of the informed consent form might indicate that the nurse is committed to sharing this information with the patient, but since it involves a lot of information, the goal is to get through it as quickly as possible. In this case, reading faster might simply serve as a strategy to ensure the interaction proceeds as quickly as possible.

Importantly, the informed consent form goes on to cover the actual abortion procedure. However, at this particular point in the interaction, it has not been established what procedure the patient will have, and as such, we see the nurse state in line 18 that the patient is going to have the "medical pill" (i.e., medical abortion), to which she responds with a soft "Okay".

The reading of the two informed consent forms does appear to be lengthy and generates little patient input. However, its inclusion is made understandable when considering the institutional goals and context of the abortion clinic. At a practical level, the reading of the informed consent forms serves two main purposes. Firstly, it acts as a sanctioned and standardised resource for communicating psychological, medical and decision-making information to the patient. Secondly, reading through the informed consent forms might also work to streamline the interaction and ensure that counselling is conducted efficiently, where all necessary information is conveyed within a short period of time.

5.3.7 Project 7: Discussion of family planning[31]

Family planning was a topic of conversation that featured in all but two counselling sessions across all the sites. More specifically, counsellors and nurses initiated a discussion on family planning through directive questioning. The most common of these are featured in the early stages of the interaction. For example, in Phase 1, counsellors and nurses would engage in history- taking which would often lead to questions regarding family planning use or non-use, also referred to as the *past use of contraception*. This was primarily done so to identify any

[31] I am aware that the term "family planning" has been problematized for various reasons. In the context of this study, I use the term as it features across the recorded data set and is part of both nurses and counsellors counselling vocabulary. Although "family planning" is often used it is synonymously when counsellors and nurses spoke about contraception.

issues patients might have had with family planning in an attempt to identify and address challenges to correct contraceptive usage. The logic often demonstrated in counselling was that the appropriate use of family planning would ultimately reduce the number of women seeking abortions. This was evident from the nurses from Site 3, who explicitly stated that they promote family planning and do not promote abortion.

A discussion of family planning was also a central component of the counselling interaction particularly when nurses conducted the session. Nurses often exhibited an interest in patients' current use, misuse or non-use but also allocated space within the interaction to discuss family planning methods for *future use*. More specifically, nurses often tried to ensure that a patient selected a family planning method that they could use after the abortion procedure – with long term reversible methods such as the Intrauterine contraceptive device (IUD, colloquially referred to as the 'Loop'), Implanon/Nexplanon and the three-monthly contraceptive injection being favoured by nurses. In addition to this, the promotion of dual contraception was a common theme when discussing family planning. This involved the use of a condom simultaneously with some other non-barrier method. Below I identify segments of talk where the *past use* and *future use*s of contraception/family planning were discussed.

5.3.7.1 Past use. Below is an example of how past contraceptive use was brought up in the pre-abortion counselling interaction.

Extract 18
Site 1 [ID:16]

```
1   N:   You're not working .hh Sophia before you found out that
2        you were pregnant (.) were you using any prevention
3   P:   ◦No I wasn't using anything◦
4                    ((15 lines of History taking omitted))
5   N:   Okay Sophia what I h. um noticed to start off with is
6        that (.) um you are not using any prevention
7   P:   (mhm yes i stopped)
8   N:   Is there a reason for that
9        (2)
10  P:   Um (2) I think the two::: two years ago I was bleeding
11       nonstop I think about twelve months bleeding
12  N:   Mhm
13  P:   everyday then i went to (ambulance and the ambulance said
14       no) I must stop maybe it was what I was using to prevent
15       my (anything) they think that maybe I have cancer or (.)
16       then I step-I stop using (   ) prevention
```

Extract 18 is an example of how family planning's *past use* was made relevant in the interaction through history-taking. The counsellor in line 1 asks Sophia if she was using "any prevention" before she fell pregnant. Sophia quietly indicates that she wasn't using anything and works to position herself as blameworthy and responsible for conceiving. During the history-taking activity, there was no actual discussion regarding the non-use of contraception. However, after a few more questions are asked, the counsellor then orients back to Sophia's non-use in line 5. The counsellor recognises that the non-use of contraception is potentially, at this point in the conversation, the reason why Sophia conceived. As such, the counsellor initiates a request for Sophia to provide an explanation through the question "Is there a reason for that?" in line 8. We then see a 2 second pause in line 9 before Sophia provides her possible medical explanation in lines 10-16. In this way, information that was established from history taking is used as a conversational resource that can be drawn on later in the interaction. In addition, the explanation also works to re-position Sophia from blameworthy to now not blameworthy, as it was due to some medical related issue that she could not use contraceptives (lines 10-16).

Across the data, the referral to previously shared information was a common conversational effort that was used to identify potentially troubled talk. In most cases, it required the patient to account for their personal situations or decisions.

Throughout the data, it was interesting to see how family planning was made relevant within the interaction, or rather how it was oriented towards. In some cases, it was through simple history-taking questions that the nurse would ask and the patient would answer. In other instances, family planning was focused on due to the particular personal history of patients, as can be seen in the below extract.

Extract 19
Site 2 [ID:11]

```
1   N:   So how many children do you have
2   P:   I do have four children
3   N:   .hh okay so four: children
4   P    Ya
5   N:   plus one mis[carriage
6   P:                [miscarriage ya
7   N:   that is five=
8   P:   =that is five
9   N:   .hh so this is six=
10  P:    =this is six
```

```
11  N:   Mt o:kay (.) what did you use for family planning that
12       you can be five times pregnant .hh and a sixth one now
13       (1)
14  N:   hu:h
15  P:   Before I was using:: the (.) injection but-now I wasn't
16       using anything now .h I was only using the (.) con-dom
17       (1.5)
18  N:   your=
19  P:   condom
20  N:   Mhm:: I hear you I hear you
21
```

In extract 19, it is through history-taking that the nurse asks the patient how many children she has. Initially, the patient indicates that she has four children, but this is expanded upon by the nurse, who states that the patient had a miscarriage and refers to her current pregnancy. In total, the patient has been pregnant six times, which causes trouble within the interaction. Trouble within an interaction is significant because, in many cases, it blocks the progression of talk. As such, it needs to be resolved, or rather repaired, for the conversation to proceed.

The nurse provides an interrogative question ("what did you use for family planning…") in line 11, which calls for the patient to account for her number of pregnancies – in this instance, the number of pregnancies the woman has had has caused interactional trouble. Taking into account the information that has already been established, the question is designed in such a way as to produce either an admission of guilt (i.e., nothing was being used) or a particularly unique explanation for each of the pregnancies (i.e., they were all wanted and supportable). Considering that the nurse has demographic information regarding the patient, it is reasonable to view this question as seeking to elicit an answer of non- or misuse of contraception.

In line 13, the associated one second silence is read as the patient's turn – an opportunity provided for her to repair the interactional trouble and account for her many pregnancies. No explanation is forthcoming, and as such the nurse prompts the patient for an explanation which we see in line 14 ("Huh"). The patient explains that she was using contraceptives in the past, but for her current pregnancy, she was not using anything, only a condom. This explanation serves as an admission of guilt and is accepted by the nurse in line 20 ("I hear you"), thus allowing the interaction to progress. Further to this, in providing her answer, the patient has actually stated that she did use a contraceptive, but its use is undermined by the fact that it did not prevent the pregnancy. In this way, the condom is acknowledged as a form of contraceptive, but used alone is not sufficient to prevent pregnancy.

5.3.7.2 Future/post-abortion contraceptive use. The selection and discussion of contraception were often brought up when sharing procedural information. For many of the counselling sessions, nurses spent some time asking patients to select a method of family planning they would use post-procedure. This often led to a discussion regarding the different methods. Below is an extract where a nurse asks a patient to select a family planning method.

Extract 20
Site 3 [ID: 119_001; patient 15 years old, Translated from IsiXhosa]

N: {…} After being cleaned, you remind the doctor about the family planning method. Which family planning method do you think you will choose between the two [Implant and intrauterine were the only mentioned options]? (1)
N: Do not delay me.
P: I choose the 10 years one
N: You choose it. Is it you who is with their mother?
P: Mh-mh (Yes)
N: Please call her because she also needs to be here when we discuss this issue of family planning so that there cannot be any misunderstanding. ((Client goes to call her mother, mother enters))
N: Parents like to fight us when it comes to the issue of family planning and it becomes as if we gave their child something without her knowing. So you have to be involved here so that we can reach an agreement with you. ((discussion of the loop failing by the mother, she suggested the needle))

Extract 20 illustrates how, straight after procedural information has been shared, family planning is oriented to. In this case, the patient is ordered to remind the doctor to insert the selected method. Directly afterwards, the patient is asked to *select* between two methods, both of which are long-term reversible. This questioning assumes that the patient has previously indicated they want to use family planning (i.e., one only needs to select a family planning method if they have agreed to use family planning). However, this has not been established in this interaction. In fact, the decision to use family planning is assumed by the Nurse through her question design which does paternalistic work. It is paternalistic in the sense that the patient's decision to use family planning has already been made by the nurse. The only real choice the patient can exercise in this interaction is that of selecting the method. By selecting a method, the patient demonstrates her acquiescence towards the use of family planning but

also to the medical/expert authority of the nurse. This acquiescence is evident in line 7, where the patient chooses the "10 year" method (which is the IUD).

The next activity in this phase is to *discuss* the particularities of the family planning method (i.e., the IUD). In the above extract, the nurse does not wish to do this only with the patient and thus requests the patient to call her mother into the interaction. This request is more than likely attributed to the fact the patient is a minor (15 years old) and that the nurse reveals that "parents like to fight us when it comes to the issue of family planning" (lines 14-15). What we also see here is another performance of paternalism. It was the nurse's decision to include the mother in the counselling and not the patients. The nurse makes the request without any input from the patient, and the patient is expected to adhere to this request by calling her mother. Across the data, paternalism was more prominent in interactions where patients were young, particularly minors (i.e., under the age of 18).

Once the patient's mother enters the room, the nurse justifies her presence in lines 14 to 17. Including parents in the discussion of family planning can be considered as a strategy to avoid potential conflict as parents are also informed about the method of selection. Interestingly, the involvement of the mother is to get her agreement on the method her child (i.e., the patient) has selected. This rationalisation effectively undermines the decision-making power of the patient who, at this point, has already chosen the IUD. Alternatively, the inclusion of the mother for the discussion of family planning might be to ensure that as many parties are informed on the selected method as possible. If the patient (a minor) misuses it, her mother – an adult who is also informed about the method due to her inclusion in the counselling session – can intervene and assist/correct her child's use. From this standpoint, the inclusion of parents is not only to acquire their agreement but also to ensure that parents are informed enough to supervise their children's use of contraception, all in an effort to avoid future pregnancies. Seen in this way, both the patient and mother are responsibilised for ensuring the proper use of contraceptives. However, it is worth highlighting that legislatively there is no requirement for parents to consent or even be consulted regarding contraception for minors.

Establishing what family planning a patient is going to use post-abortion was a central component of the interaction. As we can see in extract 22 nurses would request patients to select a method. However, there were also cases where nurses would propose a specific method of family planning. An example of this can be seen below:

Extract 21
Site 2 [ID:16]

```
1   N:   okay (1) for your age you are twenty five years old and
2        >I'd like to give< you Nordette (.) It's a very good (1)
3        family planning method (.) neh (.) it's for your age it's
4        fine (as) lo:ng as you (.) you use it correctly
5   P:   (◦thank you◦)
6   N:   the Nordette you take everyday same time (.) please (.)
7        no skipping (.) NO:: skipping
8   P:   (  ) for days=
9   N:   =NO:: skipping  yeh neh=
10  P:   =(h)(h).hh yes:=
11  N:   =even if you go wherever you take it with because there
12       must be no:: skipping .hh then I'm going to give you the
13       date for the nearest clinic (.) neh
14  P:   Mh (mh)
15  P:   yes I know
```

In extract 21, the "okay" in line 1 works to announce the shift of the topic. It is at this point that the nurse starts to talk about future family planning use. She takes into consideration the patient's age and proposes the use of Nordette [an oral contraceptive pill]. The proposal is then followed by a positive assessment of the method as "very good", which works to legitimize its effectiveness and strengthen the overall proposal. At this point, to decline the proposal, by the patient is very difficult as "Nordette" has been constructed as a "good" method by the nurse – who occupies the expert subject position.

The interrogative statement "Neh" (line 3) — meaning "isn't that so", is an opportunity for any disagreement of the proposal. None is forthcoming, and the nurse expands on her turn, constructing Nordette as appropriate and effective based on correct use. This expansion works to provide information about the method to the patient but also works to strengthen the nurse's proposal of the method.

In line 5, the patient provides a gentle acceptance of the proposal ("thank you"), and the nurse starts to elaborate further on its use and requests that the patient should not skip taking the tablet. Interestingly, the nurse repeats "No skipping" four times as can be seen in lines 7 (twice in this line), 9 and 12. Initially, this starts off as simple request "please (.) no skipping" which marks a transition relevance place for the patient. No turn is provided and so the nurse employs repetition as a conversational device. Repetition serves a variety of functions in talk, and within this extract, we see the nurse using repetition in conjunction with increasing volume to

emphasize (Longacre, 1983) the importance of not skipping on the daily routine of taking the contraceptive pill. Repetition is used as a strategy to ensure that the patient takes her pills as is required or, in the words of the nurse, "you use it correctly". In this way, "No skipping" is heard both as an explanation of proper use and a command by the nurse. The nurse repeats it three times before the patient in line 10 finally provides the conditionally relevant response to the nurse's command ("yes"). There is then further explanation by the nurse, which serves to inform the patient not only about how to use it correctly but also about where she can renew her supply ("give you a date for the nearest clinic").

In comparison to extract 19, the selection of the method is done through the nurse proposing rather than the patient selecting a method herself. Irrespective of how a contraceptive method was selected, nurses, in most cases, ensured that some time was dedicated to discussing the specifics of the method, either directly with the patient or with a third-party present. Through reading the data, phase 7 (Discussing family planning) was given considerable time in the interaction, in an effort on the part of the nurses, I suspect, to ensure that patients identified, acknowledged and corrected their contraceptive usage in order to reduce the likelihood of future abortions.

5.4 Conclusion

In this chapter, I have presented analyses of the overall structural organization that pre-abortion counselling takes within public health clinics. I have demonstrated that the sessions, as they unfold turn-by-turn, can feature up to seven projects. These projects can be considered as "distinct clusters of activity" (Heritage, 1997, p. 167) that are co-engaged in by patients and nurses/counsellors in order to carry out the business of pre-abortion counselling. As a summation, these seven projects are:

1. Setting the interaction
2. History taking
3. Establishing the reason for abortion
4. Presenting options
5. Providing procedural options
6. Obtaining verbal informed consent
7. Family planning

The key findings of this chapter are summarized below.

A major finding is that there was variability in how counselling sessions were conducted across the three sites. Although these projects fully describe the counselling sessions, the presence of various projects and the order in which they were conducted differed. Even within certain projects (e.g., Project 5, providing procedural information), there were differences in the approach. So, whilst there are common features within the counselling sessions in this study, there is no standardized counselling procedure that is used consistently across and within the three sites.

Project 1 (Setting the interaction) revealed that nurses and counsellors often initiated and set the interaction. This often-involved language-checking, and pre-tellings which established what type of talk and topics were expected during the course of the counselling. An analysis of the data showed that the second major Project (History-taking) involved the nurses and counsellors engaging in History-taking. This project primarily consisted of question-answer sequences that were used to gather patient information (i.e., the goal for this project) that could later be drawn on as a resource for further discussion.

Project 3 focused on eliciting the *patient's reasons for wanting an abortion* and appeared to be conducted through two main methods. The first of was through directive questioning, and the second was through history-taking. In both instances, patients were required to provide multiple reasons for seeking an abortion. I highlighted how patients engaged in accounting labour in order to construct their pregnancy as requiring medical attention, which I refer to as constructing doctorability. Through this process, patients legitimised their need for abortion through their own substantiations, even though the CTOP Act stipulates that in the first trimester, no reason is required (Department of Health, 2019).

The focus of project 4 (Option-listing) was how counsellors discussed options within the interaction. The data revealed that counsellors presented a menu of options. The construction of options was often done unequally, constructing one option more positively than the other. In addition to this, patients were also asked to consider their options temporally (i.e., short-term and long-term). The main goal for Project 5 was sharing procedural information. In this section, I identified how counsellors engaged in catastrophizing labour that involved sharing graphic and explicit detail of the procedure. I also highlighted how nurses normalized the procedure, and in the cases of medical abortion, actually started the procedure within the group counselling session.

Project 6 - *Obtaining (verbal) informed consent* - was a project which only occurred at site 1. Analysis of data from this site revealed that the informed consent form was used not only to share important information but also as a resource that provided structure to the interaction. I argued that the incorporation of informed consent also assisted with streamlining the interaction, which is of particular significance in South Africa, where many abortion providing hospitals are under resourced and the faster a nurse can deal with one patient, the sooner she can assist another.

Finally, Project 7 identified how Family planning was made relevant within the interaction. More specifically, the two main goals for this project were getting the patient to select a method of contraception post-procedure and discussing the particularities of the method. Within this project, there were clear examples of paternalism on the part of the nurses and I argued that this was done in an effort to ensure that patients selected and adhered to proper usage in order to reduce future abortions.

Chapter 6: Medical related discourses underpinning pre-abortion counselling

6.1 Introduction

This chapter is the second of three dedicated to reporting the analytical work I engaged in to uncover the nuances of the pre-abortion counselling interaction. In this chapter, I primarily identify and focus on discourses that are related to medical issues associated with abortion. Understanding that pre-abortion counselling is conducted in the public health sector in South Africa and is foremostly a medical interaction, I start this chapter by outlining and exploring how a medical discourse operates within the pre-abortion counselling interaction.

My objective is to present to the reader the foundational medical discourse with which other discourses within the interaction intertwine in various ways – this will be illustrated throughout this chapter and the next. I do this by focusing on three uses of the medical discourse. The first is how, through talking about medical issues, pregnant women are constructed as patients, which I refer to as "patienthood". The second way is how nurses and counsellors constructed the abortion procedure (both medical and surgical variations) and how this worked to reaffirm the patienthood of women whilst constructing themselves as experts on the topic. Finally, I show how a medical discourse is used to construct the mismanagement of contraception as a behavioural problem on the part of the patient, but one which can be resolved through medical intervention (i.e., long-acting reversible contraception).

I then move to explore how a discourse of responsibilisation was used to position pregnant women as irresponsible subjects for their lack of contraceptive use and for ultimately falling pregnant. Further to this, I also highlight how women, once constructed as patients, are then called upon to play an active role in their own abortion procedure.

The next discourse explored is that of Risk. Through this discourse, the risks of the abortion procedure are constructed as existing at two distinct levels; (1) *Physical* (e.g. breast cancer, future potential infertility and death) and (2) *Psychological* (e.g. Post-abortion syndrome, depression, regret). In this section, I show how these descriptions of risk construct abortion as a dangerous and traumatizing medical procedure that contributes to what Hadley (1996) calls

the awfulisation[32] of abortion and have the potential to alter the way in which women come to understand their own pregnancy.

This chapter closes by identifying how a discourse of support featured during the counselling interaction. I illuminate how counsellors constructed support, what it might involve (e.g., verbalising feelings) and why support was presented as useful for women who have had an abortion. Within this section, I also show how support was performed through advice giving and how a simple act of exchanging cell phone numbers between nurses/counsellors and patients is a supportive gesture that is illustrative of a patient-centred approach to counselling.

6.2 Medical discourse

Abortion, although experienced in a socio-political context, was primarily spoken about as a medical procedure within the pre-abortion counselling interaction. For the purpose of this chapter, I understand medical discourse to be any talk about medication, the abortion procedure, patients and health service providers, options, side effects and physical health (Atkinson, 1999). In the below section, I highlight how a medical discourse is used to construct: (1) women as patients and nurses/counsellors as experts on the topic of abortion, (2) abortion as a medicalized procedure, and (3) medical intervention as a means of avoiding [un]planned/[un]supported pregnancy in the future.

6.2.1 Constructing patienthood

All the counselling sessions collected in this project took place at hospitals. Within this physical space, certain subject positions operate and enable certain power relations and access to reproductive health services (i.e., abortion). For a woman seeking an abortion, the subject position of 'patient' is perhaps the most pertinent. This construction of patient, what I refer to as constructing "patienthood", is a necessary performance women had to undergo in order to justify their need for medical attention (i.e., relevant abortion procedure). In other words, abortion as a medical procedure was understood as being necessary for those who could demonstrate, discursively, that they needed it and in order to demonstrate the need for an abortion, women had to be positioned as patients. This positioning occurred in various ways, as I shall show throughout this section.

[32] The awfulisation of abortion are practices which work to construct abortion as an inherently negative experience that is characterised as being one of struggle, trauma and risk (Lee, 2003; Whalstrom, 2013)

In the data, nurses, more so than counsellors, recognized [un]planned/[un]supported pregnancies as being "treatable" through medical intervention (i.e. the abortion procedure). In many of the interactions, the nurses would ask patients about their understanding of abortion, how they fell pregnant and why they were requesting an abortion. It is important to note that although this information was requested by nurses and counsellors, women are not legally bound to provide this information as the CTOP act affords women who are less than 13 weeks gestation access to abortion on request (Choice on Termination of Pregnancy Act, 1996). The below extracts are some examples of how nurses asked patients' reason(s) for requesting an abortion.

Extract 1

Site 2 [ID: 28; Patient = Dora; Nurse= Pat]

N: .hh may I ask why did you decide to have an abortion

P: Aah (.) considering my circumstances ma'am I thought that I can't ha-I can't afford to have another baby .hh I still have a twenty months toddler

N: Mhm

P: Yes I am working but it's going to be more difficult .hh and ah she is still young, she still needs my attention

N: Okay

P: Ya

N: I understand .hh okay .hh now (.) tell me did you use any family planning

In the above extract, the nurse directly requests Dora to provide a reason for wanting an abortion (i.e., medical intervention). This is equivalent to a standard doctor-patient interaction, where a doctor asks a similar question to establish what issue needs to be treated or, put otherwise, establishes the doctorability of the patient (see earlier discussion) But, as Dora is at an abortion clinic, the issue (unwanted pregnancy) ought to be clear. By providing an answer, Dora is forced to justify her reasons for wanting an abortion, citing her personal circumstances, which are financial, and that she is already supporting a twenty-month-old toddler. By doing so, Dora has presented her pregnancy as unsupportable and problematic, and thus doctorable. In one sense, the construction of an unsupportable and problematic pregnancy works similarly to that of any other medical issue. It helps to construct Dora as someone who needs medical intervention and, thus as a doctorable patient. But in another sense, this construction is problematic for women under 13 weeks gestation, as abortions should be performed on request – no doctorability or demonstration of need should be required.

The nurse indicates that she understands the patient's reasoning for requesting an abortion. This serves to acknowledge and legitimize that Dora's situation is indeed problematic and can be addressed through medical intervention. In this way, Dora's positioning as the patient (i.e., someone in medical need) is reaffirmed through the nurse's evaluation of the situation and also serves to position the nurse as an expert on the topic.

An important aspect of constructing patienthood involved the Nurses stating why they would provide abortion services to women seeking an abortion. Below is one example of this.

Extract 2

Site 2 [ID: 14; Patient =Thembisa; Nurse= Pat]

N: Why do you want to terminate your pregnancy, young lady?

P: Because I want (.) I will not be able to (.) because I am studying, because I cannot sit down again and look after the baby and my mom said that she would not be able to look after the baby

N: Why did you not go for family planning?

[…]

N: Is it better not to do family planning and occasionally come here to do an abortion? Which one is better?

P: It is doing family planning

N: Okay, do we agree? (.) Okay, we will help you, young lady because you are coming for the first time and we believe that it is a mistake and we would be failing you if we let you come out of here without giving you any family planning method.

In extract 2, there are two separate segments of talk from the same counselling session. In the first segment, Thembisa is asked to provide a reason for requesting an abortion and, as such, begins the process of constructing herself as a doctorable patient in need of medical intervention (i.e., abortion) – she does this by providing a narrative of why her pregnancy is unsupportable. After the reasons have been provided, nurse Olwethu questions Thembisa about family planning. At this point in the interaction, Thembisa has constructed herself as a patient in need of medical intervention and nurse Olwethu has positioned her, assumingly, as irresponsible for not using family planning, in other words for creating this medical intervention through not using a different medical intervention.

What follows, but has been omitted in the above extract, is a lengthy discussion on family planning. Eventually, we see that nurse Olwethu indicates that she will "help" Thembisa and proceeds to construct the pregnancy as a "first time" "mistake". By doing so, Thembisa is still positioned as an irresponsible patient, but her pregnancy is constructed as a "mistake". In other

words, her situation is due to irresponsible inaction (i.e., inconsistent contraceptive usage) that led to a mistake (i.e., the unsupportable pregnancy). Constructing the pregnancy as a "mistake" evokes normative understandings around mistake-making and how to resolve such errors. Central to the idea of a mistake is the notion of unintentionality – which is the idea that a person did not purposively engage in action despite knowing the negative outcomes. The notion of unintentionality inherent in understandings of mistake-making resolves, to some extent, Thembisa's irresponsible subject position, but it also works to necessitate a solution to "fix" the mistake. Here the outcome of the mistake is an unsupportable pregnancy that can be "fixed" through abortion ("we will help you"), and in addition to this, future prevention of the mistake is done through the nurse making it clear that Thembisa is going to be a given a new method of family planning.

Asking women why they wanted an abortion created one of many opportunities for nurses and counsellors to position themselves as experts, or rather knowledgeable, on the topic of abortion. The below extract is an example of this.

Extract 3

Site 2 [ID:15; Patient= Anathi; Nurse = Pat]

N: So you say because of your situation there's no other=
P: =Option
N: Option for you
P: there's no other option
N: because (.) options there is but you say mos there's no other option .hh and if there's no other option then (.) yes you came to the right place neh .hh so abortion is not an easy thing. You know that. Do you know that ?
P: I feel that

In the above extract, Anathi describes her personal situation as unsupportive of the pregnancy and that there are no other viable options for her. By doing so, Anathi has constructed herself as an informed patient – one who has reviewed all the options and has selected the one which can best address her situation. In response to this, the nurse acknowledges that if Anathi has considered all the options and abortion is the only realistic option for her, then she has come "to the right place". This serves to reaffirm Anathi as a patient (i.e., that abortion, a medical intervention, is chosen to resolve her unsupportable pregnancy) but also works to construct the nurse as an expert as she confirms that Anathi has sought out the correct medical assistance for her pregnancy and situation. Further to this, we see nurse Pat construct abortion as "not an easy thing". This, too, is an expression of the expert subject position that nurse Pat can make due to

her experience providing abortion and through her institutionally relevant role as a nurse. Later in this chapter and throughout the data, we see that nurse Pat explains that she initiates the abortion procedure, whether medical or surgical, with women and goes on to explain the actual medical procedure.

6.2.2 Constructing the abortion procedure (i.e., Medical intervention)

Discussing the abortion procedure, whether medical or surgical, was a topic within pre-abortion counselling that was largely delivered using a medical discourse. Both counsellors and nurses spent a significant amount of time explaining the relevant procedure patients qualified for, depending on the duration of their gestation. Although nurses and counsellors both spoke about the abortion procedure, they did so in different ways. Below is an example of how counsellors described surgical abortion.

Extract 4
Site 1 [ID: C2; Patient = Cece; Counsellor = Tracey]

C: they then go into your vagina with the second procedure (.) which is the procedure they call manual extraction (.) and what they do with manual extraction is that they go into the vagina with a metal tube (.) and they suck the baby out (.) your baby comes out in bits and pieces (1.5) that is usually done between nine weeks and twelve weeks of pregnancy .h for you […]remember that a termination is the termination of the life of your baby

Extract 5
Site 1 ID: 559, Group counselling; 4 patients]

C: […] they push the metal tube into the vagina, into the cervix, into the uterus and they suck the baby out. The baby comes out in bits and pieces ((noise over recorder)) I want to show you a photograph um you're seven weeks six weeks (.) a:nd eights nine weeks okay so your-your um: (3) your babies are of similar (.) size to this photograph I'm going to show you

What is significant about the extracts above is the positioning of the counsellor, the woman/patient and the "baby". In both instances, the counsellor positions herself as knowledgeable and an expert regarding the abortion procedure. She identifies what the method is called ("manual extraction"), what instrument is used ("metal tube") and what the procedure involves ("go into the vagina" and "they suck the baby out"). All of this discursively operates to construct the counsellor as someone who is informed and an authority on the procedure. It is also important to note that sharing information as a practice works to reaffirm women as patients and the counsellor as an expert. Patienthood is also constructed by simply identifying who will undergo the procedure.

In terms of the description of the procedure, the counsellor goes on to explain that "they suck the baby out" (extract 4) and "the baby comes out in bits and pieces" (extract 4). This construction is significant for three reasons. Firstly, "they" in these extracts refer to the health professionals who would be conducting the procedure and not the counsellors themselves. This might be one reason why the counsellors describe the procedure in such graphic detail, as they are not the ones performing it and thus are not directly accountable for what happens during the procedure.

Secondly, the procedure is explained using descriptors which are, at best, partially medical ("suck") and which are explicit in detail ("bits and pieces"). What is problematic here is that the graphic description of the procedure can be read as a discursive scare tactic that operates to catastrophize and awfulize the abortion procedure (Lee, 2003; Sparrow, 2004). In this way, the negative aspects of the abortion procedure are highlighted both for the patient ("consequences") and inferred onto the foetus that is sucked out in "bits and pieces". Through this description, we also see the foetus personified through the signifier "baby". Conferring personhood upon the foetus also positions the woman (also patient) as a mother (Woodcock, 2011) and thus has the potential to produce feelings of guilt and shame over the loss of a constructed "baby".

This type of construction of surgical abortion has very real implications for how women/patients come to view their pregnancy and the abortion procedure. From the above, surgical abortion is a medical procedure which ends the life of an unborn baby through violent means but also denies a woman motherhood. Through this description abortion is indirectly constructed as murder.

In comparison to counsellors, nurses also tended to describe abortion through a medical framework. This often, as I present in the data below, involved them describing the procedure, discussing pain and what the patient could experience during the process.

Extract 6

Site 2 [ID 27; Patient= Lily; Nurse= Pat]

N: Then I will take you to the room where I'm going to clean you .hh you be laying ((instrument noise)) in this position with your legs up put this into the vagina open it up .hh then I'm going to put this (.) ((instrument clapping noise)) cannula
P: Mhm
N: Inside in the vagina into the womb .hh (.) when I'm putting this speculum in I'm also checking (.) whether the tablets have actually done its job it's opening the mouth of the womb (neh)
P: Okay
N: .hh So now I put the cannula in ((instrument noise)) then I'm going to suction out the contents

P: Okay
N: It is painful yes neh
P: Mhm
N: make no mistake about that .hh but what we expect from you is to really try your best to relax this part from the waist down must relax a (bit) once your body is relaxed and the womb is relaxed then we can (.) clean

In the above extract nurse Pat provides an overview of the abortion for Lily. Unlike in extracts 4 and 5 the nurse constructs herself as the one who will conduct the procedure ("I'm going to…"). What we see next is a more medicalised and non-graphic account of the procedure. In this interaction, the "cannula", which is used in the procedure, is physically present and is shown to Lily. By showing the instrument, labelling it, and stating that she will conduct the procedure, nurse Pat has positioned herself as an expert.

The nurse then proceeds to provide information on what the procedure will entail. This description of the procedure involves the nurse entering the vagina and "suction[ing] out the contents". This description is medically accurate concerning how the procedure will be conducted. In comparison to the counsellor's construction, there is no personification of the foetus. In fact, in most of the counselling sessions conducted with nurse Pat the foetus was seldom ever addressed or personified. Rather, the abortion procedure was constructed in purely medical terminology and involved only the patient and nurse (or health service provider).

Overall, nurses tended to provide more physiologically focused information regarding the abortion experience. As we can see in extract 6, nurse Pat mentions that the procedure is painful and goes on to request that Lily tries to relax in order to facilitate an easier evacuation. The introduction of pain is significant because it recognises Lily's/patients' experience during the procedure. It serves as a marker of patient-centred counselling as the experience of the patient is emphasized and acknowledged.

Nurse Pat then proceeds to provide information to Lily that will assist her during the procedure. In this way, Lily, as a patient, is required to play an active role in the procedure and take up the subject position of the compliant patient. It is only through her compliance (relaxing despite the pain) that nurse Pat is able to complete the procedure.

As has been mentioned, nurses tended to spend more time explaining what women would experience physically during the abortion procedure than counsellors. The usefulness of such description worked to normalise the experience of the abortion procedure for patients, as can be seen in the below extracts.

Extract 7
Site 2 [ID 18; Group counselling, Nurse= Pat]

N: you must have a heavy flow right .h and you must (.) you are going to have cramps because (.) it's like giving birth (.) .h you are going to have pains, cramps some of you are going to have blood clots that it is absolutely normal .h because the blood must come out whether it comes out like this .h or whether it comes out in clots but it must come out. Do you understand, ladies?

Extract 8
Site 2 [ID 16; Patient = Linda; Nurse Pat]

C: .hh the Brufen you'll take what eh-eh-eh (.) two tablets three times a day
P: Mh
C: for pain neh .hh then there is a possibility that you will have clots. Do you understand
P: Yes
C: That is very very normal
P: (Oh)
C: for you to have the clots neh

In extracts 7 and 8, the nurse is talking about the physical experiences of going through an abortion. She describes what patients need to experience ("heavy flow" and "cramps") and compares abortion, physically, to "giving birth". This is an interesting comparison as in this counselling group, there was no discussion of parenting. However, it is likely that the nurse had access to each patient's file and was able to identify which woman had given birth previously. This comparison can be understood as an effort on the part of the nurse to try and describe the abortion procedure in a way that could be most relatable to women in that counselling session. In this way, she draws on the potential mother subject position some women may occupy as a frame of reference in order to explain the procedure.

Describing the procedure is a supportive and patient-centred imperative that equips patients with knowledge of the procedure and a sense of expectancy. By doing so, patients have an idea of what the medical procedure will involve and how their bodies will react during the process. The nurse then proceeds to describe the "pains", "cramps", and "blood clots" as "absolutely normal". The presentation of the physical experience as "absolutely normal" is indicative of normalizing labour. Normalising can be understood as the process whereby certain actions, ideas and experiences are reconstructed as normal, natural and expected (Svinhufvud et al., 2017). Normalising the physical experiences of abortion reinforces the construction of abortion as a medical procedure. Many medical procedures involve bodily reactions or changes, and in the above extract, the nurse has worked to frame abortion within

the same medical lens. Through doing so, the procedure is presented as just another ordinary medical procedure with various side effects, all constructed as normal.

Through information provision and normalising the procedure, patients are now not only informed of what to expect but are also reassured that their body's reaction is normal. Normalising physical experiences may also work to mitigate any possible anxiety, or panic women may experience prior and/or during the procedure. A study conducted by Lüllmann and Lincoln (2013) found that a normalising approach to communication proved successful in motivating patients to take up medical treatments. In addition to this, normalizing abortion as a medical procedure also serves to combat the awfulisation of abortion discourse that patients may encounter elsewhere. Within the awfulisation discourse, abortion is constructed as a threat and dangerous to women and "unborn babies" on multiple levels (Hoggart, 2015; Sparrow, 2004). These negative constructs and notions of danger also extend to the procedure, as seen in the counsellors' constructions of the abortion procedure. However, talking about the abortion procedure strictly through a medical discourse is a rhetorical act that provides an alternative lens (i.e., medical lens) for patients to view abortion and their specific situation – one which is a medical issue in need of medical intervention.

It is also important for patients to be informed of what to expect in the event the medical abortion fails to initiate. Below is an example of talk, where nurse Pat explains the severity of side effects and how the patient should react.

Extract 9

Site 2 [ID 19; Patient= Sanele: Nurse= Pat]

C: same with diarrhoea, same with (.) headaches and dizziness .hh it's not suppose to be so severe. DO you understand .hh if it happens then you come to casualty so that they can help you (.) give you medication to stop these things that is making you sick. You understand

P: Yes (.) I understand

In the event of severe side effects, the hope is that, due to being informed, the patient would realize their bodies are not exhibiting the normal side effects, which would prompt them to seek medical assistance to resolve the issue. What is quite apparent here is that the talk is patient-centred and seeks to ensure the well-being of the patient. This is one of the benefits of talking about abortion through a medical lens – by doing so, everything related to it is treated as a medical issue.

6.2.3 Fixing the "problem"

Similarly, to a study conducted by Harries et al. (2009), much of the discussion concerning contraception was embedded in narratives of (self-) failure and inconsistent usage. Within many interactions, patients revealed that they conceived due to some issue related to contraception. These issues were diverse and consisted of non-use, inconsistent use, contraceptive failure (e.g., condom breaking during sexual intercourse) and contraceptives contraindicating with antibiotics. The medical discourse was used to construct a patient's lack of contraceptive usage as problematic but solvable through medical intervention (i.e., various long-term family planning methods). As such, Nurses and counsellors spent time identifying what family planning women were using, how they were using it and suggesting alternative or new methods going forward (i.e., fixing the problem), as can be seen in extract 10 below.

Extract 10

Site 3 [ID 27; Group counselling; Nurse= Olwethu, translated from IsiXhosa]

N: Dear, why did you not do family planning?
[…]
P2: I am saying that I was going to go but I came back late from school and by then, the clinic was already closed
N: You see? In your case, you should have used the long term ones, the implant and the loop. Something that you will put once and know that you will not be having the challenge of not being able to go to the clinic again. Okay, dear?

In the above extract, the inconsistent use of contraception was constructed as the woman's fault and as a failure on their behalf (and not of the system where clinic hours make them inaccessible). This results in women positioning themselves as irresponsible for acting inconsistently when it comes to managing contraception. Such positioning is fundamentally based on the assumption that women should be solely responsible for managing contraception within a sexual relationship. More pertinently, expressing the inconsistency around access and use of contraception makes relevant a particular kind of solution for women who are positioned in this way. Knowing that inconsistent use is an issue, nurses propose the use of long-term family planning, which we can see in the extract 10.

Long term contraceptive methods were strongly suggested by Nurses and Counsellors alike as these methods were constructed as requiring minimum maintenance and monitoring by women. Below are examples of some extracts where long term contraceptive usage is suggested.

Extract 11
Site 2[ID 4; Patient Nwabisa; Nurse= Pat]

N: if I can make a suggestion why don't you want go for the loop in the future. Have you heard anything about the loop or family planning (.) the loop is a (.) device that we can put (.) anyway if you sure you don't children (.)
P: mhm
N: now for the next few years neh
P: mhm
N: because you must still get married I'm just having a suggestion
P: Okay
N: for the loop to be put in. It's for ten years. You can a-remove it at any time

Across the data, nurses suggested long term methods to women, with the most common being the Intrauterine Device (IUD). When providing information about long term contraceptive methods, nurses generally emphasized two things. Firstly, they spoke about how long the method can be used for; this was usually done in years (e.g., "It's for ten years"). Secondly, Nurses highlighted that long-term contraceptives were also reversible (e.g., "you can remove it any time"). The notion of the IUD being reversible was specifically mentioned to women who were unmarried and/or did not have children at the time of the counselling. It also served to highlight the similarities between IUD and short-term methods – that both of them are reversible. In this way, the IUD has all of the positives of short-term contraception but is more economically viable (lasting many years), relatively low maintenance and also reversible. This enabled the construction of long-term methods (i.e., IUD) as both viable and favourable.

Long term family planning was also strongly advised for women who had previously conceived for reasons associated with their contraceptive usage (e.g., non-use, misuse, inconsistent use). Below is an example of this.

Extract 12
Site 3 [ID 1; Patient=Thandi; Nurse= Olwethu, Translated from IsiXhosa]

N: we advise that person to take a long-term family planning method because it shows that you are not reliable for us to trust you on the short-term ones like the pathogen and neristrate. They were there and you failed to use them until you got pregnant, isn't it? So […] we advise that you take the long-term family planning methods. The long-term family planning methods we are talking about here are the implant of 3 years and the loop of 10 years.

In extract 12, the nurse advises Thandi (the patient) to use a long-term family planning method because she is unreliable in managing short term contraception herself (see later discussion on the discourse of responsibilisation). The issue of reliability, or rather the irresponsible subject position, was established previously in the interaction but is drawn on again here ("you have

failed to use them [contraceptives]") as a basis to encourage Thandi to use long term methods. It is due to Thandi's failure with short term methods that she cannot be "trusted", by herself or by the nurse. What this essentially does is undermine Thandi's sense of agency. As such, what we see in the above extract is that long term methods are favoured because they partially remove the human element, or rather responsibility, of controlling for pregnancy. The only agentic action required, depending on the method, is for women to simply select the method they want.

From this perspective, what is problematised is Thandi's inability to manage her own family planning – a common theme across the data. As such, the counselling interaction begins to take on a paternalistic tone that can work to limit Thandi's autonomy in deciding family planning. This paternalistic approach is also rationalized due to Thandi's negative positioning as 'irresponsible' and 'failing' herself. For Thandi, the easiest way of moving into a positive subject positioning would be to take up long-term family planning. This would ensure that she moves from being an irresponsible to a responsible patient.

Nurses and counsellors also strongly recommended the use of dual protection to prevent unintended pregnancies. Dual protection was constructed as the ideal means to protect oneself and involved using a condom with another form of contraception.

Extract 13

Site 1 [ID:C; Group counselling; Patient =Sandi; Counsellor= Sara]

C: If you do not want to have another baby Sandi you need to go on proper contraception (.) such as the injection such as the tablet such as the loop .h and then what you do is you use double protection (.) using a condom on its own is not a highly effective form of contraception (1) because men don't use condoms correctly (.) they don't put it on in time if there's any contact between the genitals (.) any naked contact .h there is a chance you will fall pregnant.

In the counselling session above, Sandi shared that she and her partner were only using a condom. Counsellor Sara responsibilises Sandi not only for falling pregnant but also for not using "proper" and double protection. In this case, and according to the nurse, a condom is not considered a "proper contraception" by itself, as men may misuse it. Here the problem with condoms is that they are used by men and not by women, and as such, their correct use cannot be assured. The nurse explains that the only way to avoid future pregnancy is to ensure that Sandi, herself, uses proper protection, which means using a condom with another form of contraception (i.e., double protection). This narrative around contraceptive usage serves to reinforce that Sandi, like many other women, are individually responsible for managing

contraception within the context of a sexual relationship. This is particularly problematic as it absolves men of any responsibility for managing contraceptive usage and, by implication, the pregnancy that may result. Comparatively, women are disproportionately responsibilised for managing contraception and the resulting pregnancy.

Across the various sites and for both nurses and counsellors, condoms by themselves were often referred to as insufficient to prevent pregnancy. Below is another example of a counselling interaction where condoms and dual contraception are mentioned.

Extract 14
Site 3 [ID 4; Patient= Lerato; Nurse= Olwethu, translated from IsiXhosa]

N: Okay. Listen, you see, people like you who are not (1) who are confused as to which family planning method to use. That is what we assist with, okay?
C: Mhm
N: As much as we will give you the service, we need to fix the mistake that you have done of not using a family planning method. You told yourself that a family planning method is a condom. A condom is not a family planning method, it has to go with something, sister. That things says dual contraceptive, which means two. There has to be a condom and something else.

In the above extract, the nurse constructs the patient's pregnancy as a "mistake" that was caused due to incorrect or inconsistent contraceptive usage. Again, we see the common narrative that a condom is not an efficient contraceptive method; in fact, in this extract, condoms are not even considered to be a type of family planning. This statement may be heard as new information for many women and shift their understanding of condoms. Perhaps there is some confusion around the term 'dual' where women understand the duality of the contraception as in what it can prevent, in this case two separate issues – (1) pregnancy and (2) STDs.

In summation, this section has shown how the management of family planning or the lack thereof is constructed as a mistake by nurses and counsellors. However, through the positioning of women as patient, through a medical discourse, a viable solution to the "mistake" is presented through medical intervention. In this case, the medical intervention is long term contraceptive methods and dual protection, with long term methods being constructed as favourable and effective means of addressing the human error involved in contraceptive management. In addition to this, dual protection is constructed as the proper approach to using contraceptives. All this information is shared in the hope this medical intervention will assist women in avoiding unintended pregnancies and, in particular, abortion in the future.

6.3 Responsibilisation discourse

Talk by counsellors and nurses concerning responsibility was conceptualized as existing in a discourse of responsibilisation. In the data analysed in this study, responsibilisation was deployed not around the decision to have an abortion, but rather to regulate the behavior of women in relation to their sexuality. Responsibilisation as a discourse emphasizes individualism in health care and more specifically, self-care (Petersen, 1996). The responsibility is located within the individual, and thus not to self-care is to be irresponsible.

6.3.1 Responsibilised for conceiving

As has been shown previously, women attending pre-abortion counselling were often asked to account for conceiving. In the overwhelming majority of cases, women indicated that there had been some issue related to family planning, including not using any kind of contraceptive at all, using one kind of contraception method and it failing, medication contraindicating with contraception, lack of transport to acquire contraception and "laziness" in obtaining additional contraception. The following extracts show how contraception in relation to the pregnant woman's pregnancy was spoken about:

Extract 15
Site 3 [ID 001; Patient= Thandi; Nurse= Olwethu, translated from IsiXhosa]

P: I also want to terminate it because I am still young, I will not be able to take care of a child
N: That is why when a young person starts dating they should use family planning methods, young lady. Do you realize now that you have failed yourself? Eh? What grade are you in?

Extract 16
Site 3 [ID 04; Patient= Lerato + Nurse Olwethu, translated from IsiXhosa]

N: You simply failed yourself, finish. When you do not prevent, then that means you should not be engaging in sexual intercourse with a man. What do you expect when you had sexual intercourse with a man while you were not using any family planning method? How can you not get pregnant? (.) Mhhh? Because in the end you get pregnant. You have a child, right? What did you think you were doing now? Mhhh?

In both the above extracts, pregnant women are constructed as irresponsible subjects who have failed themselves by conceiving as a result of non-use of contraception. Nurse Olwethu in extract 16, is attempting to get the patient to account for this irresponsible subject position and to acknowledge the responsibility for conceiving. She does this by asking a series of rhetorical questions "What did you expect … not using family planning?", 'How can you not be pregnant?" and "you have a child right?". The use of the pronoun "you" in each of the questions calls for the patient to account. The content of the questions makes the irresponsible subject

position indefensible and, at the same time, serves to castigate women. The last question implies that because the patient is already a mother, she should know how pregnancy works. Considering this, the patient is constructed as an irresponsible subject, who, despite having knowledge regarding pregnancy, still conceived an unintended pregnancy.

Across counselling sessions, talk was deployed which responsiblised women not only for the current pregnancy but for preventing future unwanted conceptions as well, as can be seen below.

Extract 17
Site 2 [ID: 16, Patient= Linda; Nurse= Pat]

N: Ohh well .hh and why aren't you using anything else except a condom (.) because condom is mos to prevent neh
P: Mh hm
[…]
N: .h so (.) what are you going to use for family planning now because you must use something

Extract 18
Site 1 [ID: 556; Patient= Khule; Counsellor= Sara]

C: so you need to make sure that if you don't want to have another baby (2) don't allow your husband to impregnate you (2) it's not fair on life and it's not fair on your husband either (2) if you if you value your relationship with your husband (.) then you will have this discussion before you're pregnant with his baby (2) you won't have pregnancy aborted and then discuss it, that's the wrong way of doing it (1.2) you're an adult woman you need to take responsibility for a life
[…]
C: so going forward (.) try to make better choices for your life Sandile

In extract 17 nurse Pat enquires about what contraceptive is being used other than a condom (" why aren't you using anything else except a condom"). By doing so, nurse Pat responsibilises patient Linda for her current pregnancy, but also extends the responsiblisation to preventing future pregnancies ("you must use something"). The statement "you must use something" provides no room for disagreement from Patient Linda. It is presented as factual and given.

In extract 18, Kuhle is responsibilised through being positioned in two ways. Firstly, she is positioned as responsible for preventing pregnancy ("don't allow your husband to impregnate you") – a position that is deeply gendered as it assumes that women, and women alone, are responsible for preventing pregnancy. Secondly, she is positioned as responsible for ensuring the maintenance of a good heterosexual relationship and for looking after her husband by

making sure that life is not 'unfair' ("it's not fair on your husband either") on him. In both these positionings, Kuhle is constructed as needing to take more responsibility "as an adult woman".

6.3.2 Responsibilised for the abortion procedure

Considering resource constraints and the positioning of the women as irresponsible in needing abortion services, nurses tended to place responsibility for care during the abortion procedure on the women. This was a subject position that focused on women playing an active role in their abortion procedure, usually through self-monitoring. Below are some examples of this.

Extract 19:
Site 3 [ID 23; Patient= Jane; Nurse= Olwethu, translated from IsiXhosa]

N: You will take the pills for every 4 hours. If [there] first 4 hours ends and the baby has not come out, you ask for more pills. If the baby still has not come out, you ask for more pills again. You will stop asking for more pills once the abortion has been done. The abortion will happen on its own you will not be helped to give birth as you were helped when you were having that baby.

Extract 20
Site 3 [ID 001; Patient= Thandi; Nurse Olwethu, translated from IsiXhosa]

N: It is your duty there, young lady, okay? You will be given the first pills. After being given the first pills, you count 4 hours. After 4 hours, it is your duty to go to the nurse and say, "Sister, the 4 hours has ended, please give me more pills." Do you understand? Until the foetus comes out. You do that every time after 4 hours. If the foetus has come out it is you again who will tell the nurse that, "Nurse, it seems as if something has happened now." Do you understand? Because that is a ward and there are sick people there. The sisters… that is a gynae ward. Some have womb problems. People have very serious sicknesses. You understand, right? And therefore the nurses focus on that most of the time. Do you understand? You are not sick, right

In extract 19, the nurse describes the process followed when having a medical abortion. She focuses on the importance of taking the medication "every 4 hours". In this extract, there is a repetition of the patient's responsibility throughout the process (e.g., "you ask for more pills", "you ask for more pills again", "You will stop asking for pills when …"). The patient's role in the process is made clear and repeated multiple times. In addition, the patient cannot also expect the same level of help as she received previously during childbirth ("as you were helped when you were having that baby").

In extract 20, the nurse begins describing the procedure by positioning the patient as an agent who has a "duty" to play in the procedure. By doing so, she constructed the patient as playing

an active role in her own procedure. The nurse proceeds to explain that the patient's responsibility is to ensure that she takes a tablet every four hours "until the foetus comes out". The nurse then elaborates and positions the pregnant woman as not sick, or at least as not as sick as the other patients "who have very serious sicknesses", which requires the nurses to focus on them most of the time. By taking this into consideration, the responsibilised patient is then understood as an actor who can play a central role in their own medical treatment in order to ensure that nurses are available for other patients. This is potentially problematic at one level as the nurse has created a hierarchy of deservedness when it comes to medical attention, but at the same time could be deemed understandable as many public health facilities in South Africa are greatly under resourced. Seen in this way, the responsibilised patient is a subject position inherently embedded with the context in which the abortion procedure is taking place. In addition, framing Thembisa as responsible for her own abortion calls into question the real sense of abortion as a doctorable intervention.

6.3.3 Abortion as avoidance of parental responsibilities

During pre-abortion counselling, there were key conversational moments where available options were presented to pregnant women and sometimes discussed further. One of the options that the counsellors always raised at Site 1 was the option to continue the pregnancy and for women to become a mother.

Extract 21
Site 1 [ID C; Group counselling; Counsellor= Sara]

C: your second choice could be to be to be a mum and to look after this baby .h um to come-to stand up to the responsibility that you have-are faced with and to be a mother to a child which god has already got plans for.

In the above extract, the counsellor provides the potential subject position for the pregnant woman to become a "mum". In this instance, motherhood is constructed as a responsibility that the pregnant woman is "faced with". This responsibilisation to parent is further compounded by the counsellor drawing on a religious discourse (discussed in the following analytical chapter) that creates a narrative that the unborn child (as constructed by the foetal-personhood discourse, also discussed in the next chapter) is part of God's plan. These two discourses have placed the pregnant woman in a vexed position. If she opts to have an abortion, not only is she declining the responsibilities of parenthood, but she is also denying God the chance for their

plan to come to fruition regarding her pregnancy. Of course, it is difficult to ascertain to what extent the religious discourse may be effective in such a situation and what impact this may have on individual women and their decision-making. Nonetheless, it can still be considered as a rhetorical strategy that constructs abortion in a negative light, where selecting it results in the pregnant woman taking up multiple negative subject positions, which ultimately constructs her as irresponsible and ungrateful (to God).

The linking of responsibilisation to parent with the "God has a plan" narrative was a common feature at site 1, as is seen in the extract below:

Extract 22
Site 1 [ID 559; Group counselling, patient= Sophia; Counsellor= Sara]

C: To become the mother that god has planned for your life .h you may have not wanted this pregnancy (.) but if you didn't want it seriously you would have made sure you used proper prevention (.) now you have this baby and now you gotta make a decision with this baby

In this extract, counsellor Sara is providing the option for Sophia to become the responsible mother "god has planned" for her while foregrounding how it was only her irresponsible use of contraception that got her into her current situation. As such, Sophia is fundamentally blamed for conceiving. More importantly, the counsellor states that if Sophia was not serious about becoming pregnant, then she would have used proper contraception. This is a critical discursive moment as the counsellor has rhetorically refashioned the way in which the pregnancy is understood. She draws attention to Sophia's irresponsibility in falling pregnant. By doing this, she has used the responsibilisation discourse to reframe the conditions/situations (i.e., irresponsible use of contraception) resulting in the pregnancy, which could work to also reframe how the pregnant woman thinks of her pregnancy and her decision to abort.

6.4 A discourse of risk

The discussion of risk is a common feature in medical interactions. Medical professionals, such as nurses and doctors, are tasked with presenting risk information (Elwyn et al., 1999) with respect to a patient's unique situation, and the same can be said for those women who present themselves for abortion. The sharing of information pertaining to risk often includes the weighing of different options (Edwards et al., 2002) and their particularities. Sharing this information on the risk of abortion in counselling interactions was a common conversational activity.

The risks involved in having an abortion were a component of the counselling interaction that received, in most cases and across all sites, much attention. Pregnant women were constructed as at risk as they were the individuals seeking an abortion. Across the three sites, the risks associated with having an abortion were identified as being either (1) *physical risks* and/or (2) *psychological risks*. In addition to this, counsellors and nurses tended to emphasize the temporal nature of these risks, as in they are future outcomes based on certain decisions. The temporality of risks was spoken of in relation to short term and long-term consequences. For example, and as I will show below, death was constructed as potentially immanent (short term), whereas other risks (future infertility and psychological issues, such as depression) were presented as existing in the future, post-procedure, but nonetheless a consequence associated with abortion. In this way, having an abortion equates to the possibility of having future difficulties. Each of these risks will be explored in terms of how they featured within the risk discourse during the interactions.

Information regarding the risks of having an abortion were usually discussed verbally, but there were many instances where risks were addressed through an information sheet which the nurse or counsellor would read out themselves (e.g., site 1) or which was given to the patient and they were expected to read it themselves (e.g., site 2).

6.4.1 Physical Risk

When talking about risk, counsellors and nurses described the physical risks that were specifically related to having an abortion. Physical risks were subdivided into three kinds, the risk of: (1) *developing breast cancer*, (2) *becoming infertile* and (3) *dying/death*. Each of these is explored below.

6.4.1.1 Breast Cancer. The narrative of breast cancer as a possible risk in having an abortion has gained much public traction and is often cited as a factual outcome of having an abortion. It has been operationalized as part of the anti-abortionist's rhetoric and used to dissuade women from having an abortion (Gold & Nash, 2007). However, in contrast to such claims, research has been conducted and has convincingly shown that "spontaneous or induced abortion does not increase a woman's risk of developing breast cancer"[33] (Collaborative Group

[33]This study consisted of 53 epidemiological studies, including 83 000 women with breast cancer, from over 16 countries.

on Hormonal Factors in Breast Cancer, 2004, p. 1007). Another recent study found that "pregnancy loss was not associated with later cancer development" (Mikkelsen, 2019, p. 80).

Breast cancer as a physical risk of having an abortion was only brought up during the pre-abortion counselling interaction at Site 1, where the sessions were conducted by external and qualified counsellors. Below are some key extracts:

Extract 23
Site 1 [ID 16; Patient= Sophia, Counsellor = Tracey]

C: […] you also exposing yourself to the possibility of developing breast cancer as you get older. So there-these are very real .hh =mhm= side-effects

Extract 24
Site 1 [ID 17; Patient= Sophia; Counsellor= Sara]

C: If you have a termination (.) you more likely to develop breast cancer when you get older (.) .h um so those are important things to understand that you become susceptible which you wouldn't necessarily be susceptible (.) um if you didn't have a termination (.)

Extract 25
Site 1 [ID CG2; Patient= Cece, Counsellor= Tracey]

C: If you have a termination and you are more likely to develop breast cancer (.) if you have a termination (.) these are side-effects (.) that are genuine (1) and are factual (1.5) take that into consideration when you decide to do what you're about to do

In the above extracts, we see the construction of breast cancer as a long-term risk that could potentially occur in the future. Abortion is presented as increasing the likelihood for pregnant women to develop breast cancer, particularly when they are older. The risk of abortion leading to breast cancer is presented as "very real", "genuine", and "factual", and a risk that they wouldn't "necessarily be susceptible" to had they not had an abortion. Importantly, through talking about breast cancer in this way, two subject positions in relation to risk become available and are intricately intertwined with the pregnant woman's choice. On the one hand, pregnant women can take up a responsible subject position which actively avoids the risk of breast cancer by choosing not to have an abortion. However, to avoid this risk, pregnant women are coerced into choosing to continue the pregnancy, a decision which may not be their own. On the other hand, if a pregnant woman opts for an abortion, despite being informed and forewarned, then she takes up the subject position of "risk-taker", and any negative

consequence that she experiences will be attributed to her decision to have the abortion – in this way the pregnant woman is responsibilized for her own risk and is discursively positioned as a victim of her own choice/ decision-making.

6.4.1.2 Infertility. Unlike breast cancer, infertility was a physical risk mentioned at all the sites, albeit in different ways. Infertility was constructed as a future risk, and as such, women were often required to contemplate their decision and the future regret they may experience. It is important to note that research has shown that when abortion is conducted in a sterile environment by a trained medical professional, there is minimal risk of infertility (Upadhyay et al., 2015; Zolot, 2018). Below are examples of how infertility was brought up across the three different sites.

Extract 26
Site 2 [ID 003; Patient= Kuhle; Nurse= Pat]

N: .hh ah you may have problems falling pregnant in the future
P: Ya
N: and the way it's happening is because .hh with your ovaries giving of the egg and ovulationevermonth .hh you never know whether this was your last egg
P: Mhm
N: to ever have another baby understand .hh you understand that one
P: I do

Nurses tended to identify infertility as a problem and explain how the patient could experience it in the future. For example, in extract 26, nurse Pat states that Kuhle might have "problems falling pregnant in the future" and then, drawing on her positioning as a medical expert, proceeds to explain that future infertility could be due to the patient not producing any more eggs in her ovaries. In this way, abortion is not constructed as the actual cause of infertility, but rather the inability to produce more eggs.

When talking about infertility, counsellors and nurses sometimes deployed a narrative that required patients to think of their infertility in the future. Extract 27 is an example if this.

Extract 27
Site 3 [ID 23; Patient= Jane; Nurse= Olwethu, translated from IsiXhosa]

N: You are 20-years old and your future is still long. You will get married and want children, get a job and have your own money and want children, and children will not come. And [you will] not be able to get any children. Or it might happen that while you are pregnant, you get a miscarriage. Or you womb might get injured while it is being cleaned. Do you understand these things?

In the above extract, the discussion of infertility first focuses on the patient's young age and that she might not be able to have children in the future due to her womb being injured during the abortion procedure. Even in the case of possible pregnancy, miscarriage is forecast. Nurse Olwethu works discursively to put the issue of infertility and miscarriage into perspective for the patient. Although she may not want a child now, she might want one in the future when she has a "job", is "married" and has "money". What nurse Olwethu has done is constructed the "ideal" (heterosexual, conjugalised) conditions under which childbearing is acceptable. However, because of something the patient has done in the past (i.e., the decision to have an abortion now), she has effectively risked her future fertility within these ideal conditions. In this way, infertility is constructed as a risk which is situated in the future and not an immediate risk, such as death which is discussed below. It calls for the patient to consider her decision and the possible regret and disappointment she may experience in the future – this explored discussed further in chapter 6, which covers the pronatalist discourse.

6.4.1.3 Death. There were two cases where the risk of dying was brought up in the interaction. Interestingly, the word 'risk' was not often deployed when talking about the risks, side effects and consequences of having an abortion. Out of the four consultations where the word 'risk' was used, in two of them 'risk' was associated with death. The following quotes show this:

Extract 28
Site 1 [ID 17; Patient= Akhona; Counsellor= Tracey]

C: So there's that option, then there's of course termination which is risky to your body. You can see in the consent form it says you can die (.)
P: Ya

Extract 29
Site 3 [ID 110 001; Patient= Cebisa; Nurse= Olwethu, translated from isiXhosa]

N: So what is the risk about?
P: A risk maybe… I die
N: Mhhm

In both the above extracts death is introduced into the consultation as a risk that is shared through the consent form, which pregnant women are expected to read and sign. In extract 28, counsellor Tracey begins to talk about the physical risks of abortion and instead of starting with some of the minor risks she emphasises immediately the most extreme risk, that of dying. In

this way, the counsellor is constructed as merely the one who provides information, whereas the patient is constructed as the one who is at extreme risk.

In both these extracts, death is mentioned once-off with no exploration or further discussion. There was no effort on behalf of the counsellor or nurse to provide mitigating information such as that death is extremely rare in induced abortions, and that, based on recent empirical research, abortion is found to be markedly safer than childbirth (Raymond & Grimes, 2012), or that during the procedure medical doctors will be on standby to assist in the event of an emergency. The inclusion of death as a risk in pre-abortion counselling serves to identify and highlight, for the patient, the most extreme physical risk, thereby constructing abortion as something to be avoided at all cost.

6.4.2 Psychological trauma/post-abortion syndrome.

Across all the sites, nurses and counsellors acknowledged that seeking and having an abortion may be a difficult process emotionally. Nurses and counsellors often asked if patients had family or friends to whom they could talk or knew of places where they could go for emotional support. Research focused on patients' emotional responses to abortion has acknowledged both negative (e.g., regret, anger, guilt) and positive (e.g., relief, happiness) emotional responses to abortion are normal (Rocca et al., 2020). Research has also further shown both negative and positive emotions tend to decline over time (Rocca et el., 2015).

Throughout the counselling sessions, nurses and counsellors framed emotional talk in a way that focused primarily on the negative aspects, particularly in relation to the trauma, as can be seen in the extract below.

Extract 30
Site 3 [ID 0021; Patient= Tuli; Nurse= Olwethu, translated from isiXhosa]

N: Even psychological, and trauma. You might get mentally disturbed. And we might see you being a little maniac here because of this.

Extract 31
Site 3 [ID 001; Patient= Thandi; Nurse= Olwethu, tanslated from isiXhosa]

N: There can also be psychological trauma.

In extract 30, nurse Olwethu refers to a "little maniac", which is likely being used to imply a psychotic episode of some sort. What is interesting to note here is that the word "maniac" is

not a medical term but is used as a deprecating colloquial term to emphasise the possible psychological consequence of abortion.

Counsellors often referred to the psychological risks of having an abortion. Independent counsellors referred to Post-Abortion Syndrome (PAS) when discussing the psychological risks and effects of having an abortion, as can be seen below:

Extract 32
Site 1 [ID T16; Group counselling; Counsellor= Tracey]

C: umm two out of three ladies who have terminations develop what is called Post- abortion syndrome. They become very sad, they become very depressed, they're guilty they feel guilty ((Sophia sniffs)) they feel remorse, they have feelings of umm rejection from society because they feel as if they've done something horrible and umm it is so umm it is such a nasty condition that even in the psychological terms they've named it the post umm abortion syndrome and and people go for counselling, severe counselling in order to deal with emotions

Extract 33
Site 1 [ID 556; Patient= Khule; Counsellor= Sara]

C: and when you have a termination ((cough cough)) two out of three ladies develop what is called post abortion syndrome (.) feelings of um sadness or depression of suicidal thoughts .h women become so .h depressed that they end up going to psychologists to try to help them through .h this post abortion um period of time that has caused such conflict in their lives .h so (.) having a termination is a big deal there're a lot of consequences a lot of(them) emotional .h but there also a lot of physical .h

The above extracts are from two different sessions but cover similar content regarding post-abortion syndrome. This simple comparison highlights the scripted nature of pre-abortion counselling, whereby counsellors, and nurses, feel that certain information needs to be covered and they try to ensure that it is.

PAS, as a risk, was presented as a legitimate psychological condition that involved various negative emotional consequences. As is described above, PAS, according to the counsellors included feeling “remorse”, “sadness”, “guilt”, “self-loathing”, “depression”, and “suicidal thoughts”. In addition to this, when independent counsellors introduced PAS they often led in with the crude statistic that “two out of three ladies” develop the condition, yet backed this claim up with no empirical evidence. The use of statistics could have been one attempt by the counsellors to solidify the existence of PAS and thus render it incontestable.

PAS was constructed as a legitimate and severe psychological condition that requires professional intervention –“go for counselling, severe counselling”. The counsellor has taken

a whole series of negative emotions and carefully inserted them into a branded psychological condition. Importantly, PAS is dependent on pregnant women actually going through with the abortion. Thus, on the one hand, if the patient is to decide against abortion, she is avoiding the extreme psychological hardships associated with PAS. However, on the other hand, if she opts to have an abortion, then she is seen as subjecting herself to psychological harm (Lee, 2003).

The legitimacy of PAS is also of great concern. Although PAS is presented as a factual syndrome, it is not formally recognised as a diagnostic category within any recognised medical diagnostic system, including those associated with the "American Psychiatric Association, American Psychological Association, and the American Medical Association, each [of which] decline to recognize PAS as a legitimate psychiatric disorder based on an overwhelming lack of credible scientific evidence" (Husain & Kelly, 2017, p. 575). However, despite its lack of legitimacy, it is still used in current abortion provisions (as evidenced in extracts above). This is particularly problematic as talk of PAS focuses attention on the abortion itself and ignores the context and other socio-cultural realities in which the pregnancy is experienced (Kelly, 2014); it also tends to invoke a complex politics of the foetus one wherein the foetus is often personified (Macleod, 2009). In addition, the quality of counselling is also part of the context. Talk that responsibilises, blames and catastrophises (i.e., emphasising negative physical and psychological effects) can, in and of itself, contribute to negative emotions following abortion.

6.4.3 Presenting multiple risks

Psychological risks (e.g. PAS) and Physical risks (e.g. infertility, breast cancer and death) were deployed within the wider discourse of risk and, as such, were often presented in the encounter together, as can be seen below:

Extract 34
Site 1 [ID 561; Group counselling; Counsellor= Tracey]

C: umm two out of three ladies who have terminations develop what is called Post- abortion syndrome … you must also remember that if you have a termination you are exposing yourself to the possibility of not having another baby again (.) and you also exposing yourself to the possibility of developing breast cancer as you get older.

The risk discourse and the presentation of risks worked hand-in-hand to construct abortion as threatening in multiple ways. The position of being at multiple risks has implications when considered in relation to the choice discourse and how they may feature interdiscursively in the interaction. Furthermore, risks are not only considered multiple but are presented as existing in the short term (e.g., death) and long term (e.g., breast cancer, future infertility). This highlights the power of the risk discourse in terms of dissuading women from having an abortion.

6.5 A discourse of support

Support is a dynamic concept that takes on a different meaning depending on the context in which it is to be explored. The psychological literature on social support identifies four distinct types, namely; (1) emotional, (2) instrumental, (3) informational, and (4) appraisal (Usta, 2012; Willis, 1991; Wu et al., 2018). In the following section, I identify and unpack instances of support talk.

Multiple instances of talk about support and supportive practices appeared in the sessions. One of the most interesting features of support was how it was introduced into the interaction, as seen below.

Extract 35
Site 2 [ID 5; Patient= Anathi; Nurse= Pat]

N: hey (.) do you have someone perhaps that you can talk to that you trust .hh if things get too much for you because .hh maybe you not going to feel it now but when it does get to you ( ) is there someone that you can trust
P: maybe here
N: to talk
P: Mhm
N: family, friend
P: Ya I talk with my friends because my family is too far now
[…]
P: mh
N: you can always go to your nearest clinic there's a psychologist there
P: mh
N: .hh then they do assist if you want to just talk because sometimes it's just good to talk you know
P: yes
N: there just verbalise your feelings seeing how you feel and how it affects you .hh because um some people do get depressed after a while neh
P: Yes ( )
N: because this is absolutely not an easy thing

In the above extract nurse Pat introduces the topic of support into the interaction, and more specifically, emotional support. Across the data, it was always either the nurse or counsellor who introduced the topic of emotional support. Nurse Pat, in extract 35, asks the patient if she has someone trustworthy whom she can trust and talk to. In this case, the patient indicates that she does. The nurse also adds that the patient can seek support from her nearest clinic, where there is a psychologist. By doing so, the nurse has provided referral information of where the

patient can receive social support if she finds she needs it in the future. However, at this point, it is still unclear why she would need support.

The nurse's description of support entails the patient talking to another person and "verbalise your feelings" because some women do become "depressed" afterwards (abortion). What follows is the nurse describing abortion as "absolutely not an easy thing". In this case, abortion is presented as an experience that is difficult and has the potential to have some psychological effects. As such, support (i.e., talking to another person) is constructed as a possible way of dealing with the possibility of psychological outcomes (i.e., depression). In summation, what we see above is the nurse making the topic of support relevant, describing what being supported would involve (i.e., talking to another person about your feelings), why it is useful (i.e., because abortion is not easy) and where one can access this type of support. Here, the type of support that the patient is receiving is more informational/educative than direct emotional support – this was the primary way in which support was spoken about between nurses and patients.

6.5.1 Offering support

Although not common across the data, there were instances where counsellors spoke about the support that they provided. This was primarily done by the independent counsellors and was in response to what patients had just said, as we can see in the below extract.

Extract 36
Site 1 [ID 16; Patient= Sophia; Counsellor= Sara]

P: I don't even know what to do now
(1.5)
C: You know if you don't know what to do the best thing to do is nothing for a while (.) think about it don't rush into decisions you might regret for the rest of your life. That's why we here (.) to offer hope, to try help you mal-make your decision, your decision remember it's yours, that we maybe just guide you a little bit to make some wise choices when you feel like you can't cope. Like (if) you're feeling desperate, confused, anxious (and don't know) what to do .hh that's why we're here. Just because we really care (.) and I think realizing it's twins is such a double gift. It's almost like yoh

In the above extract, the patient makes a statement that she is unsure of what to do. By doing so she has positioned herself as an undecided patient. This subject position is problematic in the interaction because a decision, eventually, needs to be made by Sophia. In response to this, what unfolds next is a discussion of the emotional support provided by the counsellor. In relation to the patient's statement and her reflective positioning, the counsellor responds

through providing some advice. She does this by suggesting that the patient wait a while before making a decision and not to rush into it. This piece of advice is justified as it seeks to avoid the patient running the risk of making a regretful decision, which can be considered a negative subject position. However, it is important also to highlight that for many patients, time is of the essence – too long of a delay in decision-making has very real implications for that procedure they qualify for (i.e., medical or surgical), and if left for too long can result in abortion no longer being a legally viable option. The counsellor's suggestion to wait and to do nothing for a while can simultaneously be read as a viable option and a delay tactic. It may work as a delay tactic as, through further information and some contemplation, Sophia may decide against abortion or possibly even miss the cut-off for abortions on request, or even second trimester abortions.

The advice given is centered around decision-making and the guidance and support the counsellor can offer. We see that the counselor affirms that it is the patient who is responsible for making the decision. This can be considered as support talk as it positions the patient as the sole decision-maker and serves to reaffirm the patient's autonomous agency regarding her situation. It is also indicative of a counselling approach which, at least in this segment of talk, is patient-centred as the power to make the decision is acknowledged as being solely the patients.

There is also a philosophy of care being introduced by the counsellor, which works to position her as a support provider. She describes her role as one which is to "help" and "guide" the patient to "make some wise choices". We cannot say with certainty what exactly the counsellor means by this. However, when read within the context of the full interaction, it appears that what constitutes a wise decision is one wherein the patient is in a correct state of mind and not experiencing any inner turmoil – the exact opposite of what Sophia is. The assumption here is that a person who is going through personal and emotional difficulties cannot make a "wise" decision and thus needs guidance to help navigate through these hard times – which is what the counsellor offers to assist with.

The imperative here then is to try and shift Sophia's subject position from undecided and unknowingness to informed and rational through offering support. In this way, Sophia is constructed as someone who is in need of support and the counsellor is constructed as someone who, according to her own descriptions, can provide the needed support. The importance of support for Sophia's situation is also highlighted when the counsellor makes mention of

Sophia's multiple pregnancy. In other words, if support is constructed as something required for a single pregnancy then, in the situation of a multiple pregnancy the logic would follow that it is even more warranted.

Exchanging contact details was a supportive action in counselling sessions conducted by nurses and independent counsellors. It was a supportive gesture that communicated to patients that help was available if they needed any. The exchanging of contact details, mainly mobile numbers, was primarily done near the end of the counselling and was mainly concerned with ensuring that patients understood the procedural information shared, as can be seen below.

Extract 37
Site 2 [ID 19; Patient= Sanele; Nurse= Pat]

N: Do you want my cell number
P: Yes
((Shuffling noise))
N: here you are
P: Thanks

Extract 38
Site 2 [ID 17; Patient= Lerato; Nurse= Pat]

N: Okay .hh I'm going to give you my number neh
P: (.)
N: that is just for in case you are unsure right
P: Okay
N: When you phone me you going to tell me who you are, what I gave you, when I gave it to you and what have you experienced right .hh
P: Okay

What is interesting in extract 37 is that the nurse offers her personal cellphone number to patients and not the casualty or clinic's number. In extract 38, the nurse provides her cellphone number if the patient is unsure of anything. Through this simple, supportive gesture, the nurse is demonstrating a patient-centred approach to counselling, one where informational support is ongoing even after receiving treatment. It is also reassuring for patients to know that if they do need any support, they have direct access to a nurse, but more importantly, they have access to a person with whom they are familiar.

There were also instances where counsellors requested the cellphone numbers of patients in order to follow up with them, as can be seen in the below extract.

Extract 39
Site 1 [ID 17; Patient=Akhona; Counsellor= Tracey]

C: So I want you to go home and just really really think about this and what will be best for you ((sniff)) and maybe chat with ((audio recorder switched off – prolonged silence))
(.)
C: because its huge (news) what is your due date my girl. Do you know?
P: No
C: So it was just a scan
P: Ya
C: do you mind if I just take your cellphone number then I can follow up with you
P: okay

In the above extract, counsellor Tracey suggests that Akhona goes home and contemplate her pregnancy and what decision to make. In this counselling interaction, Akhona has already expressed why she wants an abortion. However, the counsellor's closing advice is for her to reconsider her decision. What is different here is that the counsellor requests Akhona's cellphone number and not the other way around. Counsellor Tracey justifies this request by stating that she would like to follow up with Akhona. This is a supportive gesture, but in this case, Akhona is unable to reach out for support from the counsellor. From this perspective, Akhona only has the option of receiving support reactively, whereas in extract 38, Lerato, having the nurse's cellphone number, was able to request support and thus access support proactively.

6.6 Conclusion

In this chapter I provided a detailed analysis of the discourses that in some way or another relate to the medical component of pre-abortion counselling. I started this by showing how the medical discourse was used by nurses and counsellors to construct women who present for abortions as patients. This is done by identifying an issue (i.e. unintended pregnancy) and constructing it as something that can be solved through medical intervention (i.e. abortion). However, in order to do so much labour is required on behalf of the patient to perform her pregnancy and personal situation as warranting an abortion.

I also demonstrated that in using a medical discourse, nurses and counsellors were able to establish and maintain a subject position of expert. This was largely achieved through information dissemination regarding how the abortion procedure would occur (i.e., medical or surgical). It was also through information sharing of the procedure that counsellors and nurses

were able to construct a version of abortion – this varied from being relatively graphic to roughly medically accurate. Contraceptives as a medical intervention were also highlighted as key behavioural changes that women needed to adopt in order to avoid future unintended pregnancies and, potentially, abortions.

The responsibilisation discourse showed how nurses and counsellors used the narrative of responsibility to regulate the behaviour of women in relation to their sexuality. This involved chastising women for falling pregnant due to contraceptive misuse and trying to discursively and, through behaviour, shift them from an irresponsible subject position (i.e., contraceptive misuse) to one of responsibility (i.e. will now use contraceptives effectively through LARC).

Following this, I drew attention to how risk was introduced into the pre-abortion interaction as a discourse. Notably, I identified that the risk of abortion was emphasised in terms of its physical (i.e., Breast cancer, infertility and death/dying) and psychological (post-abortion syndrome) threats to the patient's well-being. Not only was inaccurate information shared when risk was discussed, particularly around breast cancer, infertility, death and PAS, but it also worked to leave women in a precarious subject position in relation to the decision they would make. On the one hand, to choose to have an abortion is to potentially risk one's well-being on a physical and psychological level; however, to continue the pregnancy is to face the socio-personal issues that initiated the patient to seek an abortion in the first place.

In closing this chapter, I focussed on support and how it was spoken about within the counselling session. The topic of support was made relevant as abortion was constructed as "not an easy thing" and could be emotionally difficult for patients. I illustrate how nurses and counsellors offered support through exchanging contact details with patients.

In the next chapter, the last analysis chapter, I examine the discourses that focus on women, motherhood and the foetus. In doing so, I discuss how talk of choice is introduced into the interaction and inter-discursively works with discourses of religion and foetal personhood.

Chapter 7: Discourses that focus on Woman and the foetus

7.1 Introduction

In this chapter, I present my analysis of four discourses that are thematically related to constructing pregnant women and the foetus. A common topic in relation to abortion is the issue of choice, including under what conditions women are empowered or restricted to make their own reproductive choices. Choice was a dominant topic of talk within the pre-abortion counselling interaction. I refer to talk of this nature as a discourse of reproductive choice; it is the first of the four discourses I present in this chapter. My aim is to provide analytical insight into how choice, or rather the various choices with which the women were presented, were constructed and communicated during counselling. There are three main elements of this discourse, which appeared in my data, that I present in this section. The first element is the *individualization of choice*. Within this element, decision-making is located at an individual level, and autonomous decision-making is reaffirmed and encouraged. I show how this individualization ignores the contextuality of pregnancy (i.e. seeing pregnancy as purely an individual experience rather than embedded within a myriad of interpersonal, social, cultural and economic realities) and how women are encouraged to decide through a process of information provision followed by deep contemplation.

The second element of this discourse focuses on *choice and consequences*. Here women were not only constructed as responsible for selecting an option regarding their pregnancy but were also responsibilized for the potential physical and psychological (discussed in chapter 5) risks they might experience due to their decision. As presented in the previous chapter, risks were exclusively discussed in relation to abortion and not in relation to continuing the unwanted pregnancy. The last element of this discourse is about the *morality of choice*, which was addressed within the counselling interaction. In this section, I show how morality, which is underpinned by Christian values, is deployed within the interaction. In addition to this, I also present instances of talk where patients acknowledge their legal right to have an abortion and how this causes trouble within the interaction and leads to a discussion between the counsellor and patient concerning ‘legal rights’ and ‘moral rights’.

The second section of this chapter explores religious discourse. As has been mentioned in the introduction and methodology chapter, the counsellors at Site 2 were associated with a Christian organization and drew heavily on a religious discourse throughout the interaction.

One of the major indicators that a religious discourse was being deployed was by counsellors using certain religious signifiers such as “praying”, “God”, “Blessings” and the “sanctity of marriage”.

The pronatalist discourse is the third discourse of focus in this chapter. The pronatalist discourse fundamentally takes parenthood, and by implication, children, as something that is inherently desirable (Meyers, 2001). This sentiment is echoed in my data as I unpack how *motherhood is constructed as the preferred choice* out of the three viable options presented to women in counselling (e.g. (1) continued pregnancy and mothering, (2) abortion and (3) continued pregnancy and adoption). I show how parenting was promoted and how a religious discourse was interdiscursively used to not only support pronatalism but also to construct parenting as part of “God’s Plan”.

Within this discourse I also go on to show how children were constructed as *bringers of joy and fulfilment* into the lives of parents; this, by implication, enables potential children to be positioned as *wanted subjects*. The ‘wantedness’ of children and parenting were put into perspective when counsellors emphasized the privilege of pregnancy by comparing patients’ situation to others who were childless, and “desperate” to have a child. These two elements of the discourse worked to reinforce childrearing as inherently positive and intrinsically desirable. In addition, some counsellors also engaged in talk that *downplayed the hardships of parenthood*. I present segments of talk that highlight how parenthood was described in primarily positive ways. Talk of this nature enabled the problematic assumption that if having children does not entail hardships, then there is no need to have an abortion.

The foetal personhood discourse is the fourth and final discourse that I discuss in this chapter. I explore the two key strategies counsellors used to construct the “foetus” as a person. The first strategy involved *describing the morphological characteristics* of the foetus. Counsellors would describe the foetus both in terms of physical characteristics (e.g., arms, legs, hair) but also in terms of its functionality or rather animation (e.g., beating heart, lung capacity, ability to breathe). Often photographs from a brochure or a small ‘educative’ model were present during the explanation. The second strategy involved the use of the signifier “baby” when talking about the foetus. I explore how the use of the signifier “baby” worked not only to confer personhood upon the foetus but also to position patients as already mothers.

7.2 Reproductive Choice discourse

The notion of choice is a central tenet of both liberal feminism and the reproductive justice movement. Choice and autonomous decision-making are also core principles enshrined in the CTOP Act and have been a controversial theme in abortion debates globally. Choice is often understood as essential to bodily autonomy, but the idea of choice can also be limiting when it is seen as an individual activity separated from the social context. In some cases, the social context may severely restrict the options available, which essentially makes "choice" no choice at all. .

Throughout the data, transparent and frequent instances of discourses of choice and rights were deployed by both counsellors and patients. Talk about choice often involved talk about rights and vice versa. This can be expected as the CTOP Act in South Africa not only stipulates that abortion is a right but also that the choice to have an abortion (i.e., decision-making power) is that of the woman alone (i.e., autonomous decision-making).

Below I explore how choice and rights were constructed in the interactions. I do this by looking at how: (1) the individualization of choice is constructed in the interaction, (2) this individualization not only places responsibility on women to make a decision but also requires them to accept responsibility for potential consequences, and finally (3) choice is discussed as a moral issue, and how morality enters into the interaction.

7.2.1 Individualisation of choice

Across the data set, choice was often individualized, constructed as "unfettered" and isolated from the social context in which women were experiencing their pregnancies. This construction of choice is particularly problematic as it ignores the contextual conditions (e.g., economic resources, gender relations, culture, social norms etc.) in which a choice is made (Chiweshi et al., 2017; Marecek et al., 2017, Petchesky 1990). Without acknowledging these societal realities, choice is constructed as something that is easily made by a pregnant woman – a decision made independent of society and the social context. Both nurses and counsellors re-affirmed for women that the decision that they were about to make, or already had made, was completely their own, as we can see in the below extracts.

Extract 1

Site 3 [ID 23; Patient= Jane; Nurse= Olwethu, translated from isiXhosa]

N: It has to be your own decision, not your boyfriend's, not your mother's. Do you understand, young lady?

Extract 2
Site 2 [ID 3; Patient= Lerato; Nurse= Pat]

N: good .hh the decision to undergo this procedure was purely my own and did not involve the counsellor in anyway
P: Mhmm
N: So this is your own (it) didn't involve me
P: yes this is my own decision
N: .hh ya
P: hh
N: although the involvement of father, parent, guide(nt) was suggested by the counsellor the final decision to be solved was left to you
P: to me (.) Yes=
N: and you absolutely sure about it
P: sure about it

Autonomous decision-making, which indicates an effort to adhere to the principles of reproductive rights enshrined in the CTOP Act, was often emphasised by counsellors and nurses. Here, decision-making has been constructed as occurring on the individual level. Although the nurses in extracts 1 and 2 put forward the possibility of including other parties (e.g. "boyfriends", "mothers", "father, parent, guardian"), the final decision is left to be made, or in the words of the counsellor "solved", by the patient. This construction of choice celebrates the autonomous decision-making right of women regarding their pregnancy. The possibility of including other parties talks to the point that the decision may be one that is difficult and that close relatives or partners can offer support or assistance to help the patient in making her decision. It also could refer to the possibility of third parties coercing the woman into having an abortion, about which she may be ambivalent or actively against. From another perspective, constructing the decision-making as a purely individual activity might also serve to remove all accountability from parties, including the nurse ("So this is your own, it didn't involve"), and to firmly locate it on the shoulders of the patient.

Nurses and counsellors were not the only ones in the interaction who emphasized the individual level of decision-making. Some patients were aware of the laws governing abortion in South Africa and made reference to them in the session, as can be seen below.

Extract 3
Site 2 [ID P1; Patient= Noxi; Nurse= Pat]

P: I need to be strong because I have to finish my studies and all of that and since I'm doing Law .h it has changed the way I'm thinking (cause) they say you must not confuse .h the morals

and Law so they-since the abortion (pregnancy) is legal and there's nothing wrong about it if you have valid reasons then it's fine

In the above extract, the patient draws on a legal understanding of abortion to validate her reason for seeking an abortion. Using a legal understanding, the patient not only justifies her reason to have an abortion (i.e., it is legal) but is also indirectly implying that the decision to do so is hers. In this way, the patient has positioned herself as an 'informed patient' to the extent that she is aware that abortion is a legal and acceptable choice for women to make. However, this self-positioning was rare across the data; it is interesting that Noxi, in this case, attributed her position to her engagement with Law through her studies. In fact, studies conducted in South Africa still reveal that many people are not fully aware of their rights to safe and legal abortion under the CTOP Act (Macleod et al., 2014; Ramakuela et al., 2016)

Although the choice was constructed as primarily an individual one, the final decision was constructed as one that patients should arrive at through a process of reflection and deep-processing of necessary information (e.g., risks, relevant procedure). In other words, the final choice should not be rushed into, as can be seen in the below extracts.

Extract 4
Site 3 [ID 23; Patient= Jane; Nurse= Olwethu, translated from isiXhosa]

N: So I am giving you this date so that you can go back and think thoroughly, whether it is really necessary for you to do this after hearing all that has been said about it, okay?

P: Yes

N: Then if you feel like you have to do this no matter what, you come back on the date that I will give you. But if you feel like you want to keep your baby and do family planning that is still up to you. It is your decision. We do not force anyone, okay? And if you do not come back on that date that I will give you, I will not call to ask why. Do you understand, dear? Eh-eh. So I am giving you a chance to go and think at home.

Extract 5
Site 3 [ID 003; Patient= Lerato; Nurse Olwethu, translated from isiXhosa]

N: Even after you have heard about these things, we give you a chance to go home and decide whether you really want to continue after this procedure after you have heard about all its complications and risks, okay? So if you still want to continue on the 9th of September you will come back and do the abortion. If you do not want to continue we will see by you not arriving.

In the above extracts, a period of reflection/contemplation is constructed as a necessary process before making a final decision. The logic here is that the patients now have the information on

complications and risks to self-govern responsibly (Macleod, 2006). This assumes that patients are rational decision-makers and that, with information and sufficient consideration, they will arrive at a choice that is best for them (Peterson, 1999).

In extract 4, the use of the word "necessary" ("whether it is really necessary") and the phrase "no matter what" work to frame abortion as a possible but not preferred choice. In contrast, continuing the pregnancy is also presented by the counsellor as something the patient may "want" to do. In both these cases, the counsellor has constructed the choice as one which is made solely by the patient through the use of the pronoun "you" (e.g., "If you feel like", "you want to keep your baby", "is still up to you"). Further to this, the counsellor assures that "we do not force anyone". This serves to reaffirm that the choice the patient will make is hers and hers alone. What has been presented here is a neo-liberal[34] understanding of choice, whereby the patient's individuality has been upheld through (1) suggesting contemplative reflection, (2) personalising choice through the use of the pronoun "you", and (3) affirming that she will not be forced. In doing so lends a subtle and covert dimension of coercion.

6.2.2 Choices and consequences

In discussing choice in the interaction, women were also asked to consider the possible outcomes their decision may have on them both physically and psychologically (see chapter 5, where this was discussed in detail). Instances such as these highlighted the intersection of choice, risk and responsibility discourses. Below are extracts which illustrate this.

Extract 6
Site 1 [ID 559: Group counselling; Counsellor; Tracey]

C: […] it is your decision for the three of you (1.3) it's your right (2) but remember that even though it's your right (2) you will have to live with the knowledge that you've taken the life of your baby away (.) yourself (5) this is a big decision that affects you forever

In extract 6, we see the deployment of both a choice ("your decision") and rights ("your right") discourse, where patients are constructed as having an unfettered autonomous choice to have an abortion. However, directly after that, the counsellor issues a caveat that there are consequences associated with the choice to have an abortion. In this case, the consequences presented are ending the life of the patient's "baby", a decision which, according to the

[34] Neoliberalism as I have used it here refers to political ideals which inform various aspects of healthcare, such as decentralization of healthcare, the operation of a free market (e.g. privatization and derugluation) and most relevant, the emphasis on individual freedom and the expression of one's choice freely (Harvey, 2005 as cited in Glasdom et al., 2015; McGregor, 2001)

counsellor, will affect the patient "forever". The construction of the effects of abortion as long-lasting is significant because it adds an important aspect for consideration. It works to re-enforce the idea that deciding to have an abortion is, indeed, a "big decision", and possibly awful. Through this framing both choice and the resulting consequences are constructed as directly linked to the patient's decision. In this way, to choose abortion is to also choose negative consequences, which further works to responsibilize women not only for their decision but how they experience life post-abortion.

The consequences of women's choices were also spoken about in more overt ways and in relation to various types of risks (see chapter 5 discussion of physical and psychological risks) as can be seen in the below extract.

Extract 7
Site 1 [ID 17; Patient= Sophia; Counsellor= Tracey]

C: you have a baby that is growing inside of you .h and you are <u>now</u> making a decision (.) on what to do about the life of this baby .h there are going to be huge psychological, spiritual and emotional consequences (.) as a result (.) of your decision for yourself .h it is your choice (.) you will make the choice but you will also need to deal with the consequences

Extract 7 is a common exemplar in the data of how choice, risk and responsibilization discourses intersected. In this extract, the patient is positioned as not only being responsible for deciding regarding her pregnancy but also responsible for "the life of this baby". Through this construction, the woman is positioned as the custodian of the unborn foetus. This works to decentralize the consequences of the decision away from the woman. Instead of the woman making a decision about her pregnancy, she now has to consider the life of the "baby". In this way, the choice is no longer woman-centred but rather foetus/"baby" centred.

In extract 7 we also see an overt description of "psychological, spiritual and emotional consequences". This works to construct the risks of abortion as many, ultimately affecting every aspect of her life. The counsellor highlights that it is the patient's choice but also that she would need to deal with the "consequences". At this point, the patient has now been constructed as (1) a decision-maker for herself, and the "baby", (2) at risk (if she opts for abortion) and (3) responsibilized for any consequences due to her choice. All of this builds a compelling case against abortion as a viable choice. In other words, for the patient to avoid risks and consequences, she must choose not to have an abortion. Because autonomous decision-making is valued, or rather tolerated, in reproductive health in South Africa, counsellors and nurses

counteract the use of neo-liberal discourses[35] (i.e., choice discourse) by deploying them alongside other competing discourses (i.e., awfulisation of abortion) that construct abortion in purely negative terms, thus implicitly engaging in directive counselling practice.

The forewarning of possible consequences of abortion was a common activity in most counselling sessions. Counsellors spent substantial time and effort sharing this information and, in some instances, even offered guidance to patients. The below extract focuses on one of the more specific consequences of having an abortion, namely 'regret', and how the counsellor offered guidance.

Extract 8
Site 1 [ID 17: Patient= Akhona; Counsellor= Sara]

C: You know if you don't know what to do the best thing to do is nothing for a while (.) think about it don't rush into decisions you might regret for the rest of your life. That's why we here (.) to offer hope, to try help you mal-make your decision, your decision remember it's yours, that we maybe just guide you a little bit to make some wise choices when you feel like you can't cope.

In extract 8, the consequence of focus is that of regret. Here, regret, or as Kimport (2012, p. 106) defines it, "abortion regret", is constructed as a negative consequence caused by some loss (e.g., unborn foetus, motherhood). This loss is fundamentally based on the assumption that women always attach to their pregnancy (Kimport, 2012), and their pregnancy has an inherent positive value. This attachment can occur on multiple levels (e.g., emotional, psychological, social, and spiritual). In this extract, it is clear that the counsellor is suggesting that having an abortion (i.e., terminating the valued pregnancy) could result in experiencing feelings of regret post-procedure (i.e., caused by loss). Not only is regret assumed to be a negative emotion, but it is also constructed as long-lasting ("rest of your life"). To avoid regret, the patient is encouraged to think about her situation and not to "rush into decisions".

Regarding choice, we also see an instance of guidance being offered by the counsellor. Macleod (2006) highlights how pastoral guidance involves caring for and guiding the members of the flock. Caring and guiding are demonstrated using words such as "offer hope", "help you", and "guide you a little". The offered guidance is also presented as something that could prove helpful if the patient feels they cannot cope. In addition, guidance can also involve warning members of the flock of potential risks and consequences (Macleod, 2006), which is

[35] Here neo-liberal discourses are conceptualized as constructing patients as rational, autonomous decision-makers that exist in a context where they are entitled various rights and enjoy freedom (Dean, 2002).

illustrated in extract 8 concerning regret but in all the extracts that talk about choice and consequences. It is important to stress that pastoral guidance mostly occurred in sessions conducted by independent counsellors affiliated with a Christian organisation.

7.2.3 Choice and morality

The talk about choice and selecting an option often featured some talk relating to the morality of abortion. Most of the discussion concerning the morality of abortion occurred in counselling sessions conducted by independent counsellors. In addition, there were instances where morality was not explicitly spoken about, but the moral stance of counsellors was made clear through their talk and how they constructed abortion. The below extract is an example of a patient introducing morals into the counselling interaction.

Extract 9
Site 1 [ID C; Group counselling, patient= Fundiswa; Counsellor= Sara]

P: […]since I'm doing Law .h it has changed the way I'm thinking (cause) they say you must not confuse .h the morals and Law so they-since they pregnancy is legal and there's nothing wrong about it if you have valid reasons then it's fine
C: mhm
P: Ya and I (do not mix) it with emotions
[…]
C: Mhm .h you know Fundiswa um (1) I: accept the fact that you-it is your right it is according to the rules of this country it is your right to have a termination
P: *yes*
C: .hh but one of the things you might need to understand as a human being is that just because something .h you have the right to do something
P: Mhm
C: doesn't mean it is the right thing to do
P: to do (.) yes
C: .h and so it is not sensible to remove emotion .h from a highly emotive um behaviour .h and circumstance that is occurring in your life right now .

In extract 9, Fundiswa provides an account of her view of abortion. She understands abortion from a legal perspective, citing how one should not confuse morals and the law. Fundiswa goes on to demonstrate her knowledge of abortion law within the South African context and has positioned herself as an informed patient, at least at a legal level. Furthermore, she adds that she does not "mix it [her decision] with emotions, " which creates trouble within the interaction.

The troubled talk in the interaction cues the counsellor to engage in pastoral guidance again, with the objective being to indicate to the flock, in this case, the patient, the error in their ways

and to correct their path. Here there are two things that need to be corrected: firstly, to affirm that legal rights are not tantamount to moral rights, and secondly, that it is "not sensible to remove emotion" from decision-making. Fundiswa's removal of emotion is constructed as a potential threat (i.e., "not sensible"), and as such, the counsellor seeks to warn her against removing it from the decision-making process.

When talking about the morality of choosing to have an abortion, counsellors often deployed a discourse of individuality which centred on the idea of the patient getting to know themselves – i.e., engaging in self-management through the technology of self-knowledge (Macleod, 2006). This often involved the counsellor requesting the patient to consider their personal morals, ethics and situation. Below is an extract illustrating this:

Extract 10
Site 1 [ID C2; Patient= Cece; Counsellor= Tracey]

C: it is your choice you get to decide (.) on whether you want to have this (.) baby or not .h but just because it is your right (.) does not mean it is the right thing to have an abortion (1.4) you have to listen to your inner voice .h you have to listen to your morals and your ethics as a human being .h and you have to decide (.) whether what you have here [points to head] is the same as what you have here [points to heart], so that you are able to make the decision that's going to affect you positively in your life

The argument that legal rights are not the same as moral rights is followed by a call for the patient to take into consideration her "inner voice", "morals" and "ethics" and to ensure that the decision she makes is one where there is no inner conflict. Here, not only is decision-making ("your choice") individualised, but so is the morality of actual decision/choice. The counsellor calls for the patient to reflect personally and find a choice that aligns with her feeling (i.e., the heart) and her personal circumstances (i.e., the head). If the patient can decide with no inner conflict, her decision will ultimately have a positive effect on their life. However, the underlying implication is that this is not possible with abortion.

Extract 10 is also an indication of a head-and-heart approach to counselling (Joffe, 2013) which attends specifically to the patient's emotional well-being. This applies to the whole abortion process. In this instance, we see the counsellor call attention (in both extracts 9 and 10) to the importance of emotion during decision-making, particularly when considering the morality of the choice to be made. From this perspective, a woman's moral choice is constructed as consisting of her personal circumstances and her internal beliefs and values.

Interestingly, when counsellors refer to “the right thing” and “morals”, there is an assumption that women will understand what they mean (as if there is a common notion of what is right and moral). In other words, no framework for considering morals is directly referred to. However, independent counsellors often started the session by stating they were from a Christian organization. As such, counsellors identify their position as Christians and thus it can be inferred that to speak about morals and what is right is to do so through a Christian framework (unless otherwise stated).

The morality of the choice could also be called into question by getting patients to consider their decision temporally, as can be seen in the below extract.

Extract 11
Site 1 [ID 556; Patient= Khule; Counsellor= Sara]

C: One day when you look back on your life in five years’ time .h and look back and you think (.) mt did I do the right thing (.) chances are (.) that you may regret it ((loud noise))(2) the chances that you will regret (.) keeping your baby are very little (.) you're a mother already

In the above extract, the counsellor puts forward a hypothetical situation where the patient is to reconsider her decision five years from now. This is a problematic rhetorical strategy as it shifts the event through time and personal circumstances. When the patient made her initial decision, she was embedded in a particular time within a specific web of personal circumstances, and it is based on these that she would have made her decision. It may very well be that her decision was the “best” decision for that moment in her life. However, getting the patient to reassess that decision, even hypothetically, is a request to evaluate that decision but within a different time and set of circumstances. In addition, the talk about regret constructs it as something inherently negative that overshadows its normality. In other words, although regret is a negative emotion, it is also common, normal and experienced by many people in various aspects of their lives (Major et al., 2009; Mookamedi et al., 2015).

In this extract, the “right thing” or moral thing to do is to continue the pregnancy. This moral stance is communicated quite clearly when the counsellor associates abortion with future regret. Comparatively, the counsellor also states that continued pregnancy (i.e., choosing to mother) is less likely to result in regret of the pregnancy. This is further argued by making

reference to the patient's status as a mother already. In this sense, the patient knows what to expect if she has to continue the pregnancy. However, there is no frame of reference available for the patient regarding abortion. What has essentially been constructed here is the known versus the unknown, right versus wrong.

7.3 Religious discourse

A religious discourse predominantly featured in counselling sessions that were conducted by independent counsellors associated with the Christian organization. This section presents extracts of the religious discourse featured during pre-abortion counselling. I do this by focusing on how (1) religious descriptors (i.e., "blessing" and "God's plan") were deployed and (2) how religious discourse also overlapped with the conjugalisation of reproduction discourse. The conjugalisation of reproduction discourse constructs reproduction as occurring as a natural and expected part of being in a marriage.

It is also important to emphasise that a religious discourse did not feature as often in counselling sessions conducted by nurses. In these interactions, the patient introduced talk of religion as a topic that nurses did not spend much time on. Often, nurses would suggest or remind patients that there were counselling networks they could access to help them provide religious support.

7.3.1 Religious descriptors

One of the features of the religious discourse was the reference to key religious activities, such as; prays/praying, blessings, the Bible and God. Independent counsellors either positioned themselves as Christian by directly stating so ("I am a Christian") or through their talk and use of religious discourse. It was through positioning themselves as religious that counsellors constructed meanings associated with abortion, its risk, pregnancy and parenthood. These are presented below in the following extracts:

Extract 12
Site 1 [ID 17; Patient= Akhona' Counsellor= Sara]

C: […] my value system is from the Bible, I'm a Christian. I don't say you have to run your life like that but it's worked for me (.) and we take our values from the Bible and we believe God gives life and that precious gifts and he knows you from when you were formed.

Extract 13
Site 1 [ID: 16; Patient=Sophoa; Counsellor= Tracey]

C: […] I have counselled so many girls of every culture, my own culture, that struggled with - after terminations (.) cause when God puts that baby in your stomach, he also puts it in your heart and now its babies

There are numerous references to religion in the above extracts. In extract 12, the counsellor clearly positions herself as a Christian and how it, as a belief system, has "worked" for her. This serves as an interactional caveat that ensures that the counsellor cannot be blamed for proselytizing. Further to this, the counsellor constructs the foetus as significant, as life was bestowed upon it by God ("God gives life"). Explanations of this sort can challenge patients' conceptualization of their pregnancy and the foetus.

Continuing in extract 12, the counsellors who drew on the religious discourse tended to construct the foetus as "precious", "special", and a "gift" from God — constructing the foetus as a gift evokes normative understandings of gift giving and receiving. In the above extracts, the pregnant woman is constructed as someone who has been given a "precious gift" from God. Gifts are generally thought of as something given to another person out of appreciation or due to some special event (e.g., birthday, graduation); usually, the intent of the gift-giver is to celebrate something positive in another's life. In the above extracts, the gift giver is God, an entity which is understood, by followers of the faith, as all-knowing and divine – an entity who can bestow upon others the gift of life, and in this case, the unborn "baby". In relation to this, pregnant women are positioned as the gift-receiver. Following the traditional role of the gift receiver, one should be grateful and accepting of the gift. However, in this case, to decline the gift (i.e., opt for abortion) is not only to go against God's plan but to decline the gift of life. In this way, choosing to have an abortion, as is located within the religious discourse, is seen as going directly against God (i.e., committing a sin). As such, choosing to abort the pregnancy means that patients are not only positioned as gift-refusers but also as potential sinners who are deviating from God's plan for them and the unborn foetus.

Talk of babies as "special gifts" and "double blessings" were common descriptors which featured multiple times in a counselling interaction. Below is another example of the use of these descriptors.

Extract 14
Site 1 [ID 17; Patient=Akhona; Counsellor= Sara]

C: You need to just go home and be quiet ((sniffing)) and haaah ((slight laughter)) just really

absorb all this knowledge now. These special gifts because I mean not (.) many m-everyone's blessed with a baby and to be blessed with two, is a double blessing. So I want you to go home and just really really think about this and what will be best for you.

In extract 14, the counsellor is not directly stating that the patient should not have a termination of pregnancy. Instead, the decision-making process is placed with the patient and constructed as taking place within a context of deep contemplative thinking (e.g., "go home and be quiet" and "really really think") and gifts and blessings. In this extract, the counsellor has successfully constructed the patient's double pregnancy as a "blessing" and ultimately something desirable. The position of the counsellor regarding the termination becomes indirectly clearer: motherhood is preferable to abortion.

The religious discourse also positions the pregnant woman as "blessed". In extract 14, the counsellor constructs the woman as "doubly blessed" as she is experiencing a twin pregnancy. Once again, the word "blessings" has ties to understandings of religion: a blessing is something positive given to one through God. Defining pregnancy as a blessing is to construct it as an experience which is positive and enjoyable. The counsellor has discursively defined the pregnancy in a primarily positive manner. In this way, the counsellor's understanding of the pregnancy is pitted against the pregnant woman's experience of her pregnancy, which, in most cases, is not positive.

Counsellors also mentioned praying a few times across the data. In most cases, praying was spoken about as an activity which preceded a major event, for example, making a decision or moments before one was to undergo an abortion procedure. This can be seen in the below extract:

Extract 15
Site 3 [ID:23; Patient= Jane; Nurse= Olwethu, translated from isiXhosa]

C: […]You should be here by 8 o'clock. Do you understand, dear?
P: Yes
C: And then we pray with you, when we finish praying we prepare your things. The doctors will admit you when they arrive. Do you understand, dear?

In extract 15, we see the display of a pastoral counselling approach evident in the offer to pray with the patient. This is evident not only through religious discourse but also through the proposed action of praying with the patient through the abortion process. It is an important statement interactionally as it suggests to the patient that abortion is an option that can be taken

up, and if it is, the patient can still expect assistance from the counsellors. In this way, the counsellors have reaffirmed their position as helpers and individuals who offer support to a woman in need.

7.3.2 Religious discourse and the conjugalisation of reproduction discourse

There were also instances of talk where a religious discourse would dovetail with the conjugalisation of reproduction discourse, as seen in the extract below.

Extract 16
Site 1 [ID: 556; Patient= Khule, Counsellor= Sara]

C: […] you and your husband (.) have got their God authority (.) to have a child together (.) this is where the s-sanctity of marriage
P: Mhm
C: is when God wanted [where] babies to be born (.) so they can create a family for this child.

Within the conjugalisation of reproduction discourse, childbearing and parenthood are legitimised only within the context of a marriage (Macleod, 2003). In extract 17, childbearing is constructed as something which occurs within a marriage (i.e., "you and your husband") but is also presented as having religious significance (i.e., "God authority", "Sanctity of marriage"). The inclusion of how childrearing, within the religious conjugal context, creates a family for both parents and child. The dovetailing of a religious and conjugalisation of reproduction discourse has implications within pre-abortion counselling. Using the two discourses, as seen above, reinforces childrearing within the marriage context. It essentially feeds into the traditionalist assumption that married women should have children and become mothers – and to do so is to adhere to the sanctity of marriage and God's plan for babies to be born.

Interestingly, the conjugalisation of reproduction discourse only appeared in counselling sessions where the patient had disclosed their marital status. In sessions where the patient was unmarried, there was little talk of non-conjugalised single childrearing. I suspect that counsellors feared constructing single parenthood as difficult or challenging (in fact, and as I present in the section below, counsellors would actively downplay the hardships of parenting) as it might further reinforce patients' decision to have an abortion.

7.4 Pronatalist discourse

A pronatalist discourse constructs childbearing, raising children and parenting in primarily positive ways. To draw on this discourse in the pre-abortion counselling interaction generally meant referring to motherhood in positive terms. The deployment of this discourse worked to get women to consider their choice as either opting to become fulfilled as a mother (to another child) or declining that opportunity. Motherhood, within the pronatalist discourse, is constructed as a valuable and fulfilling experience and thus operates as a "powerful incentive for [women] to procreate" (Morison, 2011, p. 183).

In this section, I identify and unpack the key elements of the discourse based on how they are featured in the data collected. The first element is how motherhood is constructed as the preferred choice in relation to adoption and abortion. As I illustrate below, this is achieved by unequally describing the options. The second element concerns how counsellors talk of children as bringers of joy and fulfilment. This talk was predominantly positive and worked to construct motherhood as a desirable option, irrespective of the context in which the pregnancy took place. In addition, constructing children as bringers of joy reinforced the next element of the discourse: children as wanted subjects. As children were constructed as bringing joy and fulfilment into the parents' lives, they were easily positioned as wanted subjects, particularly in regard to the role they enable (i.e., parenthood/motherhood) and in enabling God's plan. Downplaying the hardships of parenthood also featured and worked to present parenthood as a predominantly positive experience, particularly in comparison to abortion or adoption. These elements are unpacked in more detail below.

6.4.1 Motherhood as the preferred choice

The pronatalist discourse generally featured when counsellors were discussing the available options with the pregnant woman and was deployed more often by independent counsellors than nurses. For example:

Extract 17
Site 1 [ID 16; Patient=Sophia; Counsellor= Tracey]

C: You second choice might be to become the mother even though your partner is not ready or even though your partner is rejecting you, even though your partner is not supporting you the way that you want him to support you

Extract 17 is evidence of the power behind the idea of becoming a mother. Here, the counsellor has acknowledged the circumstance of the patient's pregnancy (i.e., "partner not ready, partner rejecting you") which were discussed previously in the session. In this instance, the counsellor

uses the notion of 'motherhood" (i.e. to become the mother) to dismiss these challenges. This implies that the power of the idea of becoming a mother is sufficient to overcome these hardships.

Where motherhood was brought up in the counselling session, there was a strong emphasis on the identity component rather than the activities associated with being a parent (e.g., looking after the child, supporting it financially and emotionally, and personal and social sacrifice). This is illustrated in the extracts below.

Extract 18
Site 1 [ID 561; Group counselling; Counsellor= Sara]

C: second choice might be to keep your baby (.) to become the mother that God has planned for your life

Extract 19
Site 1 [ID: C; Group counselling; Patient= Sindy; Counsellor= Sara]

C: um your second choice could be to be to be-a mum and to look after this baby .h um to come-to stand up to the responsibility that you have-are faced with and to be a mother to a child which God has already got plans for .h remember there a lot of people Sindy that um try to have babies and they can't (.) they try to conceive .h um they don't fall pregnant they try to carry a baby .h the baby doesn't last long and they miscarry (.) .h so I-it is a consideration that perhaps this baby was meant to be (.) we are only here you and I because of the choices that our parents made .h

What is interesting in the above extracts is the choice of the words "become a mother" rather than "give birth to the child" or "bring the child up". The word mother works to invoke all the cultural understandings and responsibilities of motherhood (e.g., selflessness, caring, being supportive etc.) (Maisela & Ross, 2018). The counsellor constructs continuing the pregnancy and becoming a mother as a "responsibility" and in line with God's plans. In this way, the counsellor provides two possible subject positions for the pregnant woman to take up. The first subject position is that of a mother. The alternative subject position is not specified but implied – a person who shirks on their responsibilities and goes against divine plans.

In extract 19, motherhood is constructed as a privilege for Sindy, and the counsellor does this by comparing Sindy's pregnancy to other women's infertility or miscarriages. As such, Sindy's pregnancy (and specifically the chance to become a mother) is constructed as inherently valuable, rarefied and unattainable for some. This exemplifies how the pronatalist discourse operates – to promote motherhood and childbearing.

Within extract 19, the counsellor provides external explanations to support the continued pregnancy by using phrases such as "God already has got plans for" and "perhaps this baby was meant to be". Here, religious discourse is interweaved and works in tandem with a pronatalist discourse. It is important to note that both these discourses value motherhood and procreation. By referring to the pregnancy as God's plan, the social realities in which the pregnancy was conceived and is currently being experienced are invisibilised and trumped through religious discourse. Although the pregnancy may not have been part of Sindy's plan, it is, however, a part of God's, and in that way, the pregnancy is constructed as possibly part of Sindy's destiny.

7.4.2 Children as bringers of joy and fulfilment

When discussing the option to continue to parent and for the pregnant woman to become a mother, counsellors constructed babies as entities that bring "joy", "happiness" and "fulfilment" into the lives of those who will allow it. The below extracts are exemplars of such talk:

Extract 20
Site 1 [ID 561; Group counselling; Counsellor= Sara]

N: there some people who cannot have babies and so what happens is that your baby could be a joy, a happiness and can be fulfilment for that family who would be desperately wanted a baby but who can't have (2.8) so think very carefully it is your choice

Extract 21
Site 1 [ID 556; Patient= Khule; Counsellor Sara]

C: the chances that you will regret (.) keeping your baby are very little (.) you're a mother already
P: *mhm*
C: you know what your nine year old means to you know what that child um the value the fulfilment and the purpose and the love that you feel

Extract 22
Site 1 [ID 16; Patient= Sophia; Counsellor Tracey]

C: and um I can be almost be very certain that your joy and happiness and purpose in life comes from that little seven year old
P: Ya that's true

In extracts 20, 21 and 22, the "unborn baby", as established using the personhood discourse, is constructed as an inherently valuable entity. Using the examples of actual children and of adoptive parents, the "unborn baby" is constructed as a potential bringer of only the most

positive emotions such as “joy”, “happiness”, and “fulfilment”. The cost, the difficulties of raising children and parents’ ambivalence about children are not referred to at all. These positive descriptors potentially influence how pregnant women come to think of their pregnancy and the consequences of the decision they make (i.e., going through with an abortion). Wanting to experience these positive emotions simply requires the woman to continue her pregnancy and ultimately become a mother. In this way, the pronatalist discourse is used to construct motherhood as a childbearing experience full of only positivities that a child can bring.

In extract 21, the counsellor uses the examples of existing children to emphasize further how positive having another child will be for the patient. Regarding cultural understandings of motherhood, it would be virtually impossible for the woman to disagree. The reinforcement of children as bringers of joy is also seen in extract 22, where the counsellor has described how the patient’s “joy”, “happiness”, and “purpose” comes from her child. What we see next is agreement from the patient. To refute the counsellor’s claim would only allow the patient to be positioned as a bad mother.

In contrast, choosing an abortion amounts to a life where a woman is not a mother and thus cannot experience all those positive emotions as described by the counsellors. Put differently, to be happy and content; a woman must go through with her pregnancy, whereas opting for abortion is for the woman to choose the dreadful state of childlessness (or fewer children).

7.4.3 Children as wanted subjects

Counsellors and nurses often ask pregnant women to consider their situation in relation to other women who are unable to have children (i.e., childless). – “you have seen women from your communities who are unable to have babies, right?” (Site 3, ID 28). Considering future childlessness was also brought up in the interaction when counsellors and nurses discussed the possibility of future infertility.

It was through drawing attention to those who were childless that counsellors and nurses were able to construct children as wanted subjects and to further construct motherhood as desirable. As shown above, childrearing and becoming a mother are constructed as valuable and fulfilling experiences. However, this also has implications for how one considers the alternative – childlessness. Throughout counsellors and nurses' talk, those who are childless were described as being “desperate” to have children, as is seen in the below extracts:

Extract 23
Site 1 [ID 16; Patient= Sophia; Counsellor= Tracey]

C: Once those sixty days are up your baby then becomes um adoptable and that's when a family who are desperate to have a baby but who can't have a baby they will then take um control. They will have that baby um as their own and um you will no longer be financially or psychologically or emotionally umm attached (.) to that baby. It will then be adopted by some other family member.

Extract 24
Site 3 [ID: 002 1; Patient= Tuli; Nurse= Olwethu, translated from isiXhosa]

N: You should know that abortion is not the only thing that you can do. There is also adoption. Some people are desperate for children.

Extract 25
Site 2 [ID: 004; Patient= Nwabisa; Nurse=Pat]

N: Is there no nothing that I can say .hh is there anything that I can say .hh that will change your mind. Say for instance .hh that there is a (.) adoption options no neh . That if you carry the baby you can give the baby to someone who desperately wants one

In the above extracts, nurses and counsellors describe those who cannot have children as "desperate". Interestingly, across the sites, counsellors and nurses never specified who exactly is desperate, as can be seen in extracts 23, 24 and 25, where descriptors "families", "people" and "someone" are used. There is no mention of specific sexes or genders who are more desperate than the other. This is a subtle and powerful nuance to this type of talk as it implies that both parents are desperate to have children, further reinforcing childrearing/parenting as deeply desirable. In other words, it is not only women who want children but also men and the broader family. In this way, children and childrearing are constructed as innately wanted.

Desperateness works subtly within the pronatalist discourse. Those unable to have children are desperate as they seek "fulfilment", which is only attainable through having a child and entering into parenthood. Conversely, those who can have a child (i.e., pregnant women in the pre-abortion interaction) but opt for abortion are considered unappreciative and ultimately decline the socially valued role of the parent. Thus, two subject positions are created and pitted against each other – the people who cannot have children (i.e., the childless) and those who don't want children but are pregnant (i.e., the fecklessly pregnant). The childless deserve sympathy, while the fecklessly pregnant do not.

These two subject positions are then used to construct adoption as the 'next-best-choice' (as seen in extracts 23, 24 and 25) within the pronatalist discourse and the pre-abortion interaction. Adoption, at its core, requires two key actors: one person who is childless and wants a child, and the other, who is unable to support or does not want a child. Both positions have an issue which the other can solve. However, it can only be solved through the option of adoption. This way, these two subject positions become relevant in decision-making and are co-opted to serve a pronatalist agenda. Adoption is then viewed as a "next-best-choice" as it results in a child being born (and not terminated) – a key tenet of the pronatalist discourse. It enables childless persons to experience the "joy" and "fulfilment" that only having a child can provide whilst at the same time providing a solution for fecklessly pregnant women. Effectively, adoption has been discursively produced as a 'win-win' option that is particularly difficult to decide against. To decline adoption (i.e., to have an abortion) is not only to deny life but also to deny the happiness of another woman. To accept adoption is to gain some reprieve from the fecklessly pregnant position.

What is also interesting in extract 23 is how Sophia, once giving the child up for adoption, is then positioned as unattached to the child ("no longer financially or psychologically or emotionally attached"). Such an explanation of the adoption process undermines the statements of motherhood as innately joyful. Thus, in this interaction giving birth and giving the child up for adoption is described as relieving the woman of all responsibility and, therefore, as a positive path to take.

7.4.4 Downplaying the hardships of parenthood

As has been illustrated, the pronatalist discourse works to convincingly construct childrearing and children as inherently desirable and wanted. Part of this involved acknowledging but simultaneously downplaying the hardships one may encounter when parenting a child, as seen in the extracts below.

Extract 26
Site 1 [ID 17; Patient= Akhona; Counsellor= Sara]

C: You can choose to parent (.) and that can be challenging but it's rewarding because you're getting life and you're getting to build in these precious lives
P: Ya

Extract 27
Site 1 [ID C2; Patient= Cece; Counsellor= Tracey]

C: your next choice could be to keep this baby (.) mt if you keep this baby, it may not be necessarily very easy to look after it .h you may struggle to tell your parents, you may have to choose a different path in your career .h but ultimately when you have a baby it doesn't change your goals or objectives your .h um plans for life can still go ahead (.) you can still achieve exactly what you're going to achieve in the rest of your life with a baby (.) as you would have without a baby (2) so don't think that having a baby (.) is going to affect your life (1.2) in a negative way where you never gonna be able to achieve your dreams (.) I know a lot of women who've had babies (.) and they are very successful people in life.

In both extracts 26 and 27, parenting is acknowledged as involving some hardships, but in both instances, more emphasis is placed on the positives outweigh the negatives. In extract 27, parenting is described as "rewarding" because, as the parent, the patient would be rearing the child.

In extract 27, three challenges are mentioned but are effectively nullified by the counsellor stating that "when you have baby it doesn't change your goals or objectives". This serves to position the patient as not really knowing the consequences of having children. The counsellor proceeds to effectively explain that the patient can achieve all the things she would want with a child. In this way, the counsellor has attempted to construct parenting as an attractive option that does not have to restrict one's life.

7.5 Foetal personhood discourse

Within the pre-abortion counselling interaction, counsellors went through intricate efforts to construct the foetus as a person. Michaels and Morgan (1999) refer to this process as "person-making" (p. 6), which involves a wide range of practices that are used to construct the foetus as an entity which is separate from the pregnant woman; this can be achieved by assigning sex to the foetus, naming the foetus, providing and examining ultrasound scans of the foetus and so on.

I conceptualise any talk which seeks to construct the foetus as a person, through person-making, as part of the foetal personhood discourse. One of the primary ways the foetus was constructed as a separate person was through anthropomorphizing. This essentially involved describing, in relation to the foetus's development, the human physical characteristics the foetus has or is in the process of developing. This is seen in the below extracts.

Extract 28
Site 1 [ID:16; Patient= Sophia; Counsellor= Tracey]

C: the baby is already this size (.) this is a little model (.) just to show you exactly the size of your baby. The baby's already got the formations of legs. It's got little arms. It's already got a head that's forming. And so it is vitally important to know that what comes out is not just cells that look like blood clots (.) they are in fact (.) the baby that you have already conceived.

Extract 29
Site 1 [ID 559; Group counselling; Counsellor= Tracey]

C: Your baby at eighteen weeks is already fully developed (2) it's got eyes, legs, heart all it's doing from about nineteen twenty weeks is growing bigger, getting fatter, brain development is increasing and the lung capacity is increasing so that it can breathe. Babies of twenty two twenty three weeks twenty four weeks .h survive and they live .h so it it vital for you to understand .h that hat when you make a decision

In the above cases, both counsellors refer to images of the foetus in the organization's brochure. The construction of the baby is achieved by the counsellor listing all the physical characteristics the foetus has. In extract 28, the counsellor lists specific physical features such as "legs", "little arms", and "a head". The same format is followed in extract 29, where the counsellor emphasises "brain development", "ability to "breathe", and "survive". In both these extracts, the counsellors have provided sufficient morphological information for the pregnant woman to consider the foetus a baby. As such, the foetus has been successfully constructed as an individual baby/person who can "survive and [they] live".

In both extracts, the counsellor emphasizes that it is "vitally" important that the patient understands that what is growing within her is "in fact" a baby and "not just cells". The vitalness of sharing this information implies that the counsellors are putting forward a construction of the foetus that they regard as the truth and what is needed for the patient to decide. The personification of the foetus is the counsellors sharing their own understanding of the foetus with the patient. However, this construction becomes problematic when it is taken as the only way to conceive the foetus. In other words, the description of the foetus is used to re-conceptualize how the patient should view their pregnancy and the unborn 'baby' within them. It challenges any alternative construction the patient may have regarding the foetus, which does not recognize it as solely a baby.

The description of the foetus in some cases extended to include its gender, sex and sometimes explicit reference to its functionality, as can be seen in the below extract:

Extract 30
Site 1 [ID 17; Patient= Akhona; Counsellor= Sara]

C: […]I have little brochure here that you can take home ((sniffing noise)) at sixteen weeks at thirteen weeks fine hair starts to grow on the head
P: Mhm
C: do they tell you the gender or the sex of the babies?
P: No
[…]
C: because you can tell already and at twenty weeks you are going to start feeling movements already. The ears are already starting to work, that's how quickly it becomes a baby,

In extract 30, the counsellor starts to identify physical characteristics that the foetus has, such as "fine hair starts to grow", and then proceeds to ask the patient if she is aware of the "gender or sex of the babies". In this case, the foetus has been personified through the description, but the counsellor also attempts to construct the foetus as a subject that is gendered or sexed. This is conversationally important because if the patient entered the conversation beyond a short "no", then she would have been co-opted into personifying the foetus as a co-constructor along with the counsellor. In addition, we see the description of the physical features and the animation/functionality of the foetus. The counsellor describes the foetus as moving and having ears that are working. At this point, the foetus has been constructed not only as having the same anatomy as a human being but also as having the same functionality, thereby enforcing the construction of the foetus as a baby.

There were also cases where the foetus was constructed as a person by describing the abortion procedure, as is captured in the following quote:

Extract 31
Site 3 [ID 4: Patient=Lindy; Nurse= Olwethu, translated from isiXhosa]

N: Nothing will be hidden on that day. It does not mean that when you do an abortion, the foetus is just taken and thrown away just like that. That whole process of giving birth will happen to you. The baby will come out the same way a baby would have come out. Do you understand? You will see him [or] her.

"Foetus", as a signifier, was seldom used during the interactions. Extract 31 is one example of when a nurse used the signifier foetus when she was describing the abortion procedure. Although she uses the signifier foetus, she constructs the foetus as a baby through her description of the abortion procedure. The nurse describes the procedure as equivalent to "giving birth" to a baby. It may also be the only other medical procedure which is relatable to the patient. Nonetheless, equating abortion to giving birth and using the signifier "baby" has

contributed to constructing the foetus as a baby. The personification of the foetus is further solidified in this interaction when the counsellor states that "you will see him [or] her". By utilizing the pronouns, him and her, the nurses discursively assign sex to the foetus – a practice often referred to in the medical discipline as "foetal sexing" (Harrington et al., 1996).

The foetus is also constructed as a person through the signifiers of death, as can be seen in the below extract:

Extract 32
Site 3 [ID 27; Group counselling, Patient= Thandi; Nurse= Olwethu, translated from isiXhosa]

N: […] you will give birth to a dead person, who is a tiny thing, dear. Do you understand?
P: Mhm
N: ((Yes)), because a child will come out of you, here from you. Being that tiny thing. It is not blood that is going to come out, it is children. Do we understand, people?

Similarly to the previous 32, the counsellor personifies the foetus by describing the abortion procedure. In extract 33, the counsellor explains bluntly to Thandi that she "will give birth to a dead person", which will be a "tiny thing". By describing the abortion process in this way, the counsellor has constructed the foetus as a person/child who dies upon abortion. Once again, the abortion procedure is constructed as being similar to birth, with the only distinction being the foetus/baby will not be alive.

The foetal personhood discourse is particularly problematic when discussing the procedural elements of abortion and the choices that are available to a woman. As shown above, the foetal personhood discourse is used to construct the foetus as a person and, in most cases, a baby. By deploying this discourse, the foetus goes from being an abstract entity to being constructed into a person who is valuable and significant.

Through this discourse, it is clear to see how a foetus can discursively be constructed as a fully formed baby. By positioning the foetus as a baby, pregnant women are positioned as already a mother. However, the position of a mother cannot be assigned when using the signifier "foetus". By positioning the pregnant woman as a mother invokes particular social roles and responsibilities regarding parenthood and motherhood from which only the most neglectful would abdicate (Macleod, 2008). Thus, accepting to be a mother in this context would mean continuing the pregnancy, whereas deciding to go through with the abortion would end a baby's life, a decision made by the mother herself.

7.6 Conclusion

In this chapter, I focused on discussing the discourses used to discuss reproductive choice, religion and foetal personhood in pre-abortion counselling. The discourse of reproductive choice consisted of three additional aspects. The first was the individualisation of choice where nurses and counsellors emphasised that the decision to have an abortion was the patients' right. This was a neo-liberal expression of choice that was emphasised not only on an individual level but also due to the legal context within South Africa. Closely related to the individualisation of choice was how each choice had associated consequences for the patient. This involved nurses, but more specifically counsellors, highlighting that although a patient can choose what option to take, they are also choosing what consequences they will have to experience (e.g., have an abortion, continue the pregnancy or adoption). Here a narrative of "your choices have consequences" was very evident and intersected with both responsibility and morality.

A religious discourse also featured in some of the data, primarily attributed to the counsellors who were associated with a Christian organisation. These counsellors often incorporated religious terminology into their counselling sessions such as; "pray", "God", "blessings", "gift from God", and emphasised how marriage provided the sanctity and right for a woman to give birth and for a child to be born.

Discussions of marriage and childrearing provided the opportunity to deploy a pronatalist discourse which often interwove with talk of religion. Within the pronatalist discourse (1) motherhood was constructed as the preferred choice, (2) children were constructed as bringers of joy and fulfilment, (3) children were constructed as wanted subjects, and the counsellors downplayed the (4) hardships of parenthood. The combination of all these aspects of the pronatalist discourse constructed pregnancy, childrearing and motherhood as a positive experience and a viable option for patients.

The final focus of this chapter was the foetal personhood discourse which was deployed to construct the foetus as an already existing person. This was achieved through the use of signifiers such as "baby" and "your child" and detailed descriptions of the foetus' anatomical features (e.g., it has hands, legs, a heart) and physical capabilities (e.g., having a heartbeat, breathing on its own). These descriptions, which the counsellor introduced without consent, provided a particular understanding of the foetus – one which could alter how a patient thinks of their pregnancy.

Chapter 8: Concluding discussion

8.1 Introduction

In this last chapter, I revisit the research questions posed for this study and discuss the implications these findings have for understanding pre-abortion counselling within the public health sector in South Africa. The overarching objective of this study was to explore the following question: How are pre-termination of pregnancy consultations conducted in the public health sector in the Eastern Cape, South Africa? The following research questions were posed to guide the research process: (1) What is the overall conversational structure of the pre-abortion counselling consultation? (2) What information is requested and provided by women (and/or third party if present) and the health care provider during the consultation? (3) What reflexive and interactive subject positions are located/made available within the counselling conversation, and (4) What discourses are drawn on when women, healthcare providers, and third parties take up or offer particular subject positions?

Research on abortion and pre-abortion counselling continues to grow at a global level. At a contextual level, much of the research investigating pre-abortion counselling has been conducted in countries outside Africa. Although the findings from such studies have proven helpful in addressing issues in those contexts, an African-focused study looking into pre-abortion counselling is needed to generate the data for evidence-based and contextually relevant action/intervention.

Although the research on pre-abortion counselling is growing, little is known about how it takes place as an interactional activity and, more specifically, at the level of talk between all those involved (i.e., pregnant individuals, those offering to counsel, and any third-party members such as partners, parents, friends etc.). The recorded in-situ data I examined to answer the research questions were collected from three sites and analysed using a combination of Discursive psychology (DP) and Conversation Analysis (CA). Theoretically and methodologically, DP and CA were utilised in this study to guide the investigation of how pre-abortion counselling is conducted in terms of both its content (i.e., what discourses are deployed) and structure (i.e., where and how these discourses and associated turns were deployed throughout the interaction). This allowed for an examination of talk that focused on speech's macro and micro aspects and investigated how the two reciprocally feed into each other and shape the pre-abortion encounter.

Three analytical chapters (chapters 5, 6 and 7) were presented and discussed in detail to answer the research questions. Chapter 5 explicitly focused on the structure of the encounter. I showed the seven main projects across the data set, including individual and group counselling sessions. The projects varied in how they featured and ranged from context setting (project 1) to the discussion of family planning (project 7). In chapter 6, I gave the medically related discourses underpinning pre-abortion counselling and showed how the discourses of patienthood, responsibilisation, risk and support were deployed within the interaction. Many of the discourses that featured seldom appeared in isolation. Often where one discourse was deployed, it referred to another, a key feature of discourses, as Parker (2002) outlined. This was evident in chapter 7. In chapter 7, the discourses centred primarily on the pregnant woman and the foetus and were concerned with reproductive choice, religion, foetal personhood and pronatalism.

In this chapter, I summarise the key research findings and present the thesis's central argument, which explores how varied and non-standardised counselling practices across sites have implications for how women understand their pregnancy, abortion, and decision-making. The variation of counselling practices is problematised in relation to the content, structure, and format of counselling and explored in relation to how counselling may undermine reproductive justice in a space where such justice needs to be centred and promoted. In addition, the findings from this study will be assessed through the lens of the supportability reparative justice framework (Macleod, 2019). This conceptual framework, as I illustrate below, can be used not only to identify micro and macro injustices in pre-abortion counselling but can also be used to think through ways of improving practice by providing support for pregnant women across the dimensions of the individual material, individual symbolic, collective material and collective symbolic (Macleod, 2019)

8.2 Summary of findings: Examining the content and structure of counselling talk

A primary focus of this study was to investigate the structure of talk in the pre-abortion counselling interaction. This was achieved by mapping out important conversational projects across the data set.

Project one involved **context setting** where counsellors/nurses and patients introduced themselves briefly. Project two involved **history taking** and the counsellor/nurse collecting information about the patient's pregnancy through a series of questions about the patient's age, occupation, marital status, and socio-economic status. **Establishing the reason** for wanting an

abortion was project three. This project usually followed directly after project two and involved pregnant women engaging in talk that constructed themselves as patients needing medical intervention (i.e., constructing their situation as doctorable). It was during this project that patients were responsibilised for conceiving.

Project four was **presenting options,** in this project, counsellors engaged in option-listing (Toerien et al., 2011), where they presented the available options to the patient based on their situation (information gathered through projects one and two). The options presented were usually (1) continuing the pregnancy, (2) adoption and (3) abortion. Options were not described equally, and a bias was clearly identifiable in the unequal way each option was described. Continued pregnancy and adoption were primarily spoken about more positively among the independent counsellors who drew on religious, conjugalisation and pronatalist discourses to emphasis the positives of childrearing and motherhood whilst downplaying any potential hardships. Alternatively, abortion, whether surgical or medical, was discussed negatively drawing on a discourse of risk to highlight the unproven physical and psychological consequences.

Presenting options often ended with abortion being discussed as the final option. This provided the transition into project five, which was **providing procedural information.** Here, counsellors and nurses provided information regarding the abortion procedure, whether medical or surgical. For the most part, a medical discourse was deployed to describe the procedure, but, as mentioned previously, there was significant variation in how this was done, with independent counsellors providing graphic descriptions of the surgical procedure. Importantly, it was also within this project that the discourse of support featured.

Project six was **obtaining (verbal) informed consent.** This project was primarily managed by nurses and involved a 'talking through' of the informed consent form with the patient. In some cases, the informed consent form was used as a guide for the counselling interaction where the nurse would read it out section-by-section and pause to elaborate on important points such as presenting options (which would then overlap with project 4) and procedural information (overlap with project 5). Two discourses that featured in this project were the risk discourse and reproductive choice discourse.

Discussion of family planning was project seven and could appear any time during the counselling session where it became relevant. It was often brought up in project three (Establishing reason for abortion), where pregnant women would disclose that there had been

some contraceptive mis/non-use that resulted in the pregnancy. This information was problematised in the earlier projects of the interaction and was sought to be resolved by the nurse/counsellor by the end of the session. This often resulted in nurses and counsellors getting patients to decide on a LARC in the counselling session so that arrangements could be made post-abortion for the patient, with the objective being that the patient would not find themselves in the same situation in the future.

Central to this study was also exploring how pre-abortion counselling took place at a discursive level. The focus was placed on identifying the discourses deployed in the counselling interaction. The discourses that were identified were thematically organised into those discourses which had a strong focus on the (1) medical and related aspects of abortion (chapter 5) and those discourses (2) which focused on pregnant women and the foetus (chapter 6). Although these discourses were thematically organised, they did not appear in isolation, with many of the discourses interdiscursively (Bhatia, 2010) referring to others across the data set.

The **medical discourse** was one of the first discourses often deployed in counselling. It was used to construct the pregnant woman as a patient who needed medical intervention based on the circumstances in which the pregnancy was embedded. The construction of *parenthood* required co-construction from both the counsellor and pregnant women. Pregnant women were asked questions relating to their reason for wanting an abortion, socio-economic status (e.g., employment, age, relationship status) and contraception. The responses to the questions were only resolved once the pregnant woman's situation was co-constructed as "doctorable" (Heritage & Robinson, 2006). In other words, their situation was constructed as being medically sanctioned, which legitimised the need for medical intervention.

Once patienthood had been constructed the medical discourse was used to talk about the *abortion procedure*, whether medical or surgical and about avoiding abortion in the future through proper contraceptive usage, primarily through long-acting reversible contraceptives (LARCs). The description of abortion varied depending on who was doing the counselling (i.e., nurse or independent counsellor) and whether the counselling session was a group or individual session (due to time restrictions). The medical abortion was described in general medical terms whereby instructions to take medication were explained, followed by a description of what to expect (e.g., bleeding, headaches, dizziness). This talk worked to normalise the medical abortion procedure, and post-abortion support was also mentioned. However, the surgical abortion procedure was often described by independent counsellors in graphic detail,

particularly in relation to the extraction of the foetus (e.g., "*your baby comes out in bits and pieces*"). In addition, the surgical abortion procedure was constructed as not only ending the life of the baby but also denying the patient the role of becoming a mother.

The medical discourse was also deployed when talking about contraception and was interdiscursively woven into the **discourse of responsibilisation**. Firstly, women, from the outset, were taken to be the agents responsible for ensuring effective contraceptive usage. Secondly, pregnant women, often through co-constructing their position as a patient, needed to talk about their contraceptive use/misuse. Patients were problematised as being irresponsible regarding contraceptive usage. As such, nurses and counsellors sought to address this issue medically by promoting LARCs.

The **discourse of risk** was a common discourse that featured across sites. Under this discourse, pregnant women were constructed as jeopardizing their physical and psychological well-being by deciding to have an abortion. Within this logic, the only way to avoid such risk is to avoid abortion and continue with the pregnancy – often without any consideration of the context in which the pregnancy would continue and the personal circumstances of the pregnant woman.

In terms of physical risk, abortion was constructed as causing breast cancer ("*developing breast cancer as you get older*"), possible future infertility ("*you may have problems falling pregnant in the future*") and even resulting in death ("*termination which is risky to your body. You can see in the consent form it says you can die*"). Emotional and psychological hardships associated with the decision to have an abortion were discussed by both nurses and independent counsellors and formed part of the risk discourse. Nurses tended to discuss the emotional consequences of abortion in general terms, citing emotions such as "sadness", "regret", and "loss". In comparison, independent counsellors referred to general emotional responses but used them as a walkway to transition into discussing post-abortion syndrome (PAS). PAS was constructed as a severe ("*depression, 'suicidal thoughts"*) and legitimate psychological condition that affects most *("two out three ladies develop the condition"*) women who decided to have an abortion. Often talk of physical and psychological risks featured together or in the proximity of each other within the counselling interaction. Ultimately, they both served the same purpose – to construct abortion as a medical procedure that negatively affects the patient both physically and psychologically. In this way, the risk discourse was used to position the patient as at conditional risk: they are at risk physically and psychologically only if they decide to have an abortion. To avoid such risks, one needs to avoid having an abortion.

Closely associated with talk concerning the emotional and psychological difficulties of abortion was a **discourse of support**. Overall, this was a positive discourse that acknowledged that support might be needed by those patients who decide to have an abortion. Both nurses and counsellors shared contact information, usually cell phone numbers, with patients. Nurses were primarily concerned with providing information and procedural support, either at the clinic or when the patient was at home. They would also share the contact details for psychological support as it was covered in the informed consent patients needed to sign before the abortion procedure. Independent counsellors emphasised the emotional aspect of support and encouraged patients to contact them at any point after the counselling session. This was usually offered towards the end of the session once detailed information about the abortion procedure had been shared. Independent counsellors reminded patients that deciding is something that should not be rushed and that contemplation of the newly received information was required – it was within this conversational context that post-counselling support was offered.

A **discourse of reproductive choice** featured in many of the counselling sessions. One way in which it was deployed was to *individualize and decontextualize* the decision of whether to have an abortion. This is particularly problematic because it ignores the contextual realities (e.g., gender relations, support, finances, etc.) in which the pregnant woman is located and how these may contribute to making the pregnancy (un)supportable/(un)wanted. While decision-making agency is foregrounded, it is presented as purely residing within the individual pregnant women. Combined with the discourses or risk and responsbilisation, however, this conceptualisation suggests that whatever choice is made by the patient is one they make alone, and thus they, alone, are *responsible for the consequences* that are experienced. Here we see the interdiscursive nature of discourses and how choice and risk feature within the counselling interaction.

The independent counsellors, being affiliated with a Christian organization, introduced **religious discourse** into the counselling interaction. Simple descriptors used to refer to the foetus as a "blessing" and "gift" and narratives referring to "God's plan" aided in shifting focus away from the pregnant woman and onto the foetus and God. The narrative of the pregnancy being part of God's plan was particularly emphasized when the patient was married. This invoked the conjugalisation of reproduction discourse and was used to provide further rationale for continued pregnancy that resulted in not only following God's plan but also the pregnant woman becoming a mother, as is expected within marriage.

Talk of continued pregnancy and childrearing was a common feature in the interactions between independent counsellors and pregnant women. A **pronatalist discourse** often flowed naturally through the deployment of the religious discourse. In the pronatalist discourse, childrearing and parenting, particularly motherhood, were spoken about in positive ways, e.g., as fulfilling. Motherhood was constructed as the preferred choice for pregnant women. Not only did it mean avoiding physical and psychological risks associated with abortion, but it was also constructed as being deeply rewarding ("*the fulfilment and the purpose and the love that you feel"*) and as following the gendered responsibility of motherhood, also known as 'god's plan'. Within this discourse, children were constructed as wanted subjects due to the joy and happiness they bring, and the hardships associated with parenthood were largely ignored.

The pronatalist and religious discourses were both dependent on the conceptual understanding of the foetus as a human baby. This subject position was one that needed to be created and established during the session, and this was achieved using the **foetal personhood discourse**. Within this discourse anthropomorphising, which involved describing the physiological aspects of the foetus, was used to construct the foetus as having the physical ("*formation of legs…little arms*"), gendered ('*did they tell you the gender or sex of the babies*?') and functional ('*ears are already starting to work*') characteristics of a human baby. By doing so, a specific and contextual understanding of the foetus, now baby, was constructed and referred to throughout the many discourses already deployed in the counselling session (e.g., religious, pronatalist, medical).

8.3 Why is pre-abortion counselling in this mould problematic?

The data collected and analysed in this study provide some of the first empirical data from actual pre-abortion counselling in the public health sector. In this section, I consider the significance of the findings within the broader context of reproductive healthcare in South Africa and identify areas for improvement. I do this by highlighting both the micro-level and macro-level injustices and challenges facing pre-abortion counselling services. I then move on to discuss the usefulness of using a supportability reparative justice framework to address the micro and macro injustices at the individual, collective, material and symbolic levels.

As documented in this study, pre-abortion counselling practice is problematic due to the disconnect between (lack of) policy and everyday practice. As a reminder, the CTOP Act stipulates the following in terms of counselling:

> The State shall promote the provision of **non-mandatory** and **non-directive** counselling, before and after the termination of a pregnancy (Choice on Termination of pregnancy act, 1996)

At a micro level, in its current mould, counselling has, as I argue, very clear characteristics of directive counselling that filter into the interaction through the discourses that counsellors deploy. These discourses are used as discursive scare tactics to awfulise abortion (Lee, 2003) and create abortion negativity (Lee et al., 2004) in an effort to dissuade patients from selecting abortion as an option. In addition, there are a series of macro-level realities that contribute to the disconnect between policy and the practice of counselling across sites. These include: (1) variation in length, format and who conducts the counselling, (2) counselling being made mandatory to receive abortion services, (3) and variation in the content and structure. These micro and macro-level issues are identified and discussed below.

8.3.1 How discourses deployed can lead to bias and directive counselling

This study provided some of the first insights into not only what discourses feature in pre-abortion counselling in South Africa but also how these discourses were put to use within the interaction. The central question asked in the analysis was, "What is the purpose of this discourse here (within a certain project)?" This was guided by exploring how the deployed discourses positioned the nurses/counsellors, patients, and other relative subjects (i.e., the foetus) within the interaction and whether the discourses use/delivery was in line with the goals of the CTOP Act and, more broadly, reproductive justice.

Bias in the counselling session was achieved through both what and how information was shared. A key example of this is where options were being discussed (project 4, 'presenting options'). Independent counsellors, although presenting all the available options (the "what" or the interaction) to the patient, did so unevenly (the "how" of the interaction). Continued pregnancy and adoption were spoken about only in positive terms. Abortion was awfulised, and the risks associated with abortion post-abortion were highlighted. This indicated a prejudice towards abortion and the promotion of parenting – despite the personal situation of the pregnant individual.

Bias in counselling was also discursively apparent when the medical discourse was deployed. Within this discourse, both nurses and counsellors went into detail regarding the process of abortion. Of particular significance was the description of surgical abortion – which involved

graphic description of how the foetus is extracted. The critical question to consider is why the need for such detailed information with regard to abortion? In most other clinical encounters, the graphic details of the surgical procedure are not discussed; typically, only the general aims and methods of the surgery are communicated (i.e., core information sets[36]) with the patient (e.g., to remove a tumour) (McNair et al., 2016). The rhetorical significance of using graphic description within the medical discourse is interdiscursively dependent on the foetal personhood discourse.

The foetal personhood discourse is used to construct and convey personhood to the foetus. No longer is the foetus an abstract entity; rather, it is positioned as a developing and functioning human being. This fundamentally changes how the foetus is understood and how abortion as a procedure is viewed morally, especially in relation to decision-making. The combination of how surgical procedural information is shared (i.e., excessively graphic) and the foetal personhood discourse serve to construct abortion as equivalent to violent murder. This is a quintessential example of a discursive scare tactic to dissuade pregnant women from the option of abortion and in the direction of any other option. In this case, any option other than abortion is a moral victory for the independent counsellor – one that is achieved through directive information sharing.

Misinformation was another means by which the counselling session could become directive. Data from this study show that misinformation was prevalent when discussing the risks (physical and psychological) associated with abortion and that independent counsellors, in particular, discussed post-abortion syndrome without providing any substantial evidence. All information shared was framed as factual by the independent counsellors, and this meant it was not open to scrutiny or questioning by the patient during counselling. All the patient could do in such circumstances was to listen to the information.

8.3.2 How reproductive choice discourse is used

It was positive to find that the pre-abortion counselling sessions in this study included a discourse of reproductive choice that emphasized that decision-making is placed solely on pregnant women. However, there were also instances where discursive strategies (i.e., discursive scare tactics, narratives of implicit norms of parenting) were employed and worked

[36] Core information sets can be defined "as a minimum set of consensus-derived information about a given procedure to be discussed with all patients" (Main et al., 2017, p. 1) in order to obtain informed consent.

to undermine choice. This was discussed in detail in chapter 7; here, I summarise how the reproductive choice discourse was used across the dataset.

The discourse of reproductive choice was used by counsellors to provide the following readings: (1) a *decontextualized* viewing of pregnancy as bound within the individual women rather than being embedded within individual and collective material (i.e., resources, legislation, socio-economic context) and subjective realities (i.e., personal experiences of pregnancy and reproductive healthcare), and (2) the *individualization* of choice that worked to position women not only as responsible for their decision but also for the potential risks that are (according to the counsellors) associated with abortion. In addition to decontextualizing and individualizing reproductive decision-making, the discourse was also used to undermine choice by shifting focus away from the pregnant woman to the foetus – usually re-conceptualised as a "baby" through the use of the foetal personhood discourse. This shifting of focus is of great concern and is an injustice. Reproductive justice requires a consistent and enduring focus on women and their situation and wellbeing.

8.3.3 'Mandatory' counselling and variation

Data for this study were collected at three public hospitals in the Eastern Cape of South Africa. Across these sites, there was evident variation and non-standardization in how counselling was conducted. This means that women seeking abortion services are not guaranteed the same level of service across sites. Mandatory counselling and variation in counselling services are discussed below.

8.3.3.1 Mandatory counselling. Across all the sites, counselling was constructed as part of the abortion services that pregnant women were expected to attend. There was no talk or opportunity not to attend the counselling session, proceed with signing the informed consent form, and have the abortion procedure. I suspect there were two main reasons why counselling was assumed to be a mandatory aspect of abortion provision. The first relates to the resources available and the daily activities of each facility. For two sites, the nurses who conducted counselling were also responsible for other components of the abortion. In addition to counselling, nurses were also responsible for administrative tasks (capturing details of the patient, obtaining consent), assisting or performing the abortion procedure (whether surgical or medical), as well as ensuring that patients were provided with contraceptives post-abortion. Sites in this study where understaffed (macro-level issue), as indicated by staff members

themselves and through observation during on-site visits, and this resulted in those nurses who were available having to perform multiple roles at once to ensure that all patients received abortion services. Counselling allowed for combining other related services, as seen in site 2 where the nurse would conduct group counselling, provide information and, in the cases of medical abortion, would also administer medication to start the abortion process (see Chapter 5). In this light, making counselling mandatory is an adaptive response by nurses to an under-resourced environment to ensure that multiple tasks are conducted in the shortest amount of time.

The second reason why counselling was made mandatory, I argue, was to enable directive counselling. Independent counsellors constructed counselling as essential and that the information shared needed to be heard by the patient before they made a decision. It was viewed as the first process in seeking an abortion. From the patient's perspective, however, it seemed to be considered as another obstacle or challenge that needed to be navigated in receiving abortion care in South Africa. As I have shown in Chapters 5 and 6, patients would be interactively positioned as irresponsible; they would offer no resistance to this positioning as they were aware that any resistance would cause interactional trouble and delay the procedure. In other words, patients' talk in the counselling interaction was strategic and did not necessarily reflect agreement with the statements being made in the session. Patients were required to construct their situation as doctorable and needing medical intervention to receive the medical service they required. From the patients' perspective, counselling could be regarded as a means to an end or simply another bureaucratic procedure.

From the independent counsellor's perspective having a mandatory counselling session allowed them to share their understanding, often misinformation (e.g., PAS), with patients and "guide you [patients] a little". Mandatory counselling provided the opportunity and space to talk about aspects of abortion in an unregulated manner. As far as I am aware, independent counsellors were left to their own devices when counselling patients. They also constructed their role as assisting the nurses who were already working under constrained conditions.

8.3.3.2) Variation in counselling. Although data were collected at only three sites, there was variation in a number of aspects. One of the first areas where counselling varied was (1) *length and format*. The average length of counselling sessions for both group and individual counselling was 16:08 minutes, with the shortest being 7 minutes and the longest being 36

minutes. In terms of format, out of the 28 counselling sessions recorded for this study, 21 were individual, and 7 were a group. Nurses provided both group and individual counselling, whereas independent counsellors only provided individual counselling.

Counselling sessions also varied based on (2) *language spoken*. Site 1 and 2 provided counselling in English, whereas all the counselling sessions at site 3 were conducted in isiXhosa. This is positive to observe that patients are given an option to select the language of communication if possible (see project 1 – context setting), seeing as though the Eastern Cape is the home of the indigenous Xhosa people.

Another area of variation where the *(3) Persons responsible for conducting counselling*. Nurses and independent counsellors provided counselling services for pregnant women and varied in their delivery in the (3) *content and structure* of the counselling interaction. Across the sites, the content (i.e., discourses that featured) was largely dependent on who was doing the counselling. Counselling conducted by nurses tended to draw on medical, responsibilisation, risk, choice and support discourses, whereas independent tended to draw on discourses of choice, religion, pronatalism and foetal personhood. Structurally, although seven projects were identified throughout the dataset, not all projects appeared in every session. Out of the seven projects, project 1 (providing procedural information) and project 2 (family planning) were the most frequently occurring in both group and individual sessions. They are also the two projects that are most aligned with the medical and public health focus of abortion provision (i.e., medical assistance and future prevention).

At the time of data collection, the areas of variation identified above resulted from a lack of policy and guideline documents to assist in providing instruction for not only what should be included in pre-abortion counselling but also how it should be conducted, particularly in relation to the CTOP act. A lack of policy and guideline documents provides an opportunity for pre-abortion counselling to operate in the public health sector in unregulated and varied ways. This is problematic because it means that pregnant women seeking such services will more than likely have very different experiences but also receive counselling that only partially aligns with the goals of reproductive justice and which, in some cases, seeks to implicitly undermine their reproductive decision-making – through troubling their understanding of abortion using discursive scare tactics and misinformation.

8.4 Moving from reproductive justice to a *reparative* justice framework

Reproductive justice has provided the necessary framework for governments, service providers and citizens to think behind the prominent biomedical and public health approach to understanding healthcare. As a reminder, reproductive justice can be defined as:

> The complete physical, mental, spiritual, political, economic, and social well-being of women and girls, and will be achieved when women and girls have the economic, social, and political power and resources to make healthy decisions about our bodies, sexuality, and reproduction for ourselves, our families, and our communities in all areas of our lives (Asian Communities for Reproductive Justice, 2005)

From the definition above, it is clear that reproductive justice works as a conceptual tool that recognises that health encompasses all the systems (micro and macro). It is an intersectional approach that locates health and rights within a context of interconnected systems whereby the personal is inextricably linked with social processes, both physical and symbolic. From a reproductive justice perspective, "actions, services, and interventions that promote justice and equity around reproduction and health are sought" (Macleod & Feltham-King, 2020, p. 320).

Reproductive justice and injustices can and do take place on various levels (i.e. personal, interpersonal, and societal). Concerning abortion, Macleod (2016) has focused on highlighting the social and environmental circumstances in which people are embedded that make pregnancy 'unwanted'/'(un)supportable, acknowledging that health is hindered or enabled at both macro and micro levels. However, although reproductive justice helps think through how to avoid injustices in the future, an approach is needed that directly deals with not only identifying injustices but also thinking through how the harm they cause can be remedied

Reparative justice provides the conceptual framework to extend reproductive justice. It carries the same core principles of reproductive justice but is primarily focused on addressing injustices through recompense or restitution. This requires not only identifying injustices and understanding the myriad of realities that enable them but also acknowledging that when a person's rights have been constrained or restricted (i.e. injustice), then a social remedy or repair needs to occur.

In terms of reparations, Ernesto Verdeja (2008) calls for recognising that reparations must take place at both an individual and collective level. In addition, Verdeja (2006) also argues that reparations must include both material and symbolic components and work towards what

Fraser (2003) defines as "status parity". This then produces, when combined, a model of four unique yet interrelated reparative dimensions: (1) Individual material, (2) Individual symbolic, (3) Collective material and (4) Collective symbolic.

Below I describe each of these dimensions – identify what injustices occurred at these levels and how they can be potentially repaired for the future.

8.4.1 Individual material dimension

Reparation at the *individual material* dimension places "greater emphasis on the autonomy of individuals" (Verdeja, 2006, p. 458) and enables people to seek necessary health services through the availability of financial resources, or at the least the ability to acquire financial resources and then to exercise autonomy in deciding what services to seek. Abortion services in the public health sector are free, so access should not be a problem from an individual financial perspective. However, an individual's finances encompass more than paying for the actual service; it also includes transport to the facility and time taken off work or school. Therefore, the active encouragement by nurses or counsellors (in particular) for women to take additional time to consider their decisions (and to come back later), as well as the scare-mongering that undermines women's decisions, is an individual material injustice.

From this dimension, person-centred counselling requires ascertaining if a decision has been made already and whether the person is acting on that decision; this would work to obviate any further spending. This would also include allowing patients to decline pre-abortion counselling if they so choose and to proceed with the abortion procedure provided, they have given informed consent. Where pre-abortion counselling has been conducted, a more concerted effort to respect the patient's decision is required. As this thesis outlines, various discursive attempts undermine or challenge the legitimacy and understanding of patients' final decisions. Patients must be recognised as experts in their own lives, irrespective of their circumstances.

8.4.2 Collective material dimension

The *collective material* dimension is primarily concerned with issues relating to distributive justice (Verdeja, 2006). Here, the concern is about providing resources to those who have experienced injustices to "create the material basis and security necessary for them to become full participants in social, political, and economic life" (Verdeja, 2006, p. 456). Applied to pre-abortion counselling, it refers to creating supportive environments where non-directive and patient-centred counselling can take place. This would require more explicit guidelines about pre-abortion counselling being included in the CTOP Act and implement in practice with the

abortion wards and clinics. Collective material justice also means having the space to conduct private, individual counselling and the human resources so that nurses do not feel obliged to do group counselling or to rush through the counselling session.

At a practical level, it would also require resources to be made available for re-training and upskilling those who offer pre-abortion counselling within the public health sector. To date, a policy brief (Mavuso et al., 2017) and an abortion counselling certificate (Macleod et al., 2020) course have been developed and implemented, in partnership with the Department of Health in the Eastern Cape, by researchers and psychologists from Rhodes University. The abortion counselling certificate seeks to operationalise the principles of patient-centeredness and non-directive counselling as called for by Mavuso et al. (2017). Such initiatives highlight how evidence from research can be used to inform action-based intervention research and how it can improve the reproductive service delivery landscape. At another level, it also shows that change in the public health sector requires buy-in from tertiary education institutions and the government.

8.4.3 Individual symbolic dimension

The *individual symbolic* dimension recognises that each person's experience is unique and valid and should not be reduced, aggregated or lost in presenting more generalised information, such as statistics. Put simply; it is the understanding that injustices affect 'individuals as individuals' (Verdeja, 2008, p. 214). When this dimension is applied to the case of pre-abortion counselling and specifically the data presented in this thesis, it requires that patients are allowed to speak openly and to be heard by those offering counselling. As shown in the data in chapters (3 analysis chapters), counselling interactions are often dominated and directed by counselling – with the patient contributing only when requested. In such cases, deep listening is unlikely to occur. Within the counselling session, opportunities for the patient to talk and be acknowledged not only need to occur more frequently but also to take centre stage, especially if the counselling session is to be described as patient-centred. Furthermore, recognising patients as individuals can be particularly difficult in a group counselling setting with multiple patients. A group counselling session with strangers does not provide an interactional environment conducive to deep listening but rather makes it easier for the individual to become lost among the collective.

It is also worth noting that allowances should be made for women who may be unconflicted, have already made a decision or are repeat clients, and who may prefer the group counselling

format, especially if it structured with more relevant information that relates to their (and the other group member's) specific needs and circumstances. In addition, group counselling may also offer individuals comfort knowing that others are in a similar situation to them and can empathise with their experiences.

8.4.4 Collective symbolic dimension

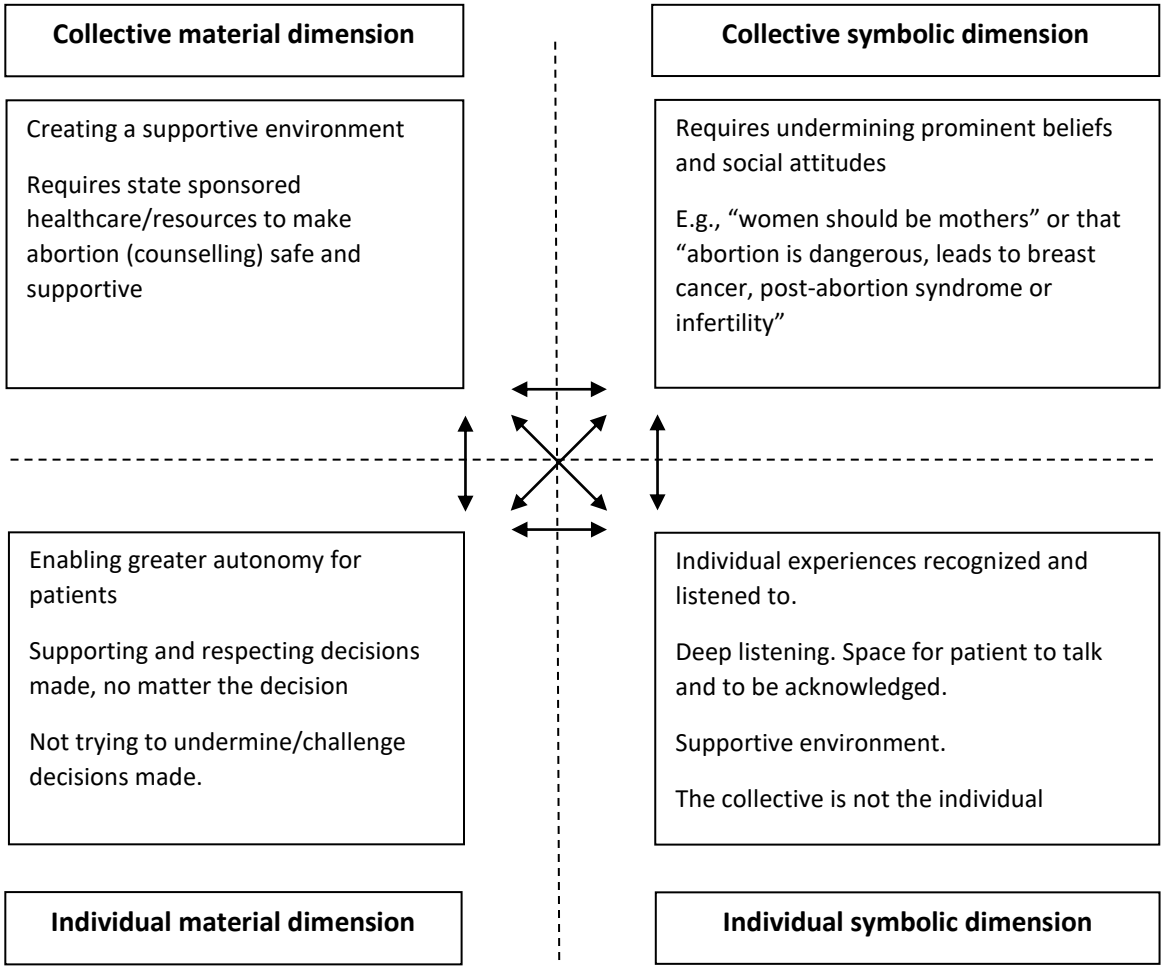
The *collective symbolic* dimension "implies highlighting repressions, recognising victims' experiences of these repressions, condemning narratives that legitimate the repression and that place responsibility for suffering on the victim" (Verdeja, 2008, as cited in Macleod & Feltham-King, 2020, p. 321). It requires a concerted effort to undermine the prominent beliefs and social attitudes evident in the discourses deployed in pre-abortion counselling. Before this can occur, there first needs to be an understanding of what discourses feature in pre-abortion counselling and how the discourses are used. For example, in this study, the risk, responsibilization, and pronatalist discourse worked in ways that constructed abortion as risky on multiple levels, that it was the patients' lack of responsibility for falling pregnant and that the desired outcome to their current situation is parenthood. These discourses work in ways that disempower pregnant people in the pre-abortion counselling interaction and are forms of micro injustices. Although there is space in pre-abortion counselling to discuss risks, responsibility and parenthood, they need to be done in factual ways and used to empower pregnant people. In other words, justice can be done through discourse, or reparations can start at the level of talk.

Considering the talk independent counsellors engaged in during the interaction, I would also recommend that independent counsellors are not given access to patients through the public health system. It is within these spaces, as documented throughout this thesis, where they can use the counselling session to actively dissuade women from having abortions.

The figure below summarises Verdeja's (2008) four-dimension framework and how it can be applied in relation to pre-abortion counselling within the South African context.

Figure 2

Reparative justice/care: Pre-abortion counselling.



When understood using the four dimensions above, Reparative justice provides the conceptual framework that can be used to identify issues that either enable or threaten reproductive justice. By discussing the multiple injustices that occur in pre-abortion counselling and applying the four dimensions, one can appreciate more clearer that reproductive justice is indeed multi-dimension. The reparative justice approach highlights the "complex interfering of material and symbolic issues at both an individual and collective level" and provides the basis for recognising that there needs to be more of a concerted effort to move beyond the public health approach, which focuses on individual responsibility (Macleod & Feltham-King, 2020, p. 328). As an extension, the reparative justice framework foregrounds the personal and the collective. It takes into account that at both levels, material and symbolic realities infiltrate the pre-abortion counselling interaction, function as injustices and ultimately undermine the reproductive rights of patients in the South African public health system.

The approach's central purpose and strength are recognising that reproductive injustices are multi-dimensional. Each dimension must be considered along individual/collective and material/symbolic lines. Those seeking abortion services, and in the case of this thesis, those seeking pre-abortion counselling, need to be supported across all four dimensions. A lack of support or injustice in any of the dimensions can act in ways that effectively undermine reproductive healthcare for those who are seeking it. For example, increasing *collective material* conditions are essential but can be undermined when counsellors/nurses draw on negative discourses which construct abortion as dangerous, going against god's plan and the dispreferred option in dealing with [un]planned/[un]supported pregnancy.

The dimensions discussed above can be conceptually thought of as the expressions of empowerment (Vizheh et al., 2021). They provide the framework researchers, activists, and people can use to make sense of their experiences by identifying and interrogating the relevant dimensions. Such a conceptual tool is useful in identifying injustices and in thinking through what needs to be changed for the injustice to be repaired and ultimately produce an environment where individuals feel empowered regarding their reproductive lives. In this way, reparations are seen as the necessary foundation as we strive towards ensuring reproductive empowerment for all.

8.5 Limitations of this study and recommendations for future research

In closing, I reflect on some of the limitations experienced whilst conducting this research and discuss future possibilities for exploring pre-abortion counselling as a research topic. One of the reasons for researching pre-abortion counselling is the limited studies available on the topic, especially when wanting to understand the discursive and conversational nature of the interaction. Although not the first to look at counselling, this study is one of the first to explore how pre-abortion counselling takes place in everyday practice within the public health sector in South Africa. In this section, I discuss some of the limitations, or what I, in some circumstances, would consider challenges, as well as put forward my recommendations for future research.

8.5.1 Limitations

One of the limitations of the study was that data were collected from only one province in South Africa, and so the findings emanating from this study, although helpful, may not necessarily reflect the everyday practices of pre-abortion counselling at public hospitals in other provinces.

From a data collection perspective, this study received ethical approval to audio and video record counselling sessions. Including video, data would have allowed for the visual aspect of the counselling session to be analysed. It could have been used to supplement the audio recording analysis – often referred to as an "integrated analysis" (Parry, 2010, p. 376). Interactionally important moments like silences could have been analysed for what is occurring non-verbally, which could have added to the validity and reliability (Murad et al., 2014) of the conversation analytical aspect of the study. However, none of the patient participants in this study agreed to have their counselling session video recorded. Participants were not questioned further regarding their decision, but issues relating to privacy are thought to be the main reason. I am grateful to the patient and counsellor/nurse participants who agreed to participate in this study and to have their interactions audio recorded.

Not necessarily a limitation, but an issue worth mentioning is the number of counselling sessions that made up the overall **sample size**. Data collection took place over a few months in two waves, and the final counselling session sample size consisted of 21 individual and 7 group counselling sessions. Although this data proved sufficient to identify patterned talk and formulaic overall conversation structure, a larger sample size might have captured aspects that take place in everyday counselling but were not present in the interactions recorded for this study.

Data collected in this study come from public hospitals located in two large cities in the Eastern Cape. The Eastern Cape is one of nine provinces in South Africa and has historically been in the bottom three poorest provinces since 2006 (Maluleke, 2020; Stats SA, 2016; Stiegler & Bouchard, 2020). Provinces in South Africa differ on various key features such as demographics (e.g., race, gender, poverty rates), funding received from the government for healthcare spending, and public health facilities available (both in terms of geographical location and providing services). These will to some extent, impact the healthcare to which people have access and the resources allocated to providing that healthcare. There is potential for this study to be replicated across different hospitals in the Eastern Cape and South Africa. Such research will be useful in assessing, at a national level, whether pre-abortion counselling is conducted in the same mould as documented in this study or perhaps reveal variance from province to province. In addition, it would also be helpful to compare how counselling is conducted in healthcare facilities in urban and rural areas and to assess the differences across the public and private healthcare systems.

8.5.2 Recommendations for future research

In this section, I present and discuss recommendations for (1) continued research, how the data from this study can be used to (2) inform policy and communication awareness training (CAT), and highlight the importance of (3) creating and sustaining e-health platforms to support patients and service providers.

8.5.2.1 Continued research. There are multiple possible avenues for future research which seek to explore pre-abortion counselling as a general research topic but that could also continue investigating counselling at an interactional level. As mentioned previously, data were collected at the three public hospitals in the Eastern Cape. It would be worthwhile exploring how pre-abortion counselling is conducted across the other eight provinces. This would enable findings to be compared, and any similarities or differences explored and analysed further. It would also be interesting to see how pre-abortion counselling takes place within the private healthcare sector. Research has shown that many South Africans hold the perception that public hospitals are "bad" and private hospitals are "good" (Maseko & Harris, 2020). Still, research-based evidence is needed to identify what exact aspects of healthcare provisions are problematic.

Data from this study can also be used to inform future **quantitative research**. For example, a questionnaire could be developed that focuses on the specifics of the counselling interaction, such as; what information was shared, whether the counselling session was mandatory, did patients feel pressured or uncomfortable at any point, were risks discussed, did patients feel empowered through the counselling and later abortion procedure, and so on. Although a similar study was conducted by Birdsey et al. (2016), their study sampled patients from only one clinic in KwaZulu-Natal that dealt with specifically offering abortion services to individuals under 12 weeks of gestation. It would be worthwhile to expand this type of research across various provinces and facilities (i.e., clinics and hospitals). As has been found in this study, if variations in counselling approach and style differ within and across hospitals in one province, it is more than likely that the variation would exist across the country. This can only be empirically stated through future research. The strength of this type of quantitative research is that it would allow for the quick collection of data across multiple hospitals and aid in producing a cross-sectional overview of how patients experience pre-abortion counselling. In addition, there is also the potential for these data to be collected longitudinally.

The four dimensions of the reparative justice framework can also be used to inform quantitative research. Most notably and recently, Upadhyay et al. (2021) developed a scale that measures the latent construct of sexual and reproductive empowerment. Understanding that empowerment can be experienced on multiple dimensions, the scale produced has been refined to include the following seven: (1) Comfort talking with a partner, (2) choice of partner, (3) support, (4) Sexual safety, (5) Self-love/acceptance, (6) Sense of future and (7) Sexual pleasure (Upadhyay et al., 2021). The scale is still in its early stages of being validated, specifically within the United States context, but is showing great potential in being a measure used to assess how structural and individual-level factors can impact individuals' empowerment. The developers call for researchers outside of the USA to test and develop further the scale in their respective contexts, acknowledging that in certain contexts, some dimensions may be more salient. This is currently my focus transitioning into my post-doctoral research, and I hope that the sexual and reproductive scale can be operationalized as a tool for identifying areas of possible injustices (i.e., in cases where respondents score low on certain sub-scales), which in turn could be used to empirically identify and prioritise dimensions for intervention/improvement.

8.5.2.2 Informing policy and communication awareness training (CAT). One of the significant contributory reasons pre-abortion counselling in the public health sector is so varied, even within one province, was a lack of clearly established counselling guidelines at the time. Where guidelines did exist, they were often province-specific and outdated. One of the outcomes of this thesis has been the contribution and production of a step-by-step counselling guide for providers based on a client-centred approach to counselling[37] (Mavuso et al., 2018). It is hoped that these guidelines and continued research on abortion counselling more broadly provide the empirical evidence that can be used to advocate for a closer detailing of what and how abortion counselling is conducted in South Africa under the CTOP Act. There is evidence of these already as the South African department of health has released national clinical guidelines for implementation of the CTOP Act informed by some of the key findings from this PhD Study (see Department of health, 2019).

In 2017 researchers (including myself) compiled a policy brief titled "Revamping pre-abortion counselling in South Africa" (Mavuso et al., 2017). In this policy brief, we summarise and report on some of the critical findings emanating from two research projects looking at pre-

[37] This can be guideline document can be download using the following link: https://srjc.org.za/wp-content/uploads/2017/06/Abortion_Counselling_Guide_Version_1-1.pdf

abortion counselling in South Africa. Based on these findings, we make a series of recommendations. One of the recommendations relevant to this study and future research is for those responsible for conducting pre-abortion counselling to undergo training that consists of; (1) listening to real-time counselling audio interaction, (2) cooperatively working with colleagues and the facilitator to identify problematic communicative practices, (3) critically exploring the *format* (group vs individual), *structure* and *content* of the counselling. This idea was born from my reading of the Conversation Analytic Role-Play Method (CARM) developed by Elizabeth Stokoe (2011) and adapted to focus more on the content of counselling talk than the role-play aspect. The central idea was to facilitate sessions that are not only about developing specific skills (although these are important too) but creating spaces for providers to hear the narratives and examples of current counselling practice. The aim is to facilitate a learning process through data engagement and reflective dialogue amongst those who conduct counselling.

The pre-abortion counselling guidelines produced (Mavuso et al., 2018) have been operationalized and used to develop an accredited abortion counselling certificate course (ACCC) at Rhodes university that is offered to nurses providing pre-abortion counselling. The course is run by CSSR members and is part of one of my colleagues, Yamini Kalyanaraman, PhD. To date, there have been three full training rounds that aim to: build nurses' skills in abortion counselling; promote client-centred and contextually relevant counselling based on reproductive justice principles; dispel myths regarding abortion consequences with evidence-based research; and ultimately benefit clients who access the service (Y. Kalyanaraman, personal communication, September 29, 2022). Some of the data in this PhD form part of the training. For example, audio and transcript data of the actual counselling session are played for participants and unpacked in more detail in terms of how such talk might be supportive or problematic and forms part of the communication awareness component of the training. Action research is being used to design, conduct and improve the training course, and initial feedback has indicated that participants find the training beneficial but also a supportive space. After some period of time, it could be insightful to collect recorded data of those participants who have completed the ACCC and to analyse the data as has been done in this PhD. Such a study would shed light on to what extent the training has influenced the daily counselling practice of participants.

8.5.2.3 Creating and sustaining e-health platforms. One of the issues throughout this research process is that the hospitals where data were collected are under-resourced, and it falls

on nurses to ensure that patients receive all the necessary services. As has been discussed already, this puts a lot of pressure on nurses to perform multiple roles (e.g., administrator, counsellor, nurses administering medication etc.). One way in which this could be alleviated is through the use of creating and sustaining e-support/e-health platforms. An example would be creating a WhatsApp Chatbot service that works on prompts. A user would send a message to the WhatsApp e-support contact and would receive information through prompts; from there, the user can select an option that is relevant to them; below is one example of what information could be included.

Figure 3

Example layout of WhatsApp options

Press 1	Basic information regarding medical and surgical abortion (including legal information). CTOP Act information.
Press 2	Abortion service providers in your region (prompted to select province and suburb)
Press 3	Decision-making (options available; abortion, parenting, adoption)
Press 4	Request e-counselling or referral to in-person/online abortion counselling
Press 5	Contraceptive information (options and accessibility)
Press 6	Psycho-social support services (request someone to contact you)
Press 7	Report an emergency or crime (medical, police services)
Press 8	How to identify illegal/unsafe service providers

For example, selecting option 4 could provide information toll-free[38] services that offer free abortion counselling services. This could include referring users to physical sites where they can receive counselling but also provide counselling either telephonically or even in an online chat. In South Africa, Marie Stopes is one of the few support centres that offer abortion counselling over the phone for free. Safe2Choose is an international organisation that provides online counselling through a chat box. The counsellors are also all medically trained and provide clients with "relevant information to the individuals situation […], address common questions, validate emotional experiences, ensure safety, and act as a support person through the abortion process" (Safe2Choose, 2022).

It is also important to note that e-health services have been attempted in South Africa on a smaller scale. For example, Bhekisisa, an independent media organisation, created a service

[38] In South Africa, toll free numbers are numbers where the called party is charged for the call instead of the caller.

one that uses a person's location from their phone to locate abortion clinics close to them. It has proven quite difficult because the service is dependent on resources, information and turn-over of staff. For this reason, I have suggested setting up a WhatsApp bot because, once operational it can be maintained by a third-party IT company. An ideal approach would be to get the department of health involved, so that information can be easily integrated and updated into the WhatsApp bot when required. However, although the South Africa government has started to digitalise many services, challenges such as; the digital divide, lack of skills, and lack of penetration of technologies to all citizens have impacted the success rollout of these services (Blom & Uwizeyimana, 2020; Pillay, 2012).

Growing digital abortion e-health services in South Africa is important. Telephonic and online chat counselling allows people to access these services anonymously and for their information to be kept private. These are faceless encounters that do not exist within the confines of a public hospital, and as such, individuals might feel more willing and safer to share personal information. These interactions may also lower the chance of callers being shamed, chastised and responsibilised for becoming pregnant because to do so in a digitally mediated interaction could lead to the individual putting the phone down or logging off. In these spaces, power operates differently. The patient could leave at any moment, whereas I have shown in my data many patients endure the counselling interaction because it is presented as a mandatory service and a precursor to receiving an actual abortion. In this way, digitalizing abortion counselling in fact, could be a step in advancing reproductive empowerment in South Africa because it provides a domain for people to exercise their autonomy.

E-health platforms are not only concerned with making services available online. Huang et al. (2010) put forward the idea that there are other "e's" which could be incorporated into e- health. I have taken these and reconceptualized what they could look like if implemented within the South African context. E-health abortion services in South African should also strive to be;

- Efficient: Having counselling sessions that address the specifics of the patient (i.e. are patient centred).
- Enhancing quality through upskilling call agents/counsellors and communication awareness training
- Empowering people to be more active and informed in their reproductive decisions
- Ethics: thinking through the emergent ethical issues that present themselves through offering services in new ways

- Equity: Making e-health services available for free should go a long way in increasing accessibility for all.

The benefit of such the WhatsApp platform is that it is free and can be made available 24/7. This could lighten the load on the public health system and would act as a central point where patients can receive a wide array of information relating not only to abortion but also to other reproductive issues and services. The goal of e-health services is not to replace on-site pre-abortion counselling but merely to provide another avenue to access information and services easily and safely. Chatbots can be created across all popular social media platforms (e.g., WhatsApp, Facebook, Instagram).

In closing, I hope I have successfully identified and discussed the conversational landscape of pre-abortion counselling in South Africa. I have provided a summary of the key findings and discussed how current counselling talk practices are problematic. I have argued for a shift from reproductive justice to reparative justice and shown how we may use the framework to make sense of the injustices that occur at various levels but also the ways in which we might seek to bring about change. Thereafter, I discussed some of the limitations and challenges this study experienced and concluded by providing recommendations for future research. I hope those reading this thesis, and the many (already) and forthcoming outputs, to be a fertile foundation for future investigation.

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Appendices

Appendix 1: Ethical approval letter (Rhodes University)

RHODES UNIVERSITY
Where leaders learn

Rhodes University Ethical Standards Committee, Rhodes University, P O Box 94, Grahamstown, 6140
Tel: +27 46 603 7366 . Fax: +27 46 603 8934 . Email: ethics-committee@ru.ac.za

25-Mar-2015

Dear Prof Catriona Macleod

Ethics Clearance: Investigating how Pre-Termination of Pregnancy (PTOP) consultations are conducted within the public health sector in the Eastern Cape, South Africa.

Principal Investigator: Prof Catriona Macleod

This letter confirms that a research proposal with tracking number: RU-HSD-14-12-0004 and title: **Investigating how Pre-Termination of Pregnancy (PTOP) consultations are conducted within the public health sector in the Eastern Cape, South Africa.** was given ethics clearance by the Rhodes University Ethical Standards Committee.

Please ensure that the ethical standards committee is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators. Please also ensure that a brief report is submitted to the ethics committee on completion of the research. The purpose of this report is to indicate whether or not the research was conducted successfully, if any aspects could not be completed, or if any problems arose that the ethical standards committee should be aware of. If a thesis or dissertation arising from this research is submitted to the library's electronic theses and dissertations (ETD) repository, please notify the committee of the date of submission and/or any reference or cataloguing number allocated.

Yours Sincerely,

Professor M. Goebel: Chairperson RUESC.

Appendix 2: Ethical approval letter (Department of Health)

Eastern Cape Department of Health

Enquiries: Zonwabele Merile
Tel No: 040 608 0830
Date: 19th May 2015
Fax No: 043 642 1409
e-mail address: zonwabele.merile@impilo.ecprov.gov.za

Dear Prof C. Macleod

Re: Investigating how Pre-Termination of Pregnancy (PTOP) consultations are conducted within the public health sector in the Eastern Cape, South Africa (EC_2015RP3_60)

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE

PGDP EASTERN CAPE 2004 - 2014

Ikamva eliqqamboleyo!

Appendix 3: Permission letter to conduct research

CRITICAL STUDIES IN SEXUALITIES AND REPRODUCTION RESEARCH PROGRAMME ● Tel: (046) 603 7329 ● e-mail: cssradmin@ru.ac.za

3 June 2015

Dear [Insert name]

Re: Request for permission to conduct research at [insert site name here[

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Rhodes University and the University of York are collaborating in a research project about pre-termination of pregnancy consultations in the two countries. The purpose of this study is to investigate how first trimester pre-termination of pregnancy consultations are conducted within the public health sector in South Africa. It is envisaged that the data collected from this study will allow for a future comparison of a similar study yet to be conducted in Great Britain. As you may know, in Britain abortion may only be performed if it is recommended by health service providers, while, of course, in South Africa a woman may request an abortion up to 12 weeks of gestation. In addition, the social acceptability of abortion and length of time in which abortion has been legal is very different in the two countries. We believe that these differences will have implications in terms of how the pre-termination of pregnancy consultations are conducted. Through this research, we hope to be able to understand best practices around pre-termination of pregnancy counselling in the two countries and to assist in developing ideas on how to improve this aspect of care. We wish to investigate differences across: these two national locations, which differ in their abortion legislation and the levels of social acceptability of abortion; the woman's reproductive age, which has implications for obstetric health risks and possible reasons for seeking a termination of pregnancy; linguistic/cultural features of the consultations, which may shape how healthcare, health-related, and biomedical practices are described in each of the languages used in our study settings (i.e. isiXhosa and English). Our objective is to establish what the implications of these differences/similarities are for the termination of pregnancy health service provision.

We are aware of the fact that the Department of Health has put significant effort into the development of Termination of Pregnancy sites and has provided support for services providers in these facilities (despite opposition to termination of pregnancy from some quarters). As a research team, we share the appreciation of the importance of these services and hope that we

can make a contribution to this effort of the Department by conducting in-depth qualitative research in the area.

The research is funded by the South African Research Chair Initiative of the National Research Foundation and the Department of Science and Technology and will be conducted by a team of senior researchers, researchers and Doctoral and Master's students. The principal investigator is the under-signed, Prof Catriona Macleod, the SARChI in Critical Studies in Sexualities and Reproduction and Professor in the Psychology Department of Rhodes University.

In this letter we request permission to conduct the research at **[insert cite name]**. Should the managers of these facilities not be willing or able to participate, we shall approach similar facilities, and we request your permission to do so.

Data collection in South Africa will involve:

1. Audio or video recording (depending on participants' preference) 75 first trimester pre-abortion consultations between consenting practitioners and women and/or third parties. Sampling will be stratified by the reproductive age of the woman (25 women in each of three age categories: below the age of 20, 20-34 and 35 and above). A researcher will obtain consent, record demographic information and operate the recording equipment, but will not attend the consultations.
2. Interviewing a sub-sample of consenting women after the consultation about their experiences of the consultation.
3. Interviewing practitioners at the end of each day concerning their experiences of the consultations conducted during that day.
4. Waiting room observations which will be overt and non-participatory in nature.

Before the study is implemented, informed consent will be gained from CEOs/managers of the facilities, health service providers, women seeking a termination of pregnancy, and relevant third parties who accompany the women. Information shall be provided verbally, in the preferred language of the participant, and in written form. Participants will only participate in the study once they have stipulated their conditions of participation and signed the informed consent form. Reception staff will be informed of the waiting room observations beforehand. Notices will be placed on the walls of the clinic informing the women of the observational aspect of the study. Women will be informed that should they not wish their interactions in the waiting room to form part of the observational data, they are free to let the researcher know. Please find the letters and informed consent forms that will be used for each of the above-mentioned groups attached for your perusal.

The following ethical procedures will be followed:

- Participation in this study will entirely voluntary, and participants will be free to withdraw from the study at any stage, if they wish to;
- The names of the participants will not appear in any published documentation;

- The field notes documenting the observations and recordings (video and audio) will be stored in a password protected files and hard copy data will be stored in a secure storage space located in the Critical Studies in Sexualities and Reproductive (CSSR) building;
- Only researchers working on this research study will have access to the raw data;

We wish to draw your attention to the fact that, in addition to the above-mentioned ethical principles of voluntary participation, assurance of appropriate confidentiality and anonymity, and the right to withdrawal, the following will apply:

- Although contextual information regarding the clinics (type of facility, average numbers of patients seen, socio-economic and demographic feature of the area) will be included in the research reports, the areas in which the clinics are located will not be revealed and all efforts will be made to ensure that the specific clinics are not identifiable.
- The research is not meant as an evaluation of the clinic's or individual health service provider's performance.
- In feedback meetings, the results from all the clinics will be aggregated in such a way as to make it impossible to identify a particular clinic, health service provider or health service user.
- Health service providers will also be assured that it is not the intention of the research to evaluate their performance and that the information they share will not be shared with the managers of the facilities.

It is envisaged that the research will be of immediate benefit to health service providers in the sense of encouraging reflexive discussion of issues around pre-termination of pregnancy consultation sessions. The more substantial benefit will be in terms of the potential input to termination of pregnancy services in future. Women may benefit in terms of being able to talk with a researcher about their experiences with a non-judgemental researcher.

In terms of risks of participating in the actual research, these are envisaged as being manageable. They are:

(1) Health service providers may see the research as a form of personal evaluation of their performance.
(2) A woman may not engage in full disclosure in the consultation if she is aware that the session is being recorded.
(3) Third parties may not engage in full disclosure if they are aware that the session is being recorded.
(4) Women may feel some distress in recounting how they felt about the consultation in the post-consultation interview.
(5) Women may feel uncomfortable with a researcher observing the interactions they have with health service providers in the waiting room area.

These risks will be ameliorated respectively through:

(1) The above-mentioned stipulation that data concerning particular health service providers' consultations will not be shared with managers of the facilities. This will be emphasised in health service providers' informed consent forms.
(2) Ensuring the women are completely comfortable with being recorded; consultation

sessions will not be recorded where there is any doubt about a woman's level of comfort with the recording. The women will be given the power to switch off the recording in the middle of the consultation should they wish to.

(3) Ensuring that third parties are completely comfortable with being recorded; where third parties are uncomfortable about having what they say recorded, but the woman gives permission, the sections containing the third parties' input will be deleted.

(4) Interviews will be conducted in such a way as to concentrate on the consultation and not on the woman's reasons for wanting to undergo a termination of pregnancy. Interviews will be conducted in a sensitive manner, and if need be, women will be referred to additional counselling support should this be deemed necessary.

(5) Women will be made aware that observations are taking place and that no identifying information will be requested from the woman and/or third party members. Participants will be informed, though the notices placed in the waiting room that if they do not wish their interactions to be part of the field notes, they can communicate this with the researcher.

The senior researchers are experienced in conducting research on reproductive health issues and will ensure that full training of researchers is conducted and that the risks attendant on participating in the research are minimised. Where difficulties may arise (e.g. women relating a traumatic experience), the participants will be referred for counselling to the nearest suitable centre. Permission to refer patients to these centres will be obtained from the centres beforehand.

Once the stages of data collection and analysis have taken place, the researchers will offer feedback meetings to the relevant stakeholders (health service providers, managers, Department of Health). The form of these feedback meetings will be negotiated with the relevant stakeholders.

A full ethical protocol has served before the Rhodes University Ethics Committee. Ethical clearance was obtained on . Please see the attached letter in which ethical clearance is provided.

We formally request the permission of your department to conduct this research and the authority to approach the clinics that might participate in this study. We envisage data collection occurring in 2015 and 2016.

Please do not hesitate to contact me, should you have any further questions regarding this project. The contact details of the principal researcher investigator, Prof Catriona Macleod are: Tel: 046 603 7328; cell: 082 802 9187 and email: c.macleod@ru.ac.za.

Yours sincerely

Prof Catriona Macleod

PRINCIPAL INVESTIGATOR

Attachments:

- Research proposal;
- Rhodes University Ethics Committee approval letter;
- Information and consent forms for health service providers;
- Information letters and consent forms for women and potential third parties.
- Additional consent form for minors.

I, _____, hereby give permission for the CSSR researchers to collect data at the named facilities for the purposive of investigating how Pre-Termination of Pregnancy consultations are conducted within the public health sector of South Africa.

Signature:_____

Date:_____

Appendix 4: Patient and third-party consent form

CRITICAL STUDIES IN SEXUALITIES AND REPRODUCTION RESEARCH PROGRAMME • Tel: (046) 603 7329 • e-mail: cssradmin@ru.ac.za

[Date to be inserted]

Dear service user

I am (insert researcher's name) from Rhodes University. I form part of a research team interested in exploring how pre-termination of pregnancy consultations are conducted in Termination of Pregnancy clinics in South Africa. This study is important in terms of helping us understand these sessions better and in terms of improving these services. Permission to conduct this research has been obtained from the Eastern Cape Department of Health and the [insert suitable hospital/clinic authority].

I invite you to participate to participate in this study. If you agree to participate in the study your participation would involve the following:

1. Allowing us to audio or video record the consultation session; and/or
2. Speaking to us about your experience of the consultation session.

If you prefer to participate in only **one** of these, this is fine.

This is how the research will work:

1. The pre-termination of pregnancy consultation that you will have with the health service provider will either be audio or video (including audio) recorded. The researcher will switch on the recording device(s) and will exit the room. She will not be present when you have your consultation with the health service provider. Once the researcher has exited the room, the consultation session will begin. After the consultation is completed, the researcher will come in and switch the recording device off. The researcher will show you where the off switch is for the recording equipment. If at any stage of the consultation you wish to withdraw from the study you can simply press the off button on the recording devices. In such an instance all previous recordings will be deleted by the researcher after the consultation.
2. The interview you will have with the researcher after the consultation with the health service provider will be audio-recorded. The health service provider will not be present during this interview. You will have a chance in this session to speak about your experience of the consultation. You will not be asked to speak about the reasons for your decision or any other aspect of your life, unless you specifically want to speak about these issues.

Please understand that your participation in this study is completely voluntary and you are not being forced to take part. Although we would really value your participation, the choice of whether to participate is yours alone.

If you choose to, or choose not to, participate in this study, the services you receive will not be affected in any way whatsoever. If you agree to participate, you may stop at any time and discontinue your participation. If you withdraw at any stage, this will not affect the services you receive at the Termination of Pregnancy clinic.

In order to protect you, we will not be recording your name for the purposes of this research. Instead, we ask that you make up a name, called a pseudonym. You can sign the consent form with this name, if you wish.

We will, however, ask that you please provide your age. Only the researchers working on this study will have access to this information.

The recordings of the consultations sessions and of the interview with the researcher will be kept in a safe place and will only be accessed by researchers on the project. The video recordings will not be used in any publications or presentations. This is to protect you so that nobody but the researchers is able to identify you. The purpose of the video recordings is to give the researchers a better picture of the consultation.

The health service providers will not have access to your interview material and will not be told what you specifically said about the session.

If, at any time in the process you feel upset, you may end your participation. For example, you can turn off the recording during the consultation and you can ask for the interview to stop. In addition, the researcher will provide details of a counsellor should you feel that you would like to make use of these services.

If you have a person with you (for example, partner, parent, friend, relative) who will participate with you in the consultation session, they must also give their consent to participating in the research. If this person does not want to participate, but you do want to, then we will simply delete the section of the recordings where she or he is speaking.

In addition to the above, one of our researchers will be observing the interactions that take place between service providers and women in the waiting room. Notices about these observations have been put up in the waiting room area. Please communicate with the researcher if you would like her to not include any of the interactions you have with the health service providers in her observations.

If you have any questions about this study, please feel free to ask me. In addition, if there are questions that you feel I have not answered, or if you have concerns about the research, you may contact Prof Catriona Macleod, the principal researcher, at Rhodes University by calling her on 046-603-7329.

If you have a complaint about any aspect of this study, you may also contact the Rhodes University Ethical Standards Committee by calling 046-603-8055 or e-mailing ethics-committee@ru.ac.za

(THE ABOVE SECTION IS TO BE KEPT BY THE PARITICPANT)

TERMINATION OF PREGNANCY CONSULTATION RESEARCH PROJECT

WOMAN PARTICIPANT CONSENT FORM:

I hereby agree to participate in this research project that seeks to explore how pre-termination of pregnancy consultations are conducted in Termination of Pregnancy clinics in South Africa. Please tick to indicate your response in the below box.

I agree to the following:	Yes	No
1.1.The pre-termination of pregnancy consultation session that I will have with the health service provider being recorded. 1.2..If you answered yes to the above question, please indicate with a tick how you would prefer the consultation to be recorded Video recorded ☐ Audio recorded ☐		
An interview with the researcher after the pre-termination of pregnancy consultation session.		
The audio recording of the above-mentioned interview.		

I understand that I am participating freely and without being forced in any way to do so. I understand that at any point if I wish not to continue I can withdraw from participating in the study without any negative consequences.

The purpose of this study has been explained to me, and I understand what is expected of my participation. I have kept a copy of the written explanation given to me.

I have received the telephone number of a person to contact should I need to speak about any issues that may arise due to participating in this study.

I understand that this consent form will not be linked to any recording, and that the conversation recorded will remain anonymous and video recording confidential.

I understand that no personally identifying information will be released in any form. I understand that these recordings will be kept securely in a locked environment.

I understand that if I do not want any of the conversations I have with health service providers in the waiting room form part of the research I will communicate this to the researcher.

My pseudonym is: _____

I am _____ years old.

I am currently (please tick where appropriate)

Employed ☐

Unemployed ☐

Still in school ☐

_____	_____
Signature of participant	Date
_____	_____
Signature of the researcher	Date

Where relevant, third party consent (partner, parent, friend, relative, acquaintance or any other person accompanying the woman)

The information shared with the person I am accompanying has also been shared with me. I understand the purpose of this study, and I understand what is expected in terms of data collection.

I agree to the following:	Yes	No
1. The sections of the recording of the pre-termination of pregnancy consultation where I speak may be used for the study.		
2. The sections of the interview with the researcher after the pre-termination of pregnancy consultation session where I speak may be used for the study.		

I am the _____ (state your relationship with the participant).

_____ _____

Signature of third party Date

_____ _____

Signature of researcher Date

ADDITIONAL AGREEMENT BETWEEN WOMAN YOUNGER THAN 18 AND RESEARCHERS CONCERNING PARENTAL OR GUARDIAN CONSENT: TO BE OBTAINED AFTER THE CONSULTATION BUT BEFORE INTERVIEW

In addition to the agreement signed above, I confirm that I have spoken to the health service provider about the possibility of consulting with my parent or guardian about my decision to terminate my pregnancy.

I confirm that:	Tick only one option
1. I have chosen not to consult my parent/guardian about my decision and that I would like to continue in my participation in the research	
2. I have decided to consult my parent/guardian about my decision and feel that I would like their consent to participate in the research	
3. My parent/guardian has accompanied me to the clinic and gives his/her consent for me to participate in the research	
4. My parent/guardian has accompanied me to the clinic and does not give his/her consent for me to participate in the research	

If you have chosen to No. 2 above, please let us know how we can contact your parent/guardian. If they do not provide their consent, we will delete the recordings of your consultation session and interview.

_____ _____

Signature of participant Date

_____ _____

Signature of researcher Date

If you have chosen No. 4 above, your parent/guardian should sign the following:

I have read and agree to all the conditions of participation contained in the letter of information and consent form provided to my daughter/custodian, and hereby consent that she may participate in the research.

_____ _____

Signature of parent/guardian Date

Appendix 5: Health service provide consent final

CRITICAL STUDIES IN SEXUALITIES AND REPRODUCTION RESEARCH PROGRAMME ● Tel: (046) 603 7329 ● e-mail: cssradmin@ru.ac.za

[Date to be inserted]

Dear service provider

I am (insert researcher's name) from Rhodes University. I form part of a research team interested in exploring how pre-termination of pregnancy consultations are conducted in Termination of Pregnancy clinics in South Africa. This study forms part of a larger study in which we hope to compare, in the future, how pre-termination of pregnancy consultations are conducted in Britain with those conducted in South Africa. As you may know, in Britain abortion may only be performed if it is recommended by health service providers, while, of course, in South Africa a woman may request an abortion up to 12 weeks of gestation. In addition, the social acceptability of abortion and length of time in which abortion has been legal is very different in the two countries. We believe that these differences will have implications in terms of how the pre-termination of pregnancy consultations are conducted. With your assistance, we hope to be able to understand best practices around pre-termination of pregnancy counselling in the two countries and to assist in developing ideas on how to improve this aspect of care. Permission to conduct this research has been obtained from the Eastern Cape Department of Health and the [insert suitable hospital/clinic authority].

We invite you to assist us in the following way:

3. By allowing us to record the pre-termination of pregnancy consultation sessions that you conduct during the day.
4. By speaking to us in an interview conducted at the end of the day about your experience of the various consultation sessions. In this session the researcher will ask you about what aspects of the consultation sessions you felt went well and what challenges you encountered with specific women or specific situations.

Data for this study will be collected in the following ways:

3. The pre-termination of pregnancy consultations that you provide will be either audio or video (including audio) recorded. The researcher will switch on the recording device(s) and will exit the room. She will not be present during the consultation. Once the researcher has exited the room, the consultation session will begin. After the consultation is completed, the researcher will come in and switch the recording device(s) off.
4. The interview you will have with the researcher at the end of the day about the

consultation sessions will be audio-recorded.
5. Interviews with individual women about their experiences of the consultation.
6. Observations of interactions in the waiting room.

Please understand that your participation in this study is completely voluntary. If you agree to participate, you may stop at any time and discontinue your participation.

In order to protect you, we will not be recording your name for the purposes of this research. In addition, the research is being conducted at a number of sites. While a general description of the sites will appear in the research (e.g. located in a town or city, offering first trimester only or also second trimester abortions), the names of the actual sites or the town/city in which they are located will not be revealed. We ask that you make up a name, called a pseudonym. You can sign the consent form with this name, if you wish.

The recordings of the consultation sessions and of the interview with the researcher will be kept in a safe place and will only be accessed by researchers on the project. The video recordings will not be used in any publications or presentations. This is to protect you so that nobody but the researchers is able to identify you. The purpose of the video recordings is to give the researchers a better picture of the consultation.

Please note that this research is NOT an evaluation of your performance (good or bad) as a health service provider. No feedback on how you, specifically, conducted the sessions will be provided to the management of the facility. When feedback is provided, it will be in form that makes it impossible for management or any other parties to identify specific individual health service providers.

Please also note that, for similar reasons of confidentiality, we will not be able to share what individual women said about their specific consultation. You will, however, have access to the over-arching findings of the research.

I am attaching the information sheet that will be given to potential woman participants for your perusal.

If you have any questions about this study, please feel free to ask me. In addition, if there are questions that you feel I have not answered, or if you have concerns about the research, you may contact Prof Catriona Macleod, the principal researcher, at Rhodes University by calling her on 046-603-7329.

If you have a complaint about any aspect of this study, you may also contact the Rhodes University Ethical Standards Committee by calling 046-603-8055 or e-mailing ethics-committee@ru.ac.za

(THE ABOVE SECTION IS TO BE KEPT BY THE PARITICPANT)

PRE-TERMINATION OF PREGNANCY CONSULTATION RESEARCH PROJECT

HEALTH SERVICE PROVIDER CONSENT FORM:

I hereby agree to participate in this research project that seeks to explore how pre-termination of pregnancy consultations are conducted in Termination of Pregnancy clinics in South Africa. Please tick to indicate your response in the below box.

I agree to the following:	Yes	No
1.1 The recording of the pre-termination of pregnancy consultation session that I will conduct with various women. 1.2 If you answered yes to the above question, please indicate with a tick how you would prefer the consultation to be recorded Video recorded ☐ Audio recorded ☐		
An interview with the researcher about these sessions at the end of the day.		
The audio recording of the above-mentioned interview.		

I understand that no personally identifying information will be released in any form. I understand that these recordings will be kept securely in a locked environment.

I understand that I am participating freely and without being forced in any way to do so. I understand that at any point if I wish not to continue I can withdraw from participating in the study without any negative consequences.

The purpose of this study has been explained to me, and I understand what is expected of my participation. I have kept a copy of the written explanation given to me.

I have received the telephone number of a person to contact should I need to speak about any issues that may arise due to participating in this study.

I understand that this consent form will not be linked to any audio or video recording, and that the conversation recorded will remain anonymous.

My pseudonym is: _____

For how many years have you been providing termination of pregnancy services? _____

_____ _____

Signature of participant Date

_____ _____

Signature of researcher Date

Appendix 6: Reasoning for consent procedures for women under the age of 18 in this study

This study seeks to explore how pre-termination of pregnancy consultations are conducted within the public health sector of South Africa. The Choice on Termination of Pregnancy Act (No. 92 of 1996) (CTOP Act) states that in the case of a minor (i.e. a woman under the age of 18) medical professionals and clinic staff shall advise the minor to consult her parents, family, guardians and friends before the termination of pregnancy. However, the CTOP also makes it clear that termination of the pregnancy will not, and cannot, be denied because such minors choose not to consult any one of the above-mentioned persons. All that is required is the consent from the pregnant woman, irrespective of her age.

The supreme court of appeal upheld a constitutional challenge to the CTOP Act by the Christian Lawyers Association in 2004. The Christian Lawyers Association challenged the provisions of the Act that allowed for minors to choose to have their pregnancies terminated without (a) the consent of the parents or guardians, (b) consulting the parents or guardians (c) first undergoing counselling and (d) reflecting on their decision or decisions for a prescribed period. Whilst the plaintiffs contended that young women below the age of 18 are not capable of making an informed decision on their own regarding the termination of pregnancies, the court upheld the rights of the minors to do so in accordance with the Constitution of the Republic of South Africa.

The Department of Health's (2004) Ethics in Health Research document, which provides guidelines for health related research, states that "adolescents may be capable of consenting themselves to certain types of research participation and that, for particular types of research, it may be desirable that they do so unassisted" (p. 22). The desirability of their participating in the research without parental consent has to do with the potential risks associated with having to seek parental consent, as would be in the case where the minor has decided to terminate a pregnancy without consulting her parent/guardian, for whatever reason.

These guidelines have been endorsed by a number of researchers (Human-Vogel, 2007; Singh et al., 2006; Strode, Slack & Essack, 2010; Strode et al., 2009). Singh et al. (2006), for example, argue that the guidelines make it possible to investigate valuable and necessary sexuality-related research on adolescents and that there is growing recognition in South Africa of the autonomous decision-making abilities of young individuals. They indicate that requiring additional parental or guardian consent may: (1) be logistically impossible; (2) serve as a breach of the confidentiality of research participants; and (3) place the participant at potential risk of harm, especially in relation to sensitive issues such as HIV, and termination of pregnancy. Each of these applies in the case of this research. Firstly, when a minor arrives for a termination of pregnancy without a parent/guardian, obtaining consent for participation in the proposed research would be logistically difficult. Secondly, if a minor has chosen to not inform her parent/guardian about the termination of pregnancy, then speaking to the parents/guardian about the research would violate her right to confidentiality. Keeping the CTOP Act stipulation regarding minors in mind, it would seem that not being able to consent to participation in a research project stands in contradiction to the adolescent's right to access termination of pregnancy services and their right to share their experience of it with a

researcher. Thirdly, a minor may have chosen to not consult her parent/guardian for a number of reasons, including, for example, fear of violence or abandonment by the parent/guardian, or the pregnancy being the result of incest, or sexual abuse by a relative. Seeking parental consent for participation in research would put the minor at increased risk.

According to the Department of Health (2004) guidelines, minors may autonomously consent to participate in a study provided that four conditions are met. These conditions are: 1) that the adolescent participant is placed at no more than a minimal risk; (2) that the nature of the research is such that, in the opinion of the research ethics committee, the parents, legal guardians or community at large are unlikely to object to the adolescent consenting herself to participation in the research; (3) the research protocol provides sufficient evidence to justify clearly why adolescents should be included as participants and why they should consent unassisted and (4) the purpose of the activity must be to meet the health needs of the mother and the risk to the foetus should be minimal. Each of these conditions will be addressed below.

With regard to the first condition, we are confident that the adolescent participant will not be placed at more than a minimal (and containable) risk by participating in the study, as the research aims to collect data about the health service encounter and not about the pregnancy or the decision to terminate the pregnancy. In addition, the opportunity for a young woman to share and reflect on her interactions within the reproductive health system may increase her chances of positive outcomes following the termination of pregnancy, particularly if all the issues of informed consent, voluntary participation, privacy and confidentiality are dealt with appropriately.

With regard to the second condition, we are guided, as indicated above, by the CTOP Act and the judgment of the constitutional court in which “the community at large” affords a minor the right to have a termination of pregnancy without the consent of her parents or guardians. Given this, the right to participate in research in which pre-termination of pregnancy consultations are investigated must follow. Although parents, guardians and local communities may disagree with the legalization of abortion in South Africa, this study only wishes to acquire consent from a minor to record and talk about consultation sessions, not to enter into any informed consent regarding the actual abortion procedure.

In regards to the third condition, research indicates that obstetric outcomes are considered to be different depending on maternal age. The extremes of the reproductive ages (older than 35 and younger than 18) are considered risk factors for negative obstetric outcomes (Cleary-Goldman et al., 2005; de Vienne, Creveuil & Dreyfus, 2009). The health service providers will have been educated regarding the differing obstetric outcomes, and it may form part of how they, themselves, think through the necessity of an abortion and how they interact with the woman during the counselling consultation. In addition, given that early reproduction is frequently seen as a social problem (see Macleod, 2011), it is possible that various socio-cultural understandings of teen-aged pregnancy may feature in the pre-termination of pregnancy consultations.

In relation to point four, the study does not aim to meet any direct health needs of any participants, and by the same token this study, in an of itself, has no direct risk for the foetus.

Participation in this study will not comprise the health of the woman or the health service provider.

Appendix 7: Example of translated data

IsiXhosa	English verbatim	English conceptual
C: Molweni bethuani P: Molo sister C: Emvakwemini. Nifikile apho kwenziwa khona i- abortion bethunana. Siyevana? Njengokuba silapha funeka si-understand okokuqala ukuba i- abortion ivunyelwe neh ngumthetho ukuba iyenziwe kwi-, kwziBhedlele ezithile ne- clinic ezithile zika rhulumente. Siyevana? Ivunyelwe ngumthetho. P: Mhmm	C: Hello, people P: Hello, sister C: After the day, you have arrived there it is being done there abortion, people. Do we hear each other? As we are here there needs be we understand firstly that abortion has been allowed, right by law, that it should be done at hospitals that are specific and clinic that are specific of the government. Do we hear each other? It has been allowed by law. P: Mhmm C: They are many then the kinds of abortion that are being done and then these abortions it	C: Hello, people P: Hello, sister C: This afternoon, you have arrived at the place where abortion is done. Do you understand? As we are here, we need to understand firstly that abortion is authorized by the law for it to be done at certain public hospitals and clinics. Do you understand? It has been authorized by law. P: Mhmm C: There are many kinds of abortion and it depends on how many months you have been pregnant. Do you understand, people? But